MEDICAL INTERACTION IN TRADITIONAL CHINESE MEDICINE

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ABSTRACT OF THE DISSERTATION

Medical Interaction in Traditional Chinese Medicine

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This dissertation employs the research methods of conversation analysis to examine a collection of 51 hours of naturally-occurring video recordings of patient-provider interactions in the context of Traditional Chinese Medicine (TCM). Drawing upon previous research on medical interaction and conversation analysis, this dissertation explores the interactional construction of TCM encounters by examining the following aspects of TCM consultations: the opening sequences of TCM encounters; bystander participation in TCM encounters and companion involvement in TCM encounters.

First, I analyze the structure of opening sequences in TCM consultations. I show that opening sequences in the context of TCM visits are organized into a series of activities, including initiating the visit, securing patient identity, initiating pulse-taking and launching medical talk; Second, I examine the *sui generis* interactional phenomenon of bystander participation. I show that when the patient displays resistance towards the doctor’s medical opinion, a bystander may join the patient’s consultation spontaneously or upon the doctor’s invitation. To help address or offset patient resistance, the bystander may enact different roles, such as an illness-free contrastive case, a witness to the
patient’s clinical manifestation and a testament to the effectiveness of the doctor’s
treatment. Third, I explore the patient’s companion’s involvement in the patient’s visit. I
show that patient’s companion’s category membership and category-bound rights and
obligations become relevant during the process of companion participation. Overall, this
dissertation has broader implications for our understanding of medical interaction,
especially interaction in the context of TCM, patient participation, patient resistance,
multi-party interaction and conversation analytic research. Future research could build on
the findings presented in this dissertation in examining the interactional organization of
TCM visits and work to provide practical implications for TCM doctors and patients.
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TABLE OF CONTENTS

ABSTRACT OF THE DISSERTATION ................................................................. ii

ACKNOWLEDGEMENTS ........................................................................... iv

TABLE OF CONTENTS .............................................................................. vi

LIST OF TABLES ......................................................................................... x

LIST OF FIGURES ...................................................................................... xi

CHAPTER ONE: INTRODUCTION .............................................................. 1

HISTORICAL BACKGROUND OF TCM ................................................. 3

BASIC ELEMENTS OF TCM ................................................................. 4

TCM IN CHINA: THE PRESENT ............................................................... 6

SPECIAL CHARACTERISTICS OF TCM ENCOUNTERS IN CHINA ............ 7

Characteristic One: Unique Physical Environment Of Chinese Hospitals .... 8

Characteristic Two: Collectivities In TCM Encounters ............................ 10

Characteristic Three: Using Diagnostic Methods In TCM To Formulate Diagnostic Evidence ......................................................... 11

Characteristic Four: Blurred Line Between Medical Expertise And Lay Knowledge In TCM ................................................................. 12

Characteristic Five: The Chronic Nature Of TCM Visits ......................... 13

PREVIEW OF CHAPTERS ...................................................................... 22

CHAPTER TWO: LITERATURE REVIEW ............................................... 24

PROVIDER-PATIENT COMMUNICATION: AN OVERVIEW .................... 24
UTILIZING CA TO UNDERSTAND HEALTHCARE INTERACTIONS ................................................................. 26

COMMUNICATION-RELATED RESEARCH ON TCM ............................................................................... 27

RELEVANT CA LITERATURE ...................................................................................................................... 30

Institutional CA ........................................................................................................................................... 31

Medical CA .................................................................................................................................................. 34

Overall Structure Of Medical Consultations .............................................................................................. 34

Patient Resistance ....................................................................................................................................... 37

Other Relevant CA Research ....................................................................................................................... 40

Membership Categories ............................................................................................................................... 40

Conversational Openings ........................................................................................................................... 41

CHAPTER THREE: DATA AND METHODS ................................................................................................. 43

DATA COLLECTION AND ANALYSIS ......................................................................................................... 47

SUMMARY ..................................................................................................................................................... 50

CHAPTER FOUR: OPENING SEQUENCES OF TCM VISITS ...................................................................... 52

INTRODUCTION ........................................................................................................................................... 52

CORE COMPONENTS IN THE OPENING SEQUENCES OF TCM VISITS .................................................... 53

Initiating The Visit ......................................................................................................................................... 56

Patient-Initiated Openings: Openings Without Summons/Answer Sequence ........................................... 57

Doctor-Initiated Openings: Openings With A Summons/Answer Sequence .............................................. 64

Securing The Patient’s Identity .................................................................................................................. 77

Securing Identity Before The Patient Sits Down ....................................................................................... 78

Securing Identity After Patient Sits Down .................................................................................................. 80

When Securing Patient’s Identity Is Omitted ............................................................................................. 88
VOLUNTARY BYSTANDER PARTICIPATION ................................................................. 187

BYSTANDER PARTICIPATION THAT COUNTERS THE DOCTOR’S LINE OF ACTION ...... 196

DISCUSSION & CONCLUSIONS ............................................................................. 216

Summary Of Findings ............................................................................................ 216

CHAPTER SIX: COMPANION PARTICIPATION IN TCM VISITS ......................... 221

INTRODUCTION ....................................................................................................... 221

SOLICITED COMPANION PARTICIPATION .......................................................... 225

VOLUNTARY COMPANION PARTICIPATION ....................................................... 268

CONCLUSIONS AND IMPLICATIONS .................................................................. 320

Summary Of Findings ............................................................................................ 320

Implications .......................................................................................................... 321

CHAPTER SEVEN: CONCLUSIONS ........................................................................ 324

PATIENT-PROVIDER INTERACTION ..................................................................... 328

The Structural Organization Of Medical Encounters ............................................ 328

Triadic Medical Interaction .................................................................................... 331

Membership Categories And Category-Bound Activities ..................................... 333

Communication In TCM ....................................................................................... 334

Practical Implications For TCM Patients And Doctors ......................................... 335

Limitations ............................................................................................................. 336

Future Directions .................................................................................................. 339

REFERENCES .......................................................................................................... 341

APPENDIX A: TRANSCRIPTION CONVENTIONS .................................................. 377
LIST OF TABLES

Table 1: Types of TCM Visits.................................................................48
Table 2: Distribution of Cases Based on How They Are Initiated..............56
Table 3: Distribution of Types of Pulse-taking Initiation.........................96
Table 4: Types of Medical Talk and Distribution........................................120
Table 5: Distribution of Two Types of Bystander Participation..................147
Table 6: Distribution of Two Types of Companion Participation...............222
LIST OF FIGURES

Figure 1-A: Crowded TCM Doctor’s office.................................................................8
Figure 1-B: Crowded TCM Doctor’s office.................................................................9
Figure 2: Phase Structure of Acute Care Visits........................................................34
Figure 3: Activity-focused Model of Medical Encounters........................................35
Figure 4: Two TCM Practitioners Participated in This Project.................................47
Figure 5: Extract 3 Office Layout and Participant Location......................................68
Figure 6: Extract 4 Office Layout and Participant Location......................................69
Figure 7: Distribution of Organs in Different Locations...........................................94
CHAPTER ONE
INTRODUCTION

Researchers have long acknowledged the importance of capturing the interactional dynamics of medical consultations, since it has significant impact on health outcomes and patient satisfaction (Frankel, 1984; Heritage & Drew, 1992; Lambert et al., 1997; Mikesell, 2013; Thompson et al., 2011). One way of understanding patient-provider communication is by examining naturally occurring conversations that take place in the healthcare setting (Heritage & Maynard, 2006). This dissertation utilizes conversation analysis (henceforth, CA; Sidnell & Stivers, 2012) to understand the “interaction order” (Goffman, 1983) of medical communication in the context of Traditional Chinese Medicine (henceforth, TCM). I show how TCM consultations are interactionally structured and describe various activities that are unique to TCM consultations. Specifically, I show how the opening sequences of TCM encounters are organized (Chapter 4), and how third parties (specifically, bystanders (Chapter 5) and patients’ companions (Chapter 6) get involved in TCM consultations.

Since the current body of literature on medical interaction focuses heavily on Western biomedicine that consist of consultation for acute medical conditions (Heritage & Maynard, 2006; Gill Teas & Roberts, 2012; see a detailed review in the literature section), this dissertation provides insight into an area that is underexplored: the interactional organization of TCM visits. Additionally, since most TCM encounters are
chronic care visits, my findings also shed light on the communication dynamics of chronic care visits. Consistent with prior conversation analytic work on health interactions (Heath, 1986; Heritage & Sefi, 1992; Heritage & Robinson, 2006; Stivers, 2007), this dissertation holds the position that the medical context is “talked into being”, meaning that the institutional setting is constructed through communication between doctors and patients.

Rooted in Garfinkel’s (1967) ethnomethodology and Goffman’s (1957) view of conversation as a social system in its own right, CA emerged as a field in the 1970s through the collaboration of Harvey Sacks, Emanuel Schegloff and Gail Jefferson. Earlier CA work primarily examined the interactional organization of everyday conversations, explicating the social reasoning underpinning action, by focusing on such topics as turn-taking, sequence organization, preference and repair (Atkinson & Heritage, 1984; Jefferson, 1987; Pomerantz, 1978, 1984; Sacks, Schegloff & Jefferson, 1974; Schegloff, 1968, 1972; Schegloff & Sacks, 1973). Importantly, these studies all focused on the social actions that are accomplished in and through different interactional practices (Atkinson & Heritage, 1984). A key contribution of CA research is to understand human communication processes from the participants’ perspective, explicating “members’ methods” (Sacks, 1984a, b, 1992; Maynard, 2012). CA was later applied to other interactional settings to understand how social institutions are created and sustained through participants’ interactional practices (Drew & Heritage, 1992; Heritage & Clayman, 2010).

Before introducing my findings, I provide some background information about TCM, one of the most widely accepted branches of Complementary and Alternative
Medicine (CAM). This background information sets up a framework that is useful for understanding what I show in the analytical chapters of this dissertation.

**Historical Background of TCM**

As an integral part of Chinese culture, TCM has been employed by the Chinese people for over 3,000 years. As early as approximately 772 BC, TCM started to break away from religion and became an independent field (Lu et al., 2004). In the meantime, many schools of philosophy started to emerge. Many terms in TCM are borrowed from concepts in these philosophical schools, such as *yin* and *yang*, *qi* (energy), and *wuxing* (five elements: metal, wood, water, fire and earth). TCM continued to evolve and mature over time with the development of Chinese civilization. Until the 17th century, TCM was the only approach to health and wellness that Chinese people knew and employed. In the late 17th century, Western medicine was introduced to China and gradually started to take over the health market because of its efficacy and safety. However, Chinese medicine still plays an important role in the treatment of certain conditions, such as the management of chronic illnesses. In Chinese society today Western biomedicine and TCM are practiced simultaneously. TCM practitioners in China receive training in both areas to practice legally, and they normally practice these two approaches at the same time. Although a lot of TCM practitioners mainly use TCM approaches for diagnosis and only prescribe TCM medicine, they may also use advanced tools from Western medicine (such as different forms of medical tests) to confirm their diagnostic theories or prescribe Western medicine for some acute conditions. It is required that all TCM hospitals have two separate pharmacies, one for TCM and one for Western biomedicine.
TCM is one of the most established and popular CAM approaches. In order to make sense of the activities and practices within the TCM setting, it is crucial to know the essential underlying assumptions of TCM, and how these assumptions may impact the medical encounters in various ways.

**Basic elements of TCM**

Rooted in the philosophical school of Taoism, TCM offers a different perspective from Western medicine on how the human body functions. There are several major underlying assumptions in TCM that influence all aspects of its practices. TCM practitioners tend to look at the human body as a “miniature version of the larger, surrounding universe” (NIH, n.d.). The ideal state of the body should be a good balance between two opposing yet complementary forces: *Yin* and *Yang*. *Yin* represents the natural force that is passive, negative and feminine, while *Yang* represents positive, energetic and masculine. *Yin* and *yang* are interdependent within the body. Physicians use the concepts of “heat”, “cold”, “dryness” and “dampness” to measure a person’s health state. Like *Yin* and *Yang*, these elements are opposite yet interdependent. The ideal state is a perfect balance, which means that the patient has the right temperature and humidity inside his/her body. Illnesses will occur if this balance is compromised. If the physician claims that you are “damp”, “dry”, “having intrinsic heat” or “cold”, it means that your body is no longer balanced. Some symptoms of being out of balance are known to the patients while some others can only be observed or felt by the practitioners. For instance, being “damp” is associated with the external symptoms of sweating too much or having eczema. Being “dry” on the other hand, will cause intrinsic heat within the body, which will contribute to symptoms such as constipation and coughing. “Heat” in TCM is
normally related to symptoms such as sore throat, toothache and acne breakout. “Cold” triggers symptoms such as insomnia, bad circulation and fatigue. These are usually symptoms that patients themselves can experience or observe. However, there are some other symptoms that are not so accessible to patients, such as the coating of the tongue, the pattern of the pulse or even the appearance of the complexion. Only after years of TCM training can physicians connect these symptoms with the patient’s health condition.

The four diagnostic methods that are most commonly used in TCM practice are inspection (wàng), auscultation and olfaction (wén), inquiry (wèn) and palpation (qiè). These four methods, along with a case history and symptom description, are used by the practitioners to gather medically relevant information from the patients. These methods are critical in TCM consultations since they reflect the fundamental concepts of TCM. They also help draw the line between TCM and Western biomedicine. It is worth noting that nowadays physicians in China use these diagnostic methods to complement Western biomedical tests, especially when patients have an acute problem.

TCM uses herbal remedies rather than chemical compounds. Also, practices such as therapeutic massage, acupuncture and dietary therapy are widely used among TCM practitioners and patients. Unlike Western medications where one drug cures one disease, Chinese herbs work collaboratively to achieve a certain effect. This is the most controversial part of TCM, since many medical scientists are concerned about the antagonistic interactions between different drugs. It is also a common belief among followers of TCM that TCM works slowly, especially compared to Western biomedicine. Patients need to use a remedy over an extended period of time for the remedy to work effectively (Jiang et al., 2012). Another major characteristic of TCM medicine is that it is
relatively low cost (Burke et al., 2003). This may offer a partial explanation for the continuing popularity of TCM medicine among Chinese people. After visiting a TCM practitioner, the patients usually take home a treatment regimen which includes TCM medicinal soup (or premade tablets).

**TCM in China: The present**

Nowadays, although many people have realized that the effectiveness of TCM therapeutic practices is yet to be scientifically validated (Nuwer, 2012), TCM is still an important, even indispensable component of Chinese people’s healthcare. Promoting TCM has always been one of the major goals of the health sector of the Chinese government since TCM is considered to be an essential part of the Chinese culture. In *Medical and Health Services in China (2012)*, the Chinese government acknowledges the significant role of TCM in Chinese people’s lives by stating that “TCM is the crystallization of the wisdom of the Chinese people and has made important contributions to the continuance and thriving of the Chinese nation.” (p.1). This document also mentions that the government strives to promote TCM in both urban and rural areas by building networks of TCM medical services. Since it is such an integral part of the Chinese culture, ideologies in TCM have greatly influenced the way Chinese people think about health and wellness. It is the Chinese government’s goal to promote a “dual” medical system, in which both TCM and Western biomedicine are combined to provide high-quality healthcare to the Chinese people.

In recent years, among many other CAM approaches, TCM has found its way into the U.S. as well. As one of the major categories of alternative medicine, TCM practices have successfully attracted attention from both health professionals and ordinary people.
According to research conducted by the CDC, “Among U.S. adults aged 18 and over in 2002, 2007, and 2012, the percentage who used any complementary health approach in the past 12 months ranged from 32.3% in 2002 to 35.5% in 2007 and was most recently 33.2% in 2012” (CDC, 2015). Many TCM practices such as Taichi ³ and Qigong⁴ are now widely accepted among adults in the U.S. Also, the Chinese American population in the U.S. has been steadily rising in recent years (PEW research center, 2019). In areas that are heavily populated by Chinese or other Asian people, TCM clinics are very popular not only among Asian Americans, but also people from other countries. Some of the top hospitals in the country have opened up centers that offer Chinese herbal treatment to their patients (Reddy, 2014).

Special characteristics of TCM encounters in China

Extensive research has been conducted in Western primary care that looks at different aspects of medical interviews. (For a more detailed review, please see the literature review chapter). There are many characteristics of the TCM medical encounter that distinguish it from medical encounters in the Western settings, and create constraints, opportunities and affordances for both parties involved in medical interactions in TCM. Understanding these characteristics helps us understand how interactants in TCM encounters manage to “do” TCM and achieve therapeutic goals collaboratively. In this section, I discuss the following unique characteristics of TCM visits in China that have an important bearing on the interactional phenomena that I examine in this dissertation:

³ A type of Chinese martial art practiced for health purposes
⁴ A type of spiritual practice used to promote health of both body and mind
First, the unique physical environments in which TCM interactions occur; second, the phenomenon that patients sometimes visit the doctor’s office in groups; third, TCM practitioners’ dependence on the four traditional diagnostic methods and the basis they form for diagnosis; fourth, the thin line between lay knowledge and medical expertise in TCM encounters; and fifth, the fact that many TCM visits are for chronic care, and how that impacts the overall structural of the encounter.

**Characteristic one: Unique physical environment of Chinese hospitals.**

TCM encounters normally take place in crowded doctors’ offices (see Figure 1). This provides an environment for many interesting interactional phenomena, including the phenomenon of bystander participation, described in Chapter 5 of this dissertation. TCM practitioners in China are faced with different challenges and tasks than their American counterparts who usually work in a quiet, private environment.

![Figure 1-A: Crowded TCM doctor’s office](image)

<table>
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Studies of primary care visits in the U.S. and U.K. have shown that they tend to follow a distinctive overall structural organization with very little variation (Byrne & Long, 1976; Heritage & Maynard, 2006; Robinson, 2003). Given the unique, busy environment in which TCM encounters usually take place, an ongoing consultation is at risk of intervention by different parties (another patient, other medical professionals and/or the patient’s companion(s)). Therefore, we might expect to see differences in how medical encounters are structurally organized in the TCM setting. In Western countries such as the U.S., medical interactions normally only involve two parties: the practitioner and the patient. Some doctors may accept walk-ins, but most patients have scheduled an appointment with the doctor beforehand. In China, on the other hand, the physical environment and scheduling procedures are different. Patients need to get to the hospital early in the day to register in the queuing system of the hospital. Each of the patients is assigned a number, according to their order in the queue. When they arrive at the doctor’s office, they usually hand the receipt to the doctor and wait for their turn. The room in which the doctor works is also the patients’ waiting room. The doctors’ computers are
programed so that they can see who is next in the queue. Patients keep track of the order of the queue by closely monitoring the activities at the doctor’s desk so that they can approach the doctor’s desk at the right moment. However, waiting in line sometimes does not stop patients from intervening into an ongoing consultation for different purposes. For instance, they may intervene to ask a practical question about their own appointment; or they may participate in the already ongoing consultation. Patients who have already been seen by the doctors may also return for something and in that case, they are allowed skip the line. Moreover, sometimes doctors share an office with another doctor. Both doctors’ patients are within range of potentially participating in the other’s ongoing consultation, which may make the ongoing consultations more permeable, and susceptible to interventions. These characteristics of the physical environment make possible various unique interactional phenomena and have an impact on how medical encounters in this setting are organized structurally.

**Characteristic two: collectivities in TCM encounters.**

A second characteristic of TCM is related to the fact that many Chinese patients come to the hospital as a group. The relationships among the co-present patients vary. They might be friends, family members or coworkers. Sometimes, patients who do not know each other might be “bundled” by the physicians because of their similar medical concerns. Current CA research on medical interaction mostly concerns interaction between one patient and one doctor. The TCM setting, on the other hand, provides an environment for participants beyond the doctor-patient dyad to participate in the consultation. This special characteristic of TCM makes the medical setting a likely domain for us to gain more knowledge about multi-party interaction, and the interactional
practices that interactants use to manage, maintain and negotiate the boundaries of
different relationship categories, as Chapter 5 and Chapter 6 of this dissertation show.

**Characteristic three: using diagnostic methods in TCM to formulate diagnostic evidence.**

The third characteristic of TCM relevant to the current project is related to the
formulation of an evidential basis for diagnosis in TCM practice, especially its
connection with the aforementioned four diagnostic methods. Looking at actual
interaction between TCM practitioners and patients may shed light on how doctors in
TCM ground their diagnosis and justify their treatment plan, and how they do so relying
on the information gathered by using TCM diagnostic methods. Many researchers argue
that medical reasoning in Western medicine is opaque (Parsons, 1951) because of the
knowledge gap between the doctor and his or her patient. In the case of TCM encounters,
the medical reasoning is both opaque and transparent, in the sense that although patients
may be capable of self-diagnosis relying on their knowledge of TCM diagnostics, and
their observable and sensible symptoms, physicians also make their medical decisions
based on other symptoms that are not necessarily noticeable to the patients. Western
medicine, on the other hand, relies heavily on technology-based tests such as CT scans,
blood tests and X-Rays. It is commonly believed that these tests are likely to give reliable
and accurate results. During the extensive medical training that they receive, Western
physicians learn how to make diagnoses based on how the body functions as a biological
system. When it comes to serious illnesses, physicians’ observations are normally
supported by test results. These tests, along with doctors’ medical knowledge, help
doctors in the Western biomedical setting formulate informed medical opinions. Medical practitioners in TCM, on the other hand, draw conclusions on the overall wellbeing of the patient based simply on the four diagnostic methods. This poses challenges for TCM practitioners when they have to justify their medical decisions. While Western physicians may formulate evidence by showing the results of technology-based tests (explaining the test results; showing the X-Rays etc.), TCM physicians have to reveal the underlying mechanism of some TCM theories (how the human body is an interconnected system, etc.). This characteristic of the TCM encounter makes diagnostic claims more susceptible to patient resistance, given that there is no visible scientific evidence for doctors to show to patients to get them on board with the diagnosis and treatment recommendations. Most data segments presented in Chapters 5 and 6 of this dissertation have some form of patient resistance.

**Characteristic four: blurred line between medical expertise and lay knowledge in TCM**

The last characteristic of TCM encounters that is relevant to the present study is related to the fine line between medical expertise and lay knowledge in TCM. As mentioned earlier, TCM was originally a part of Taoism. Many terms and much jargon in TCM are not used exclusively by professionals. Chinese people are sometimes capable of associating symptoms with health conditions. The thin line between medical expertise and lay knowledge poses special challenges for physicians. It creates potential opportunities for patients to question or challenge physicians’ medical diagnoses and decisions. TCM encounters offer a site for researchers to examine closely how patients resist physicians’ medical decisions, and the interactional consequences of their resistance. This is shown in Chapters 5 and 6 in this dissertation, where patients deploy
different interactional practices to display their reluctance to accept the doctors’ medical opinions. Similar observations have been made by Stivers (2007), who found in her research on pediatric visits that with the growing popularity of searching for medical information online, patients may have the tendency to use what they have learned online to challenge and sometimes resist doctors’ medical decisions. While this trend may be increasing in Western medicine, it is endemic to TCM because of its diagnostic techniques (the aforementioned four diagnostic methods) as well as its seemingly opaque medical reasoning processes.

**Characteristic five: the chronic nature of TCM visits**

Most TCM visits in my data collection were chronic in nature, meaning that the patients visit the doctors’ offices on a regular basis, normally weekly or biweekly, rather than coming in only for acute health problems. Although in some of the cases, the patients did have some concerns that they wished to address, their visits were not motivated by those concerns. Robinson (1999; 2003) pointed out that acute care visits are organized into a series of activities that revolve around the project of addressing the patients’ presenting problem(s). Chronic care visits, on the other hand, may be structured differently since the main therapeutic goal of these visits is to manage a chronic condition and/or maintain the body’s balance. In the case of TCM visits, patients see doctors routinely for the purpose of maintaining their health. Hence, medical activities are implemented to help accomplish this goal. In the first analytical chapter (Chapter 4), we see how opening sequences of TCM visits are organized differently than the openings of acute care visits, in ways that foster a visit for chronic health maintenance.
In summary, research is needed to investigate how TCM encounters are interactionally constructed. Past research on TCM has focused on external factors that contribute to the health outcomes of TCM practices (Xu et al., 2006; See detailed review in Chapter 2). Less is known about the interactional practices through which TCM visits are collaboratively constructed.

By examining closely medical interactions in TCM, the current dissertation contributes to our understanding of how they are co-produced by participants in an orderly way, on a moment-by-moment basis. I examine three different aspects of TCM encounters: a) the opening of TCM visits (Chapter 4); b) bystander involvement in TCM visits (Chapter 5) and c) companion participation in TCM visits (Chapter 6).

In the first analytic chapter (Chapter 4), I examine how the opening sequences of TCM encounters are interactionally organized. Opening sequences in different interactional settings have been examined thoroughly by CA scholars (Pillet-Shore, 2008, 2018; Robinson, 1998; Schegloff, 1968, 1979, 1986). These studies established that while openings of interactions seem mundane and routine, their successful unfolding is a moment-by-moment interactional achievement of all parties involved. My analysis of the openings of TCM encounter aligns with these studies by showing how TCM doctors and patients work together closely to get ready for the official medical business.

In Chapter 4, I outline the core components of TCM visit openings and provide brief explanations of the interactional task that each of these components accomplishes. I also offer a detailed analysis of how the opening phase of TCM consultations is organized by showing a case in which interactants display a clear orientation to the
normative “ingredients” of TCM openings and discuss other cases in which the same component is implemented/constructed in a different fashion.

I first examine the activity of initiating the visit. I show that most TCM patients closely monitor the registration queue and approach the doctors’ desk without having to be summoned. The summons-answer sequence occurs in only two situations: first, when the patient queue is disrupted by no-shows or patients who cut the line; second, when the doctor and/or the patient’s view is obstructed so it is difficult to keep track of what is going on.

The second component of TCM visits is securing patient identity. As established in Robinson (1998), by engaging in this activity, doctors and patients accomplish a crucial institutional task that is preparatory to dealing the patient’s presenting problem. In TCM encounters, this task carries special significance because of the registration queue. Doctors need to make sure that patients’ names match the record they see in the registration system. Additionally, since it is common for patients to use other people’s insurance, doctors need to confirm that they are charging the right insurance when prescribing the medication.

The third component, which is unique to TCM visits, is the initiation of the pulse-taking activity. Pulse-taking is a way for TCM doctors to gather medically relevant information and is also the first diagnostic activity in the patients’ visit (Luo & Chung, 2016). The initiation of pulse-taking marks the official beginning of the medical business of TCM visits. Findings of this dissertation suggest that both parties (doctors and patients) display a clear orientation towards the interactional significance of pulse-taking.
The last component of the opening sequence of TCM consultations involves the initiation of medical talk. My analysis suggests that the launching of medical talk is coordinated with the beginning of pulse-taking, meaning that doctors and patients treat the beginning of pulse-taking as an indication that the activity of data gathering should begin and that they should proceed to talk about medical issues. However, compared to medical talk initiated by the doctor, patient-initiated medical talk is noticeably delayed, delivered after a brief pause after the beginning of pulse-taking. This may indicate that at the beginning of the data gathering phase, patients normatively give the doctor the first opportunity to initiate medically relevant talk.

Findings from this chapter indicate that in line with Schegloff (1986) and Robinson and Stivers (2001)’s discovery, TCM doctors and patients work together to achieve the beginning of the TCM encounter and the successful transition from the opening sequence to the official business of the medical visit. The core components (summons-answer; securing patient identity; initiating pulse-taking, launching medical talk) of TCM openings presented in this chapter are implemented to accomplish different tasks.

In the second analytic chapter (Chapter 5), I examine the \textit{sui generis} phenomenon of bystander participation in TCM encounters. I describe how a bystander (someone unacquainted with the patient) may become involved in a current patient’s consultation. Two forms of bystander involvement are identified: solicited bystander participation and voluntary bystander participation. I draw on Goffman’s (1981) notion of “bystander”, described in his account of focused interaction. Bystanders in this chapter are co-present individuals who are unacquainted with the patient. They are in the doctor’s office for
their own visit but may still participate in the patient’s consultation due to their close proximity to the doctor’s desk. According to Goffman (1981), bystanders are not part of the ongoing, focused interaction unless they are licensed to join by one of the legitimate participants. Findings from Chapter 5 show that the doctor may recruit a bystander to join the patient’s ongoing consultation and deploy them to accomplish different tasks, such as to help formulate the evidential basis of the doctor’s diagnosis or to demonstrate the effectiveness of the doctor’s proposed treatment. When the patient is manifesting an observable, clinical sign, a bystander may be presented by the doctor as a healthy, contrastive case to show the patient what is wrong with their physical appearance. In TCM encounters, the doctor’s involvement of a bystander, showing the patient their clinical manifestation, is deployed to address patient resistance and engage the patient in the diagnostic reasoning process. Similarly, in the treatment activity, the doctor may recruit a bystander, who used to have the same condition that the patient currently has, using them as a recovered case to demonstrate the effectiveness of the recommended treatment.

In contrast, I also find that a bystander may spontaneously insert themselves into the interaction. This kind of voluntary bystander participation is also predominantly responsive to patient resistance. Most cases of voluntary bystander participation occur after the patient has displayed resistance towards the doctors’ medical opinions. Bystanders participate in the patient’s consultation spontaneously to either support the doctor’s course of action (such as diagnosis delivery and treatment recommendation) or to contest the doctor’s course of action.
In the third analytic chapter (Chapter 6), I examine a different kind of third-party involvement in the patient’s visit, companion participation. Companion participation is not a new topic in the field of health communication. Studies have pointed out that patients’ companions may play different roles in medical consultations (Laidsaar-Powell et al., 2013; Wolff et al., 2017). Within the context of TCM, companion participation is very common, given that patients frequently visit the doctor’s office with their spouses or other family members. Findings from this chapter reveal that like the bystanders discussed in Chapter 5, patients’ companions may also join the patients’ consultations spontaneously (voluntary participation) or upon the doctor’s invitation (solicited participation). Companion participation in TCM is also occasioned by patient resistance.

To demonstrate how solicited companion participation works, I show cases in which the doctors enlist the patients’ companions to assist the doctors in implementing the doctors’ lifestyle advice, such as making dietary changes or adopting a form of exercise. I argue that in so doing, the doctors invoke the spousal category by requesting the companions to fulfill their category-bound obligations (Sacks, 1992; Schegloff, 2007). However, the doctors’ effort to form a coalition with the patients’ companions may be successful or unsuccessful. When faced with conflicting sets of category-bound rights and obligations, the patients’ companions may choose to side with the patients or align with the doctors.

Next, I address cases of voluntary companion participation. Findings in this section show that patients’ companions may also contribute to the medical consultation voluntarily, without being prompted by the doctors. Patients’ companions in TCM visits frequently participate in patients’ consultations to offer medically relevant information to the doctors and to help with the diagnostic process. However, after carefully examining
the cases, I found that these reports of information are in fact sometimes “Trojan Horses”. That is while companions purportedly raise issues to support the doctors’ diagnosis or recommendations, as the interaction unfolds it becomes clear that these issues were deployed by the patients’ companions to pursue their own interactional projects, such as convincing the patients to drop an unhealthy life habit, or to adopt a practice that is good for the patients’ health. During the process of companion participation, membership categories and category-bound rights and obligations are frequently invoked and made consequential for the interactants.

By examining specific communication practices in TCM encounters, this dissertation contributes to the health communication literature in the following ways. First, although there is an extensive body of literature on patient-provider interactions (Gill & Roberts, 2013; Heritage & Maynard, 2006; Robinson, 2011), more research is needed to understand the communication dynamic of “nonconventional” medical interactions such as CAM encounters. This dissertation addresses this gap by offering insights into the interactional organization of TCM visits. As revealed by the findings from this dissertation, TCM encounters have some unique features that are related to the nature of the TCM culture and the operation of TCM hospitals. For example, medical activities involved in TCM visits are organized differently than Western primary care visits because of TCM’s unique diagnostic methods and treatment regimen. For example, the official medical business in TCM visits normatively starts with pulse-taking, rather than the doctors soliciting the patients’ presenting concern (Robinson & Heritage, 2006). Since TCM patients are not always in the doctor’s office for a “doctorable” problem, but rather for the monitoring and remediation of chronic concerns (Heritage & Robinson,
2006), doctors may request updates from patients on their past conditions, ask routine questions (such as patients’ sleep quality or appetite) or make observations of patients’ physical appearance instead of asking the patient to give the reason for their visit (Heritage & Robinson, 2006). Also, in TCM encounters, the activities of treatment recommendation and lifestyle discussion are combined, since TCM treatment is a regimen that is comprised of two components: TCM (herbal) medicine and lifestyle changes. When doctors propose a treatment plan, they recommend certain lifestyle changes for the patients as well as medicinal soup. This finding regarding the location of lifestyle discussions extends the existing body of literature that focuses on medical consultations that take place in Nordic countries and North America (Larsson et al., 1987; Johansson et al., 1994; Waitzkin & Britt, 1993). Additionally, the prevalence of lifestyle discussions in TCM visits provides further evidence that lifestyle discussions are carried out differently in different cultures (Sorjonen et al., 2006).

Second, findings from this dissertation have implications for our understanding of the intersection of territories of knowledge between doctors and patients. In this dissertation, I show that the boundaries between medical expertise and common knowledge are permeable in TCM, which may explain the prevalence of patient resistance in TCM visits. Additionally, TCM practitioners’ diagnostic conclusions build on their experience and medical knowledge, rather than presentable, scientific evidence. In this dissertation, we see doctors engaging in extensive case-building for their diagnostic claims to walk their patients through the evidential basis for their medical opinions. Sometimes, third parties such as a bystander or patients’ companions may get involved or be incorporated to help doctors build a stronger case for their diagnosis
and/or treatment recommendations. While current research on patient resistance focuses on how patients implement resistance (Stivers, 2007; Koenig, 2011), findings from this dissertation also shed light on how patients’ resistant moves are responded to by doctors. These findings have implications for our understanding of patient participation, shared decision making and patient adherence (DiMatteo et al., 2002; Elwyn et al., 2016; van Dulmen et al., 2007) by offering insights into how patients participate in the medical consultations in the institutional setting of TCM, a domain that is currently underexplored.

Third, findings from this dissertation engage in more in-depth conversation about topics in conversation analysis such as the overall structural organization of the medical consultation, and the interactional construction of relationship categories and collectivities in the institutional setting. In this dissertation, I draw on Robinson’s (2013) notion of interactional activity and look at the overall structure organization of TCM consultations as an activity that is structured around the goal of helping the patient maintain their health. I show that since these are chronic care visits there may not always be a particular reason for visit. Therefore, medical activities in TCM visits are more loosely structured than primary care visits. Findings in this chapter add to the current body of literature on other types of chronic care visits, such as the research that examines psychiatric visits (Angell & Bolden, 2015; Bolden & Angell, 2017). By focusing on the opening sequences of TCM visits, I show how the activities that take place at the beginning of TCM visits are organized in such a way as to ensure that doctors and patients can “get down to business” in a smooth, efficient manner. These findings contribute to our understanding of overall structural organization in a general sense.
My analysis of membership categories is built upon Sacks’ (1992) and Schegloff’s (2007) discussions of categories and category-bound rights and obligations. I show how such categories as doctor, patient, spouse and parents become “operatively relevant” (Sacks, 1992, p. 495) for doctors and patients during the process of companion participation. As Schegloff (2007) stated:

“one can allude to the category membership of a person by mentioning that person’s doing of an action that is category bound, and the doing of a category-bound action can introduce into a scene or an occasion the relevance of the category to which that action is bound” (p. 470).

Membership categories become relevant when interactants invoke rights, obligations and activities that are associated with these categories. For example, a patient’s father may enact being a father by making treatment decisions on the daughter’s behalf, or a patient’s wife’s membership in the spousal category may be invoked by the doctor when the doctor enlists her to help implement dietary changes, treating her as the food preparer in the family, a category-bound obligation. These findings contribute to our understanding of how membership categories and collectivities are interactionally constructed, managed and negotiated on a moment-by-moment, turn-by-turn basis in naturally occurring TCM institutional interactions.

Preview of Chapters

In Chapters 2 and 3, I provide the theoretical and methodological background of this dissertation. Chapter 2 includes a literature review of the following fields of study: patient-provider communication, communication in CAM and medical conversation analysis. I also briefly review conversation analytic research that is relevant to the
interactional phenomena covered in this dissertation. The aim of this literature review is to show how this dissertation contributes to the existing body of literature in the areas of health communication and conversation analysis. In Chapter 3, I present the theoretical backdrop of conversation analysis, as well as an explanation of how data collection and analysis were conducted in this dissertation.

There are three analytical chapters in this dissertation. In Chapter 4, I examine the opening sequences of TCM visits by showing how they are interactionally organized. In Chapter 5, I look at bystander participation in TCM consultations. Chapter 6 focuses on the involvement and contribution of the patients’ companions to TCM visits. Findings from these analytical chapters are summarized in Chapter 7. Here I also discuss the implications and limitations of this dissertation and future directions for research on patient-provider interaction, multi-party interaction and communication in TCM.
CHAPTER TWO
LITERATURE REVIEW

This dissertation is situated at the intersection of several lines of research. I explore the interaction between TCM practitioners and patients. First, therefore, it is important to review existing research in the field of patient-provider communication, specifically, the studies that focus on the interactional processes that constitute the institutional setting of medical encounters, in order to demonstrate why it is important to adopt a more interaction-sensitive approach to understand health communication. Second, I review communication-related studies that examine TCM and other branches of CAM. Although the research topic of patient-provider communication has been thoroughly examined, research on interactions in medical cultures other than Western biomedicine are rarer. This is a gap that I address in this dissertation. Lastly, this study utilizes the method of conversation analysis (Sidnell & Stivers, 2012) to examine TCM encounters from an interaction-focused perspective. In the last part of the literature review, I discuss studies in the field of CA that informed my dissertation research and upon which it builds.

Provider-patient Communication: An Overview

Health communication embodies a wide variety of topics that focus on different issues of communication in healthcare. Some streams of health communication research
examine broad, macro-level issues, such as health campaigns and promotions through the use of different media platforms (Dillard et al., 2020; Flora, 2001; Greenberg & Gantz, 2001; Jeong & Bae, 2018; Maibach & Parrot, 1995) and social determinants of health that may disproportionately affect certain demographics and generate health disparities (Marmot, 2005; Solar & Irwin, 2010; Wilkinson & Marmot, 2003). Other scholarly investigations study organizational issues related to health. For example, scholars have explored the communication dynamics within healthcare organizations from an institutional perspective (Meyer & Scott, 1983; Scott, 1995; Scott et al., 2000), focusing on different components of the communication process. On a more micro level, there is an extensive body of research that sees doctor-patient communication as the front-and-center issue in health communication (Emanuel & Emanuel, 1992; Ha & Longnecker, 2010; Ong, De Haes, Hoos & Lammes, 1995; Roter, 1977, 1984; Stewart, 1995; Stewart & Roter, 1989). It has been established that effective doctor-patient communication may enhance patient satisfaction and maximize health outcome (Pascoe, 1983; Thompson, & Sunol, 1995; Woolley et al., 1978). Hence, it is crucial to understand what constitutes effective doctor-patient communication (Hall, 2003; Waitzin, 1984) and to identify practices that may help healthcare professionals improve their communication skills (Anderson et al., 1987; Anderson & Sharpe, 1991; Roter et al., 1998). Some of these studies have adopted a more interaction-sensitive approach by examining the communicative practices that doctors and patients use in medical encounters (Fisher & Todd, 1983; Frankel & Beckman, 1982; Shuy, 1983). Specifically, research that utilizes the method of CA brings to light some “seen but unnoticed” (Garfinkel, 1964) practices of communication that interactants frequently deploy to talk the medical context into
being (Heritage & Maynard, 2006; Robinson, 2001; 2006; Teas Gill & Roberts, 2013). This dissertation furthers this line of research by identifying and examining the interactional practices that doctors and patients use to achieve their therapeutic goals in the TCM setting.

In the next section, I focus on CA research that views medical encounters as being constructed on a moment-by-moment, turn-by-turn basis in order to show the unique perspective that interaction-focused research brings to the realm of patient-provider interaction.

**Utilizing CA to Understand Healthcare Interactions**

Conversation analysts have long been interested in examining the “interaction order” (Goffman, 1983) of provider-patient communication. Earlier conversation analysis and discourse analytic work on doctor-patient interaction engages in systematic examinations of the interactional organization of primary care visits, showing how doctors and patients coordinate medical activities using both verbal and bodily actions (Atkinson & Heath, 1981; Frankel, 1983, 1984; West, 1984).

Medical CA has covered a plethora of topics, including the overall structure of medical encounters (Robinson, 1998, 2001, 2006); how patients raise their medical concerns (Halkowski, 2006; Heritage, 2011; Heritage & Robinson, 2005, 2006; Robinson, 2006; Robinson et al., 2016); how doctors deliver and ground their diagnosis (Heath, 1981; Maynard, 1991; Peräkylä, 1998, 2002; 2006) and how shared decision making is achieved in the treatment phase (Stivers, 2007; Koenig, 2011; Lindstrom & Weatherall, 2015; Landmark et al., 2017; Mikesell, 2016; 2020). These CA studies of the medical setting have offered a unique lens through which to examine closely interactants’
experiences and orientations within the medical context. Some of the communication patterns identified by CA researchers have important practical implications. For example, Heritage and Robinson’s (2006; 2011) work shows how something as small as physicians’ lexical choices (using “some” instead of “any” when asking patients if they have other concerns) can help address patients’ concerns and increase patient satisfaction. Stivers (2007) on the other hand demonstrates what constitutes patient resistance in an interactional sense, and what some of the strategies are that physicians deploy to manage this resistance. All of these studies bring to light interactional details of provider-patient communication. As Heritage and Robinson (2014) pointed out, medical CA research findings have proven to be “robust in the context of cross-sectional, preintervention studies” (p. 216). While traditional health communication research offers general findings about patterns of communication in healthcare settings, CA observations zoom in on specific communication practices that are grounded in the actual interactions that can be developed into interventions that help doctors and patient improve the effectiveness of their communication. In this dissertation, I extend the current body of literature on medical CA by focusing on a relatively underexplored therapeutic context: Complementary and Alternative Medicine (CAM), specifically TCM. In the next section, I review the existing body of literature that investigates communication-related issues in TCM.

**Communication-related Research on TCM**

TCM’s popularity has grown significantly in the past years, and it is likely to continue growing in the future (Ernt & Coon, 2001; Yang et al., 2020). Researchers who specialize in Western biomedicine have explored the possibility of integrating TCM
therapeutic methods into Western biomedical treatment options (Cohen, 2004; Klimeno & Julliard, 2007; Roberts et al. 2008) and emphasized the importance of interprofessional communication between Western biomedicine and TCM practitioners (en-Arye et al., 2009; Steel et al, 2015)). The current body of literature that examines TCM communication focuses primarily on three topics: a) the factors that may impact patients’ disclosure or non-disclosure of TCM use (Adler et al. 2009; Chao et al. 2008; Corner et al. 2009; Engdal et al. 2008; Kennedy et al. 2008; Robinson & McGrail 2004); b) how and why patients discuss TCM treatment options with their healthcare providers (Chen et al., 2000; Horneber et al., 2011; 1999; Robinson & McGrail, 2004; Xue et al., 2007); and c) the communication outcomes of discussing TCM treatment in Western biomedical visits (Liu et al., 2009; Perlman et al. 1999; Richardson et al. 2004). There are also some more interaction-sensitive studies that examine naturally-occurring TCM encounters, such as Ho (2016); Pun & Chor (2020) and Zhang & Chor (2021). These studies are focused on how certain TCM concepts, such as Yin and Yang and the notion of Holism\(^5\) are interactionally constructed by TCM doctors and patients. Although these topics are important and interesting, the focus of this dissertation is on different questions that further elucidate communication in the TCM setting:

First, what are the communication dynamics between TCM practitioners and their patients? Although TCM has now been accepted by many people in the Western society,

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\(^5\) The concept of holism of traditional Chinese medicine comes from ancient Chinese philosophical thoughts; it adopts a comprehensive point-of-view of “time-space-human” to elucidate diseases; it emphasizes the coordination and unity among humans’ social background, living conditions, mental psychology and quality of human life.
very few scholars have examined closely the communication processes that take place in TCM visits. Current studies discuss using TCM as a way of improving patients’ experience (Alder et al., 1999; Powell, 2002; Richardson et al., 2000) but fail to address what actually happens in TCM practitioners’ offices. Research is needed to understand how TCM practitioners and patients communicate with each other, and the possible health outcomes of these TCM visits. The findings of this dissertation address this gap in current research.

Second, current TCM-related studies discuss TCM in very general terms. TCM is a broad concept that encompasses many practices, such as the use of massage, Tai Chi, herbal tea, acupuncture, meditation etc. These practices come from different branches of traditional medicine with different medical ideologies. When researching TCM use, researchers very frequently combine these practices despite their significant differences. Therefore, it may be worthwhile to examine these practices individually, in a more systematic way,

Third, current research on communication in TCM is predominantly quantitative. Although these studies have yielded a general overview of TCM use in different Western societies, a focus on the actual communication practices that TCM practitioners and patients use in its original setting is needed. There has been some seminal work that investigates communication in and about TCM by looking at naturally occurring encounters (Ho, 2006; Ho & Bylund, 2008; Koenig et al., 2012 - see a more detailed review in the next section), but more studies are needed in order to obtain a better understanding of the interactional construction of TCM visits.
This dissertation fills these gaps in the literature: first, it focuses on the communication processes in actual TCM encounters, rather than conversations about TCM in Western biomedical visits. Following a different medical ideology, TCM encounters are structured differently than Western biomedical visits. It is important to look at the actual communication practices deployed by TCM practitioners and patients in order to discover the orderliness of TCM consultations in its “natural habitat”.

Also, this dissertation looks at patient-provider communication by examining the interactional practices utilized by TCM doctors and patients. While the current body of literature on TCM use emphasizes how frequent and under want situations conversations about TCM occur (Corner et al. 2009; Engdal et al. 2008; Kennedy et al. 2008), this dissertation focuses on how TCM encounters unfold on a moment-by-moment basis by utilizing the research method of CA (Sidnell & Stivers, 2012). In the next section, I introduce the main areas of CA research that have informed this study.

Relevant CA Literature

This dissertation utilizes CA to understand the interactional construction of TCM visits. Originated in the 1960s, CA is an approach to human sociality that focuses on the social order of naturally occurring everyday interactions. Seminal studies in CA were inspired by Goffman’s work on “interaction order” (Goffman, 1983) and Garfinkel’s groundbreaking studies in ethnomethodology (Garfinkel, 1967). The main subject of CA investigation is “talk-in-interaction” (Schegloff, 1987), the verbal and nonverbal actions produced by interactants when they engage in everyday conversations.

Early work on CA was primarily situated in the context of mundane conversations between friends and families (Jefferson, 1974, 1978; Sacks et al., 1978; Schegloff, 1968,
1972; Schegloff & Sacks, 1973), focusing on the basic mechanisms and principles of talk-in-interaction. Some of the key areas in CA research include turn-taking and turn allocation (Jefferson, 1973, 1984; Sacks, et al., 1974; Schegloff, 1987); sequence organization (Kendrick et al., 2020; Schegloff & Sacks 1973; Schegloff, 2007); repair operations (Lerner & Kitzinger, 2013; Schegloff et al., 1977); and action formation (Levinson, 2012). These areas of research are central to robust CA analysis since they provide a toolbox for examining closely the orderliness of human interaction. Within this extensive body of research, some topics are particularly relevant to this dissertation. First of all, institutional CA has provided a basic framework for me to understand the relationship between interaction and the institutional context. Second, my analytical work in this dissertation draws heavily on CA studies of medical interaction, particularly those that focus on the interactional practices that doctors and patients deploy in the medical activities of diagnosis delivery and the negotiation of treatment proposals. These studies offer me an apparatus through which to analyze similar issues that occur in the TCM context. Lastly, there are some core notions in CA that I applied throughout my data analysis, such as membership categorization and openings in different types of interactions. Next, I review each of these three topics by elucidating how are they connected to my dissertation findings.

**Institutional CA**

As mentioned earlier, initial investigations in CA focused mainly on mundane interactions. In their classic study on courtroom interaction, Atkinson and Drew (1979) offered a valuable perspective on how activities in the courtroom setting were interactionally organized and constructed. Inspired by this important work, researchers
brought CA into other institutional contexts, such as emergency calls (Tracy, 1997; Whalen & Zimmerman, 1998; Zimmerman, 1984, 1992); news interviews (Clayman & Heritage, 2002a; Clayman & Heritage, 2002b, 2009; Greatbatch, 1988; Heritage & Roth, 1995); classroom (Carroll, 2000; Koshik, 2002; Lee, 2007; Macbeth, 2003, 2004; McHoul, 1978, 1990). These CA studies of institutional settings have revealed some unique and important features of institutional talk and formulated how it relates to yet is different from everyday interaction. It is important when examining interaction in an institutional setting to bear in mind some of institutional interaction’s stable features, as follows.

Drew and Heritage (1992) proposed that *institutional interactions are goal-oriented*, meaning that "participants organize their conduct by reference to general features of the tasks or functions of particular social institutions as they understand them within either a vernacular or technical competence" (p. 22). This is demonstrated in many of the studies I have discussed so far. For example, 911 call-takers need to manage callers’ emotions properly to make sure that they collaboratively go through the institutional process and achieve the ultimate goal of sending help if needed (Kevoe-Feldman & Pomerantz, 2018; Whalen et al., 1988). In the case of classroom interactions, teachers utilize the unique speech exchange system in that particular setting to design their questions accordingly, so the students can maximize their study outcomes (Carroll, 2000; Waring & Hruska, 2012). In this dissertation, analysis of data revolves around TCM practitioners’ and their patients’ joint efforts to smoothly transition from one medical activity to another to successfully achieve the therapeutic goal of maintaining the
patients’ health. Hence, anything that prevents the progressivity of the consultation may constitute a form of resistance that needs to be addressed (Stivers, 2005).

A second feature of institutional talk is that interactants’ contributions are constrained by the institutional setting (Drew & Heritage, 1992). That is, the interactants display a clear orientation towards the institutional context. In certain institutions, such as in legal proceedings, news interviews and classroom interactions, interactants display a strong orientation towards the formal processes within these contexts. Another example is the case of doctor-patient interactions, where both parties understand the medical visits to have distinctive activities. They display an orientation towards this structure by producing activity-specific actions, such as getting ready for the pulse-taking activity, as I show in this dissertation.

The last feature of institutional talk that is relevant to the current dissertation is the unique frame of reference in institutional settings (Drew & Heritage, 1992). The same social action may be understood differently in institutional talk than it is in everyday conversations. For example, Heritage and Sefi (1992) documented interactions between health visitors and first-time parents during home visits. They found that the health visitor’s simple utterance, “He [the baby] is enjoying that [the bottle] isn’t he” was understood differently by first-time mothers and fathers in this institutional context (p. 367). While the father treated this as a simple observation from the health visitor, the mother oriented to the health visitor’s utterance as alluding to her not feeding the baby properly. I have identified a similar phenomenon in my data, where some patients’ actions (e.g., minimal responses, newsmarks etc.) are understood as resistant or even disruptive by TCM practitioners because by responding in this way to doctors’ treatment
recommendations patients resist fully embracing doctors’ diagnosis and/or treatment recommendations.

**Medical CA**

Earlier in this literature review, I discussed briefly some of the main topics that CA researchers have examined within the healthcare context. In this section, I go into detail about the branches of medical CA that are relevant to the current dissertation.

**Overall Structure of Medical Consultations**

Byrne and Long (1976)’s groundbreaking work demonstrated how primary care consultations have a phase structure. Figure 2 below shows the canonical sequential order of medical activities that take place during a primary care visit.

**Figure 2: Phase Structure of Acute Care Visits (Byrne & Long, 1976)**
Although Byrne and Long's phase model is widely accepted, Robinson (1999) proposed an alternative way of looking at primary care visits. He pointed out that although most medical encounters have some of the components listed in Figure 2, these visits are better understood to be revolving around the institutional goal of solving the patient's medical problem. Additionally, doctors and patients have subordinate goals that they achieve collaboratively in each of the phases (see Figure 3). Hence, medical encounters should be perceived as consisting of a series of activities that doctors and patients participate in.

**Figure 3 Activity-focused Model of Medical Encounters (Robinson, 2003)**

Robinson (2003) further proposed that this activity-focused model of medical visits may help researchers and practitioners better understand patient participation. This is evident in many studies that examine medical interactions. For example, in Activity #1 (problem presentation, see Figure 3 above), Heritage and Robinson (2006) found that
doctors formatted their questions relative to the kind of medical concerns that patients have (p. 45). Not formatting the questions properly, on the other hand, had interactional consequences. Focusing on the physical examination, Heritage and Stivers (1999) showed that doctors deploy certain interactional practices, specifically online commentary, to shape patients’ expectations about the upcoming diagnosis. In terms of Activity #3 (diagnosis delivery), Peräkylä (1998, 2001) identified different ways for doctors to formulate their diagnostic claims and described how these different formulations may encourage or discourage participation from patients. Patients also have room for negotiation in the treatment phase, as indicated by Stivers (2007). In summary, the conversation analytic model of primary care visits offers valuable insights into the facilitation of patient-centered care (Mikesell & Bromley, 2012) where patients participate in the decision-making processes. This dissertation builds heavily on Robinson’s (2003) discoveries about Western primary care. There are similarities between how TCM visits unfold and the overall structural organization of Western primary care visits (see Chapter 4 for more details) in the sense that TCM consultations are also composed of a series of medical activities. Each medical activity is motivated by a sub-goal: for instance, the activity of data collection is driven by the goal of obtaining diagnostically relevant data while the treatment recommendation activity is motivated by the interactants’ need to find the most appropriate treatment for the patient. However, as Chapter 4 reveals, since TCM encounters are predominantly chronic in nature with a different therapeutic goal than Western acute care visits, the activities are organized in a different fashion (for example, see the organization of openings in Chapter 4).
Patient Resistance

Chapters 5 and 6 of this dissertation draw upon CA research on patient resistance. Patient resistance, according to Stivers (2007), may be overt or tacit. Overt patient resistance occurs when patients (or their companions) actively challenge or contest the doctor’s medical advice. Tacit resistance, on the other hand, includes situations in which the patients (or their companions) withhold acceptance of the doctors’ medical decisions. Either way, patient resistance engenders sequence expansion and slows down the progressivity of the medical visit. CA researchers have long acknowledged the importance of patient cooperation in medical consultations in the advancement of the medical agenda (Robinson & Stivers, 2003; Stivers, 2007). As shown in the previous section, medical visits are organized into a series of medical activities. The successful transition from one medical activity to another requires that doctors and patients collaborate interactionally. Next, I discuss how patient resistance becomes an obstacle in the following type of medical activities: physical examination, diagnosis delivery and treatment recommendation. A finding of this dissertation is that patient resistance may occasion bystander or companion involvement, suggesting that it is something to which doctors, patients and others in the medical setting are alert.

Prior research on patient resistance has demonstrated that during the activity of physical examination, Western biomedical doctors sometimes forestall patients’ resistance by deploying the interactional practice of online commentary (Heritage and Stivers, 1999; Mangione-Smith et al., 2003; Stivers, 1998). Heritage & Stivers found that online commentary, “talk that describes what the physician is seeing, feeling or hearing during physical examination of the patient” (p. 1501) shapes patients’ expectations about
the upcoming “no problem” diagnosis and helps preemptively address potential patient resistance to doctors’ treatment recommendations. I show in Chapters 5 and 6 of this dissertation that TCM patients sometimes display resistance while doctors are conducting the physical examination\(^6\) by not fully embracing doctors’ clinical observations and that doctors combat this by involving bystanders and/or patients’ companions in the ongoing consultations to address or offset patient resistance.

Patients may also display resistance to doctors’ diagnostic claims, although this does not occur frequently. In the context of pediatric visits, Stivers et al. (2003) discovered that in cases where the patients (children) suffered from ear infections, their parents resisted doctors’ diagnostic claims in only 17% of their cases. Nonetheless, it is deployed by patients as a resource to negotiate diagnostic and treatment outcomes (Stivers, 2007, p. 77). In the sequential environment of diagnosis delivery, patient resistance is manifested in three different forms: newsmarks (Heritage & Sefi, 1992), questions about the symptoms and questions about the diagnosis (Stivers, 2007, p. 81). All three forms of patient resistance to diagnosis are observed in my data collection (see Chapters 5 & 6 for detailed analysis). These forms of patient resistance have in common the fact that they each generate sequence expansion and make relevant more talk about the diagnosis so that doctors and patients cannot move to the next activity of treatment recommendation smoothly. Chapters 5 and 6 of this dissertation show that within the context of TCM, patient resistance to diagnosis delivery is quite common (71% of all patient resistance cases). Similar to the research discoveries made by researchers on

\(^{6}\) In TCM visits, an important form physical examination is “inspection”, where TCM doctors carefully inspect the patients’ physical appearance and report their observations. Patient resistance frequently occurs when this activity is taking place.
Western biomedical encounters, patients in TCM resist doctors’ diagnostic claims in similar ways: they explicitly reject the diagnostic evaluation or do so in a more tacit way by withholding acceptance or delivering newsmarks.

In my data as well as in Western medicine patient resistance is observed very frequently in the treatment phase. In the case of TCM, treatment is a regimen that includes not only TCM medicine, but also lifestyle changes that patient adopt in conjunction with the prescribed medication. According to Stivers (2007), treatment recommendations in Western primary care usually come in the form of a proposal that needs to be either accepted or rejected. Hence, in both Western medicine and TCM, the absence of acceptance constitutes resistance that prevents the medical agenda from moving forward. In the treatment phase, resistance may take place in the following situations: first, patients (or their companions) may withhold acceptance of the doctors’ treatment proposal by providing no response/minimal responses; second, patients (or their companions) may deploy more overt strategies by requesting for, expressing desire of, and inquiring about a particular type of treatment (Stivers, 2007, p. 142). These ways of resisting a treatment proposal are also observed across my data collection. Additionally, similar practices have been identified in lifestyle discussions in my data corpus.

However, as Koenig (2011) pointed out, patient resistance to doctors’ treatment recommendations should be perceived as a limited form of patient agency since it allows patients to “negotiate and collaboratively co-construct what counts as an acceptable recommendation” (p. 1105). Instead of looking at patient resistance as obstructive and unfavorable, it may be worthwhile to “exploit” it as a way to create more opportunities
for patients to participate in the decision-making process. There are two gaps in the
literature on patient resistance that are addressed by this dissertation:

First, despite the extensive body of literature on patient resistance, almost no
research focuses specifically on patients’ resistance to doctors’ lifestyle advice. Given
that TCM treatment includes a lifestyle component, TCM encounters are a productive site
to explore how patient resistance unfolds.

Second, more research is needed to examine how medical practitioners respond to
patient resistance. Cases presented by Stivers (2005, 2007) have demonstrated some
patterns of doctors’ responses to patient resistance (i.e., doctors may concede or sustain
their stance) but further investigation is needed. This dissertation provides more insight
into this.

**Other Relevant CA Research**

The analysis in this dissertation is built upon important concepts in CA. These
concepts provide useful analytical tools for me to examine my target phenomena. Next, I
review the CA concepts that I draw upon in this dissertation: membership categories and
conversational openings.

**Membership Categories**

In his lectures Sacks (1992) described how social categories are interactionally
constructed and oriented to in talk-in-interaction. Schegloff (2007b) provided a
comprehensive overview of Membership Categorization Devices (MCD), the definition
of MCD and how MCD informs CA research. As Schegloff (2007b) pointed out,
membership categories are consequential because they are “inference rich” with tightly
bound rights and obligations (p. 469). A classic example of category-bound activity comes from Sacks (1972) where he associated the activity of crying with the category of “babies”, and the activity of attending to a crying baby with the category of “mothers”.

In this dissertation, I examine the role that patients’ companions play in TCM encounters. Data segments presented in Chapter 6 provide a rich context for examining how membership categories are constructed and negotiated in institutional settings. However, it is worth noting that analysis presented in this dissertation is not Membership Categorization Analysis (MCA) which follows a different set of rules and focuses on different issues (Stokoe, 2012).

**Conversational openings**

CA scholars have studied the opening sequences of different types of interactions. Some of Schegloff’s (1968, 1979, 1986) early work focused on the opening sequences of telephone conversations and identified four core components: a question-answer sequence; an identification sequence; a greeting sequence and a howareyou sequence (Schegloff, 1986, p. 117). Schegloff showed that the successful achievement of these seemingly routine opening sequences requires careful collaboration from both interactants (call maker and call recipient). Later studies on openings focus on face-to-face interactions in both ordinary and institutional settings (Kidwell, 2018; Mondada, 2009; Pillet-Shore, 2008; 2011; 2018a; 2018b; Robinson, 1998). These studies have demonstrated that interactants accomplish a variety of interactional tasks in openings, such as establishing co-presence (De Stefani & Mondada, 2018; Harjunpää, Mondada & Svinhufvud, 2018; greetings (Pillet-Shore, 2012); doing introductions and registering (Pillet-Shore, 2011; 2021). Robinson (1998) focused specifically on the opening of
medical encounters and documented a series of activities that take place in primary care visits. As Robinson (1998) put it, these activities are implemented by interactants to accomplish tasks that are preliminary to the handling of the main medical business (solving the patient’s problem). This dissertation extends the existing body of literature on conversational openings by examining how the opening sequences of TCM chronic care visits are interactionally organized into a set of activities.

In this chapter, I have reviewed several bodies of research that are relevant to this dissertation. Next, I introduce the research methods employed in this dissertation and provide a brief description of the data collection process as well as the data corpus.
CHAPTER THREE

DATA & METHODS

Primarily I use the method of conversation analysis (CA) to examine patient-provider interaction in TCM setting. In this chapter, I provide a brief introduction into CA, an explanation of my data collection procedure, and a description of my data set.

CA is rooted in ethnomethodology (Garfinkel, 1967) and influenced by Goffman’s (1983) claim that interaction is at the center of social life and is the key “institution” through which social institutions are built. As its name indicates, ethnomethodology seeks to reveal the orderliness of social life from the members’ perspective. Ethnomethodologists are concerned with elucidating and explicating the shared meaning-making processes among members in a society. By bringing ethnomethodological theory and Goffman’s “interaction order” together, CA builds on Garfinkel’s interest in everyday reasoning processes, and the orderliness and accountability of everyday action, and understands these to be built in and through everyday interaction.

CA is an inductive approach that studies naturally occurring conversations in both everyday and institutional settings. According to Heritage (1984a), CA is a “prominent form of ethnomethodological work” that has informed many other academic disciplines
Maynard (2013) claimed that CA “is both influenced by and a contribution to ethnomethodological inquiries” (p. 15). CA represents a branch of work in ethnomethodological research that pays close attention to the routine interactional practices of ordinary people.

CA understands the basic question that interactants ask throughout social interaction to be: “Why that now” (Schegloff, 1980). That is, what actions are interactants implementing, in this particular way, at this particular moment? CA researchers believe that by analyzing actions, and their composition and position, in naturalistic settings, we are able to get insight into the organization of the common-sense world. According to Atkinson and Heritage (1984a), the goal of conversation analytic research is:

the description and explication of the competences that ordinary speakers use and rely on in participating in intelligible, socially organized interaction. At its most basic, this objective is one of describing the procedures by which conversationalists produce their own behavior and understand and deal with the behavior of others. A basic assumption throughout is Garfinkel’s proposal that these activities – producing conduct and understanding and dealing with it – are accomplished as the accountable products of common-sense procedures. (p. 1)

Under the influence of ethnomethodology and Goffman’s work, CA emerged in the 1960s, starting with a series of lectures on conversation given by Harvey Sacks at UCLA (Sacks, 1992). In these lectures, Sacks demonstrated how audio-recorded interactions might be a resource for discovering the orderliness of talk-in-interaction. Later research findings continued to show what close examination of naturally occurring
conversations could reveal about the orderly construction of human interaction (Schegloff, 1968; 1972; Sacks et al., 1974; Schegloff & Sacks, 1973).

Heritage (1984a) laid out three basic assumptions of CA:

“(1) interaction is structurally organized; (2) contributions to interaction are contextually oriented; and (3) in these two properties inhere the details of interaction so that no order of detail can be dismissed, *a priori*, as disorderly, accidental or irrelevant.” (p. 241)

Aside from these assumptions, three features of CA research are exceptionally important in the study of social interaction as an institution in its own right. These features separate CA from other approaches to language and interaction in social sciences.

First of all, CA looks at conduct in interaction as a vehicle for social actions. It is useful to make a distinction between a *focal* action, or the key action a turn is designed to implement, and the *implementing* action, or the action used to produce that focal action (Mandelbaum & Pomerantz, 1990). For instance, a complaint can be implemented through an assessment, and a request for help may be implemented via a report of a problem. It is a key assumption in CA that we use interaction to accomplish actions.

Second, CA research focuses on sequences of actions. When examining conversations, CA takes into consideration not only actions, but also sequences of actions. Sequence organization is the central tenet of CA research (Schegloff, 2007). Different aspects of sequence organization have been investigated, including adjacency pairs, expansion, and conditional relevance (Schegloff, 1968; Schegloff 2007). Seeing conversation as sequentially organized is essential in CA research since the action
currently being implemented is influenced and shaped by the sequence of previously
launched actions and influences and shapes upcoming action.

Third, CA research bases its claims on participant orientations. One important
feature of CA studies is that the researchers’ understanding of what is going on in a
stretch of talk is grounded in the participants’ display of how they make sense of it.
Instead of simply looking at an individual turn, subsequent turns provide strong evidence
of what the interlocutor understands the previous turn to be designed to accomplish. This
provides CA researchers with an interaction-internal “proof mechanism” to support their
analytic claims and offers readers an opportunity to examine the evidence for themselves.

In institutional settings such as the courtroom or the doctor’s office, participants
engage in goal-oriented and role-based interactions, as Heritage and Greatbatch (1991)
pointed out. CA offers a unique perspective from which to look at institutional talk by
examining the details of actual interaction between participants. CA researchers look at
social interactions that occur in institutional settings in their own right, instead of as a
product of external factors.

CA is a useful tool for examining medical interactions (Gill & Roberts, 2012;
Heritage & Maynard, 2006; Robinson, 2011). While traditional approaches to patient-
provider communication deploy coding schemes that are developed by scholars, CA pays
“attention to how turns at talk establish nuanced action agendas that affect members’
understanding and production of talk in ways that are not always fully captured by
traditional coding methods” (Robinson, 2011, p. 502). By looking at how interactants
orient to interactional processes, CA research offers a unique perspective on how the
institutional setting is “talked into being” on a turn-by-turn, moment-by-moment basis.
Findings of medical CA research not only have implications for medical outcomes, but also have the potential to be further developed into interaction-based interventions (Robinson & Heritage, 2014). Additionally, since medical interactions in TCM remain relatively underexamined, research using CA provides valuable insight into the “interaction order” (Goffman, 1983) of medical encounters within this context.

**Data Collection and Analysis**

Data segments are drawn from a corpus of approximately 51 hours of video-recorded interactions between practitioners and patients during naturally occurring TCM consultations. Recordings for this project were made in two TCM hospitals, both located in a major city in eastern China. While one of the hospitals is affiliated with a local TCM university, the other hospital is privately owned. Two TCM practitioners participated in the data collection (see Figure 4). These recordings, as well as ethnographic notes containing details about the interactions that took place were obtained by the author over the course of three years (2014-2016). The project was approved by the relevant institutional review boards.

![Figure 4: Two TCM practitioners participated in this project](image)

Altogether, there are 21 recordings, which yielded 109 analyzable episodes of TCM consultations. Consultations in the collection varied greatly in length. Some of the
recorded visits were brief encounters in which patients visited the doctors’ offices to accomplish practical tasks such as refilling a prescription, etc. Other visits, on the other hand, lasted 30-40 minutes with thorough physical examinations and treatment demonstrations. Table 1 below contains basic information about each type of medical consultation. Additionally, field notes were taken by the researcher at the two research sites. These notes include information about patients’ age, occupation, chief medical concerns etc., as well as details about the interactions that took place between the doctors and patients. However, it was not possible to collect every patient’s demographic information. Some of the patients were in the office by themselves (26 out of 109; 24%) while some others had companions (83 out of 109; 76%).

Table 1 Types of TCM visits

<table>
<thead>
<tr>
<th>Types of TCM visits</th>
<th>No. of cases</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine visit</td>
<td>47</td>
<td>43%</td>
</tr>
<tr>
<td>Follow-up visit</td>
<td>29</td>
<td>27%</td>
</tr>
<tr>
<td>Initial visit</td>
<td>21</td>
<td>19%</td>
</tr>
<tr>
<td>Practical tasks (image reading; test results reading; prescription refill etc.)</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>100%</td>
</tr>
</tbody>
</table>

After the data were successfully collected, the research went through the following phases to conduct detailed, interaction-focused analysis:
Close examination of the collected recordings. The collected video recordings were carefully examined to understand the organization of interactants’ communicative conduct.

Identification of interactional phenomena of interest. During the close examination of the collected data, I noticed discernible patterns and identified recurring interactional practices. I decided to focus on three interactional phenomena: (1) the organization of TCM opening sequences, (2) bystander participation in TCM encounters and (3) companion involvement in TCM consultations.

Building collections of instances of the identified phenomena. After phenomena were identified, I put instances together and organized them into a collection.

Transcribing the instances. Cases of target phenomena were transcribed using the transcription convention developed by Gail Jefferson (Jefferson, 1984; Hepburn & Bolden, 2012, 2017). The goal of transcription was to provide a visual representation of details in interaction. The transcription system utilized in this dissertation is the three-line transcript system (Hepburn & Bolden, 2017) with the first line being the actual utterance in Pinyin7: The second line of the transcript includes the word-for-word English gloss of the utterance with the original grammatical structure of the utterance. The third line is the idiomatic translation of the utterance.

Embodied actions were also transcribed (shown in the transcript in italics.

---

7 Pinyin is the official romanization system for Standard Mandarin Chinese in mainland China.
and double parentheses). The overlap of verbal and embodied actions is marked by "|".

Sample transcript:

001 PAT: Wo jintian |youdianr tou:teng ne.
I today have a little headache FP.
I have a slight headache today. 
|((touches head))

(5) Analysis of instances in order to build careful, detailed descriptions of the operation of interactional phenomena. Interactional phenomena presented in this dissertation were analyzed in a line-by-line fashion.

(6) Refinement of descriptions of phenomena or practices. Based on the line-by-line analysis from the previous phase, specific practices were identified, described and explained.

(7) Collection and examination of deviant cases in order to assess the robustness of phenomena. Cases that did not fit the observed pattern were also analyzed and presented in the analytical chapters.

In addition to recording the ongoing interactions, I made ethnographic observations and took notes about the participants’ conduct. I drew diagrams of the layout of the doctor’s office (see Chapter 4 for examples of this) and documented the patients’ movement immediately prior to their visits. As I was transcribing the data segments, I used ethnographic notes to supplement the interactional details available on the video-recording. I also took notes of the demographic information of some of the patients and assigned each patient a number. However, I was not able to do this consistently since the interactional environment did not always allow me to do so.

Summary
This chapter describes the data and research methods used in this dissertation. I introduced the theoretical backdrop of conversation analysis and explained why conversation analysis was the most suitable method for this dissertation. I then introduced the data collection procedures used for this dissertation, describing how data was collected, the analytical processes involved in conversation analytic research and how they were utilized in the current study. Next, I present the findings of this study.
CHAPTER FOUR
OPENING SEQUENCES OF TCM VISITS

Introduction

CA researchers have long been interested in studying the opening sequences of different types of social activities. In his foundational work, Schegloff (1986) showed that the seemingly routine organization of telephone openings is in fact interactionally achieved on a moment-by-moment basis, through the collaboration of the caller and the call recipient. Schegloff (1986) outlined the core sequences involved in call openings: summons/answer, identification, greeting and “howareyou” sequences. Each of these core sequences accomplishes a specific task that needs to occur in a particular order.

Similarly, there are recurrent practices in the openings of face-to-face interactions (Pillet-Shore, 2008). Through the production of these opening practices, interactants “come together” to engage in shared social activities. In terms of institutional interactions, Robinson (1998)’s work outlines regular components in the opening phase of British general-practice medical consultations, including (a) greetings, (b) getting the patient to sit down and (c) securing the patient’s identity. Each of these components is designed to accomplish a particular interactional task that is preparatory to the determination of a chief complaint, which is the major medical business that doctors and patients deal with in this setting.

This chapter extends research on openings by examining the openings of TCM consultations. In the opening sequences of TCM visits, there are also recurrent standard
activities that are routinely produced. However, although most opening phases in TCM consultations involve these standard activities, they are not necessarily implemented in a standard order. The openings of TCM consultations may unfold in a variety of ways, responsive to local contingencies.

This chapter is organized as follows: I first outline the core components of TCM visit openings and provide brief explanations of the interactional job that each of these components accomplishes. These core sequences include 1) initiating the visit/summons-answer sequence (doctor’s summons and patient’s response of approaching and sitting down); 2) securing patient’s identity; 3) the initiation of pulse-taking; 4) launching medical talk. Then, I offer a detailed analysis of how the opening phase of TCM is organized by showing cases in which the interactants display a clear orientation to the normative “ingredients” of TCM openings. I also discuss other cases in which the same components are implemented/constructed in a different fashion.

Core Components in the Opening Sequences of TCM Visits

1. Initiating the visit

A summons-answer sequence is one way for TCM doctors and patients to establish focused mutual orientation and initiate a visit. However, it is worth noting that the summons-answer sequence is dispensable in many TCM visits. Only 34% of cases of TCM encounters in my collection (36 out of 109) involve a summons-answer sequence. Most TCM patients closely monitor the registration queue, which makes it normative for them to approach the doctor’s desk spontaneously when it is their turn to be seen. Hence,
no summons is needed. I discuss later how this kind of diligent monitoring is an integral part of “doing being a good patient” in TCM visits.

In cases where the summons-answer sequence does occur, it is designed to accomplish more than just “opening, and confirming the openness of, a channel of communication” (Schegloff, 1986. p. 117). It is also implemented to help achieve the transition from one patient to another, because most TCM visits take place in a multi-party environment. In producing the summons, the doctor makes it available to the previous patient that his/her visit is closed, as well as indicates to the incoming patient that his/her consultation is about to begin.

Most patients respond to the doctor’s summons through bodily actions. Upon hearing their names, they walk towards the patient’s desk and sit down in the patient’s chair. This shows that the patient orients to the doctor’s summons as indicating that they should get into position to start their consultation. It is normative for patients to sit down in the patient’s chair spontaneously, once they arrive at the doctor’s desk. In some cases, the doctor may need to invite the patient to sit down, and this kind of invitation is most likely to be occasioned by local contingencies.

2. Securing patients’ identities

Patients’ names, registration numbers and insurance information are checked when they arrive at the doctor’s desk. The doctor does this for the following reasons: first, the doctor has to make sure that the correct patient is being treated by matching the patient with the registration number in the queuing system; second, the doctor needs to ensure that they have the correct insurance information. Since it is common for family
members to share insurance, the name in the registration system may belong to the patient’s spouse, parents or other family members.

3. Initiating pulse-taking

Pulse-taking is normally the first medically relevant activity in a TCM visit. The initiation of pulse-taking marks the official beginning of the data-gathering phase of the consultation. There are two steps involved in the initiation of pulse-taking: The patient’s action of placing his/her wrist on the pulse pillow and the doctor’s action of placing three fingers on the patient’s wrist. In most cases, patients spontaneously place their wrists on the pulse pillow when they sit down in the patient’s chair – another thing that the patient has to do to enact the role of a good, attentive patient. If they fail to do so, the doctor may use different methods to prompt the patient, such as pressing or moving the pulse pillow.

4. Launching medical talk

Medical talk is usually produced in coordination with the beginning of pulse-taking. That is, the first medically relevant topic is generally proffered by either the doctor or the patient immediately after the doctor’s action of placing his or her fingers on the patient’s wrist. When initiated by the doctor, medical talk usually involves a series of questions about the patient’s health and overall wellness; when initiated by the patient, medical talk can come in two different forms: the patient may present a new medical problem or provide an update on their past conditions.

In the next section, I examine each of these four core activities individually. First, for each activity, I show a case which is a “prototype” of how things are supposed to be – how, in a normative way, the activity is interactionally organized. I also include instances
that are at variance with the “prototype” case, showing how participants responding to or accommodating the local contingencies may shape the trajectory of the activity.

**Initiating the Visit**

There are two different ways for a TCM encounter to start. First, the encounter may be initiated by the doctor by calling out the patient’s name and/or their registration number. In doctor-initiated encounters, a summons-answer sequence is produced. Second, the TCM encounter may be initiated by the patient, when they approach the doctor’s desk without being summoned (see Table 2 for the distribution of cases).

Table 2 Distribution of cases based on how they are initiated

<table>
<thead>
<tr>
<th>Type of encounter</th>
<th>No. of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor-initiated encounters</td>
<td>36</td>
<td>33.02%</td>
</tr>
<tr>
<td>Verbal Responses</td>
<td>4(11.1%)</td>
<td></td>
</tr>
<tr>
<td>Nonverbal responses</td>
<td>32(88.9)</td>
<td></td>
</tr>
<tr>
<td>Patient-initiated encounters</td>
<td>73</td>
<td>66.97%</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>100%</td>
</tr>
</tbody>
</table>

TCM encounters in my data collection are predominantly initiated by the patients.

In the following sections, I first show the canonical way for TCM visits to begin, that is, when patients spontaneously approach the doctor’s desk and sit down in the patient’s chair. In this part, I discuss three different cases in which patients, relying on various types of interactional resources, approach the doctor’s desk and sit down in the patient’s
chair promptly when it is their turn to be seen. Then I discuss two different cases of TCM openings with a summons-answer sequence. In the first case, the patient does not verbally respond to the doctor’s summons. Instead, upon hearing her name, she approaches the doctor’s desk. In the second case, the patient responds both verbally and nonverbally – he approaches the doctor’s desk, and then reports his name as well as his registration number.

**Patient-initiated Openings: Openings without Summons/answer Sequence**

In 71 of my 109 cases, the summons/answer sequence is not necessary because the patient stays close to the doctor’s desk, diligently monitoring the previous patient’s visit. There are three types of interactional resources that patients rely on to know when it is the right time to get themselves in position: verbal resources (when the doctor and the previous patient produce closing-implicative remarks or discuss certain topics); bodily actions (such as the patient standing up and leaving), and most importantly, there are social structural resources (Robinson & Stivers, 2001) that provide contexts for the patients to accurately understand the verbal and bodily resources. That is, both the doctor and the patient have knowledge about the phase structure of the opening sequence of TCM visits, which shapes the way they understand and respond to each other’s actions.

Extract 1 is an *exemplary case* that shows how, normatively, the first two components of TCM encounters (initiating the visit and securing patient identity) unfold. In Extract 1, the incoming patient has been hovering around the doctor’s desk during the previous patient’s visit (information available in the ethnographic notes). She approaches the desk at the right time, without being summoned by the doctor, apparently relying on
the following resources to determine when she should get into position without being prompted: a) the current patient’s and the doctor’s nonverbal behaviors; b) social structural resources (the phase structure of the TCM visits).

The beginning of a next TCM visit emerges out of the end of the prior visit. Most TCM visits end with the doctor and the patient (or the patient’s companion) discussing the prescribed medicine and how it should be prepared. At the beginning of Extract 1, the doctor and the previous patient are discussing the preparation of the previous patient’s medicine (lines 1 through 5). The discussion of the “cooking method” of TCM is canonically the last medically relevant activity in TCM visits, and thus is closing-implicative. The patient stands up and begins to walk away (lines 2 & 3) as the doctor is providing a response to his question (line 4). This shows that interactants orient to the discussion of cooking methods as projecting upcoming closing.

At line 6, during the 1.1 second silence where the current patient is leaving the scene, the incoming patient quietly approaches the doctor’s desk. She spontaneously sits down in the patient’s chair and places her wrist on the pulse pillow. Note that there is no verbal or embodied summons from the doctor in this extract.

**Extract 1 Exemplary opening a**

*WW_TCM_2015_7_27 TJ 1 3 11*

Participants: doctor (DOC), previous patient (PRP), previous patient’s company (PRC) and current patient (PAT)

<table>
<thead>
<tr>
<th>Line</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>PRP: Hai yong jia biede dongxi</td>
</tr>
<tr>
<td></td>
<td>Still have to add other things</td>
</tr>
<tr>
<td></td>
<td>Do we still need to add other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>002</td>
<td>prp:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>003</td>
<td>DOC:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8 See later section on the interactional organization of pulse-taking
In this extract, the incoming patient spontaneously approaches the doctor’s desk when it is her turn to be seen. She apparently relies on an array of resources. First of all, the incoming patient is able to project that the previous patient’s visit is coming to an end based on linguistic/verbal resources. The doctor and the previous patient are discussing the proper way to prepare the prescribed medicine, which normally indicates that the visit is reaching its final stage. This is when the incoming patient begins fidgeting (information available in the fieldnotes), which could be understood as preliminary to moving. Second, the incoming patient relies on embodied resources, that is, the bodily actions of both the doctor and the previous patient. The previous patient’s action of standing up (showing that the visit is nearly over) and leaving (showing that the visit is officially over) make it clear that his visit is closed. The incoming patient, upon seeing the previous patient stand up, changes her body orientation to face the patient (she was facing the doctor). As soon as the previous patient walks away from the patient’s chair, the incoming patient straightens up and then walks towards the patient’s chair. Also, the
patient’s knowledge of the phase structure of TCM visits (that the medicine preparation discussion usually comes at last) functions as a social structural resource that allows her to understand these verbal and embodied actions.

After working briefly on her computer (line 9), the doctor seeks confirmation from the patient that her name is indeed “Wang Hongren” (line 10). Note that at this point the patient is already seated, without being summoned by the doctor. The doctor’s confirmation-seeking could be understood as the doctor’s way of securing the patient’s identity, since she did not do that through the summons-answer sequence.

This extract presents a normative case of the opening sequence of TCM visits. The patient stays close to the doctor’s desk, carefully tracks the registration queue and monitors the current consultation and approaches the doctor’s desk when it is her/his turn to be seen. To achieve this seamless transition from one patient to another, the patient relies on different types of interactional resources, as the discussion above shows.

Extract 2 is another example in which the patient approaches the doctor’s desk spontaneously, without the doctor calling her name. Similar to the previous case, this extract also begins with the closing of the previous patient’s visit. The patient in this extract, a 4-year-old girl, is accompanied by her mother. She approaches the doctor’s desk with her mom when the previous patient and the doctor are still discussing plans for treatment, which provides further evidence that patients closely monitor the activity taking place at the doctor’s desk.

In lines 1 through 8, the doctor and the previous patient are discussing the patient’s preferred way of preparing the medicine (line 1), and the logistics of prescription pickup (line 4). After this is settled, the previous patient produces a closing-
implicative “xing (“okay”)”, and then stands up and leaves. In the meantime, the doctor produces “quba (“go ahead”)”, which officially concludes the visit.

The incoming patient in this segment is a 4-year-old girl who has been seeing the doctor regularly. Accompanied by her mother, the little girl begins to approach the doctor’s desk as soon as the doctor proposes that the previous patient’s father stop by and pick up her medicine (information available in ethnographic notes). The pair walks towards the doctor’s desk as the doctor is making arrangement for the previous patient’s medicine pickup. They temporarily stop approaching to yield to the outgoing patient, and then resume walking after the outgoing patient is out of the way. Even though the incoming patient here is 4-year-old, it is clear that relying on the verbal, embodied and social structural resources, she understands the doctor and the previous patient’s discussion of medicine preparation and the arrangement of prescription pickup as preliminary to the closing of the visit, and acts accordingly.

**Extract 2**

**WW_TCM_VID0003_8_7_4_21**

Participants: doctor (DOC), previous patient (PRP), current patient (PAT)

001 DOC: Jiu zhe. Zai zher jian ma. Just this. At here cook Q
002 PRP: En. Hmm
003 (0.3)
004 DOC: Wanshang rang ni ba lai na. Evening let your father come pick up
005 PAT: | (PAT begins to approach with her mother)
006 PRP: | Xing.
007 prp: | | (gets up and leaves/PAT and MOM yield)
As indicated above, there are different interactional resources that the patient and her mom use to determine the right time to approach the doctor’s desk. First, linguistic resources: the doctor and the previous patient at lines 1 & 2 collaboratively determine the previous patient’s preferred medicine preparation method. TCM patients have two choices when it comes to medicine preparation. They may either cook/decoct the medicine at home, or they may ask the pharmacy to cook the medicine for them and bring home the prepared medicine in glass bottles. The doctor’s inquiry about the patient’s preferred preparation method is a clear indication that the patient’s visit is wrapping up since the discussion of preparation methods is normally the last medically relevant activity in TCM visits. Second, at lines 4 & 6, the doctor and the previous patient also talk about the logistics of picking up the prepared medicine. The doctor proposes that the patient’s father should come and pick up the medicine (line 4). This proposal is accepted by the patient (line 6). This may provide further linguistic evidence to the incoming patient that the previous patient’s visit is coming to a close.
Third, the doctor at line 8 produces a linguistic item that is usually closing-implicative in TCM encounters: *qu ba* (“go ahead”). This item is normally delivered at the end of a patient’s visit to indicate to the patient that they may now leave. These three linguistic features indicate that the visit is ending, and this may explain why soon after the doctor brings up the topic of medication pick-up, the incoming patient and her mom slowly begin to approach the doctor’s desk.

In addition to the three aforementioned linguistic resources, the incoming patient and her mother’s knowledge about the phase-structure of TCM visits provides them with the context within which they can situate and interpret the doctor’s and the previous patient’s actions. This is evidenced in the timing of their action of approaching the doctor’s desk – since they know that talking about medication preparation projects closing, they are able to understand that the previous consultation is closing and that they should now approach.

When the patient and her mother arrive at the doctor’s desk, the mother first puts the registration receipt down, then as she is sitting down in the patient’s chair, she seeks confirmation from the doctor that she and her daughter are indeed the legitimate “current” patient (line 11):

011  MOM:  Zhang xiu|hua shi ba.
        NAME     | ( BE Q
        It is Zhang Xiuhua right?

The patient’s mother’s turn designed as a declarative with a turn-terminal *Shiba* (“right”) makes relevant a yes/no response from the doctor with a built-in preference for an agreeing response. Hence, it conveys that the mother has knowledge regarding who the current patient is – stating her name for confirmation indicates that she already knows
that it is indeed her turn to be seen, and now is simply seeking confirmation of this from the doctor (Heritage, 2013). Also, the mother’s utterance is launched as she is sitting down in the patient’s chair. When the first word is issued, the patient is already half-seated. The formulation and timing of this turn make it almost *pro forma*–the patient’s mother is simply seeking confirmation from the doctor that her supposition that she is next is correct.

The two extracts above show how patients may take the initiative and get into position for their visits spontaneously, with the help of an array of interactional resources. In both cases, the interactants’ (the doctor and the patient that is being seen) verbal and embodied actions help the incoming patients discern when it is the right time to approach the doctor’s desk. Also, the social structural resource, the incoming patient’s knowledge about the phase structure of TCM visits, allow them to discern when the previous patient’s visit is coming to a close. However, it is not always the case that the incoming patient has access to these interactional resources. In the next section, I show two cases in which the patients need to be summoned. In both cases, a summons is needed because the patient registration queue is disrupted by “no-show” patients.

**Doctor-initiated Openings: Openings with a Summons/answer Sequence**

There are some visits in my collection that are initiated by the doctor (36 cases, 33.06% of all cases). To initiate a medical consultation, the doctors may either shout out the patient’s names or the patient’s registration number. This normally occurs after the doctor has checked the patient registration system to see who the incoming patient is. In response, the patient may verbally respond to the summons, letting the doctor know that
they are present, or simply approach the doctor’s desk and sit down, answering the summons in an embodied way.

Verbal Summons and Embodied Response

Extract 3 is a case where the consultation is initiated by the doctor when he summons the patient. The patient needs to be summoned because there were two absent patients before her, which may have made monitoring the patient registration queue difficult. In this extract, the discussion of medicine preparation takes place from lines 1 to 6. This discussion occurs between the patient’s companion (off-camera) and the doctor about the prescribed course of treatment. Note that at this point, the doctor is apparently ready to move on to the next patient in line: he enacts looking for the next patient by scanning the room and producing a word search for the patient’s name (line 2): Neige Shui (“Um that person”). This expression enacts remembering someone’s name in Mandarin Chinese and could be understood as a failed name search/summons. It is abandoned when the doctor responds to the companion’s question (“Huh”?)

Extract 3
WW_TCM_VID0003 8 7 1:22
Participants: doctor (DOC), previous patient (PRP), current patient (PAT)

001 PRC: Zhei yi zhang shi ji tian de. This one piece BE how many days FP
How many days of medicine does this prescription cover?

002 DOC: Neige shui ((to other patients)). A./((to PRC)) That who. Huh
Um that person. Huh?

003 Qi: tian. wo xian kai qi tian de yao. Seven days. I first prescribe seven days PRT medicine.
Seven days. I prescribed medicine for seven days first.

004 PRC: Xian chi qi tian [ha. First eat seven days [right
Take the medicine for seven days first, right?

005 DOC: [Chi qi dian dou xing. [Eat seven days all okay
[Taking it for seven days is fine.
In this extract, the doctor, after checking the registration system (line 7), summons the next two patients in the registration queue (line 8, “Hu Longtai, Guan Junmin”). After receiving no response from these two no-show patients, the doctor then moves onto the next patient (line 10):

007  (0.3)/((checks the patient info system))
       Um |NAME .  NAME
       Um. |Hu Longtai. Guan Junmin.  
       |((reads off the computer screen))
009  ((indiscernible words from a bystanding patient))/(0.3)
010  DOC:  [Ranhou::: Fu Chenxi.  
          [Then:::  NAME
          [And then  Fu Chenxi.  
011  ((incoming patient approaches))/(0.4)
012  DOC:  Shi Fuchenxi| ma.  
           BE  NAME | Q
           Are you Fuchenxi?
013  pat:  |((walks into camera with arm extended))
014  PAT:  A.  
          Yes
          Yes.
The doctor first announces the names of two different patients ("Hu Longtai. Guan Junmin"), inferably the two patients who are scheduled to see him next. There is no apparent response from these summoned patients (line 9). At line 10, the doctor moves on to the next patient: *Ranhou Fu Chenxi* ("And then Fu Chenxi"). The incoming patient’s name here is produced as the third item of a list, attached to the previous two names by *ranhou* ("and then"), which shows that the patient named “Fu Chenxi” is the next patient in line in the registration system.

There is no verbal response from the patient named in line 10, but she approaches the doctor’s desk (line 11, information available in ethnographic notes) after the doctor’s summons, indicating that she understands it as summoning her. The patient’s action of approaching the doctor’s desk here constitutes a response to the doctor’s summons. That is, she understands the calling of her name to indicate that she is being summoned as the next patient to be seen. This is the case across the data collection: patients ordinarily respond to the summons in an embodied way by approaching the doctor’s desk upon hearing their names. The patient responds to the doctor’s summons verbally in only 4/109 cases. As shown in Figure 5 (below), although there are other patients in the office, the doctor’s view is not obstructed so he is able to see the patient approaching. Verbal responses are a rare occurrence. Patients produce them only when the office is exceptionally crowded, so the patients’ bodily action of approaching the doctor’s desk is not visible to the doctor. Extract 4 below is such a case, in which the patient responds to the doctor’s summons verbally by saying his registration number out loud.
Verbal Summons and Verbal Responses

In the following extract (Extract 4), the doctor’s office is congested with multiple patients, with the patient who is next sitting on an acupuncture table that is relatively far away from the doctor’s desk. This makes it hard for the patient to monitor the previous consultation. Additionally, the congested environment makes it difficult for the doctor to see him (see Figure 6 for the layout of the office and where the patient is seated when his name is being called). This may explain why in addition to approaching the doctor’s desk, the patient also produces a verbal response while he is on his way to the doctor’s desk (line 13). This answer may also be a way for the incoming patient to let the doctor
know that it will take him longer to get to the doctor’s desk. He needs to indicate to the
doctor that he is on his way so that the doctor does not call someone else’s name.

Figure 6: floor map Extract 4 Office layout and patient location
PAT: where the patient is sitting when being called
DOC: where the doctor is sitting

Extract 4 Numb toes
WW_TCM_VID0002_8_6_2_21
Participants: doctor (DOC), previous patient (PRP), current patient (PAT)

001   DOC:   Xing.=
          Okay
          Okay.=

002   PRP:   =Hao lei. [Xiexie a.
          =Good FP. [Thanks FP
          =Great. Thanks.

003   DOC:              [Qu ba. En. meishier
          [Go FP. Hmm. Nothing
          =Go ahead. Hmm. No problem.

004          (1.1)/((DOC checking the computer))

005   DOC:   Neige::: Wang Xiuhua.
          U::m. NAME
Um. Wang Xiuhua.

DOC: He Longtai.
NAME He Longtai.

OPT: Bu zai.
NEG at
Not here.

DOC: Luo- Li Sheng.
NAME- NAME
Luo- Li Sheng.

PAT: Li Sheng. Shijiu hao.
NAME. Nineteen number
Li Sheng. Number nineteen.

OPT: Duoshao hao.
How many number
What’s the number now.

XXX: Shijiu.
| Nineteen
| Nineteen.

pat: ((sits down in the patient’s chair
puts registration receipt on the desk, leans forward))

DOC: Zhei ren mei lai. Zhei Quan Longtai shi shui a.
This person NEG come. This NAME BE who FP
This person is not here. Who is this Quan Longtai.

( ) taiguoren yiyang.
( ) Thai same
( ) sounds like a Thai.

This extract begins with the closing of the previous patient’s visit. The doctor produces a closing-implicative xing (“okay”) at line 1, which is receipted with the patient’s expression of gratitude (line 2). At line 3, the doctor produces another closing
implicative item *qu ba* (“go ahead”), which further projects the upcoming closing of the previous patient’s visit (see Wood et al. (2015) for a more detailed discussion of closing-implicative tokens in the medical context).

After working on his computer briefly to check the registration system (line 4), the doctor at line 5 announces the name of the next patient: “Um. Wang Xiuhua”. When this summons gets no response (silence at line 6), he moves on to the next person in the queue (line 7, “He Longtai”). This again receives no response from the patients waiting in the room (0.3 gap at line 8). At line 9, a nearby patient reports that the patient whose name has just been called is not present. The doctor waits briefly and then at line 11 summons the next patient, who is the incoming patient in this extract:

```
011   DOC:   Luo- Li Sheng.
        NAME- NAME
        Luo- Li Sheng.

012   (0.2)/(( PAT stands up and approaches))

013   PAT:   Li Sheng. Shijiu  hao.
        NAME.  Nineteen number
        Li Sheng. Number nineteen.
```

According to my ethnographic notes, the incoming patient is sitting on one of the acupuncture tables, relatively far away from the doctor when his name is called (see Figure 6 on the last page for the location of the patient). Upon hearing his name, he stands up and begins to approach the doctor’s desk (line 12). When he is about half-way, he announces his own name, as well as his registration number (line 13). Here the patient’s responses to the doctor’s summons are both embodied (approaching) and verbal (announcing his name and registration number).

When the patient is on his way to the doctor’s desk, the doctor is surrounded by five other patients (see Figure 6). These people block the doctor’s view, preventing him from spotting the approaching patient. Possibly orienting to the fact that he may be
visually inaccessible to the doctor, the patient, when he is about halfway through his approach, delivers a verbal response, indicating to the doctor that he has heard the summons, and is on his way to the doctor’s desk. This verbal response is possibly implemented to deal with the length of his approach, preempts the doctor from calling in someone else. Additionally, the patient says his registration number out loud (number 19), providing evidence that he is indeed the legitimate incoming patient.

In Extract 4, the incoming patient’s visit is initiated by the doctor with a summons. Here the patient provides two different kinds of responses to the doctor’s summons: first, his embodied action of approaching constitutes an answer. Second, he responds verbally to the summons when he is already on his way. As established earlier, this verbal response is likely occasioned by the physical environment of the doctor’s office, and the fact that the doctor’s view is obstructed by surrounding patients. Additionally, two patients’ names were called before the incoming patient. The order of the patients in the registration queue has shifted because of the no-show patient. Therefore, the patient announces his arrival to let the doctor know that he is on his way, and also to prevent the doctor from moving on to the next patient.

In both Extracts 3 and 4, the incoming patient’s visit is initiated by the doctor’s summons. It is worth noting that in both cases, the patients immediately before the incoming patients were not present — their names were called, but no responses were provided. It may be argued that the incoming patient needs to be summoned in both cases, because even if they have been diligently monitoring the registration queue, the order of patients shifted due to the absent patients. In this case, the doctor produces the summons to let the incoming patient know that it is their turn to be seen.
The previous cases demonstrate two different possibilities for the unfolding of the very beginning of TCM visits. In extracts 1 and 2, the patients take the initiative to approach the doctor’s desk spontaneously, without being summoned by the doctor. As the analysis reveals, two kinds of resources help the incoming patients accomplish this: First, they monitor the interaction between the doctor and patient diligently even in the congested, busy environment of the TCM doctor’s office. Hence, they are able to pick up verbal and bodily actions by the doctor and the patient that are closing implicative. Some of these verbal and bodily resources include the doctor’s closing-implicative linguistic item of *quba* (“go ahead”) (seen in Extract 2) and the previous patient’s bodily action of getting ready to leave; second, incoming patients are able to understand these resources because of the social structural resources that provide them with the context. For instance, the discussion of medicine preparation is treated as indicating upcoming closing because it is usually the last medical activity in the visit. As shown by the data extracts, the doctor, the previous patient and the incoming patients all orient to the discussion of medication preparation methods as projecting upcoming closing. This is part of TCM patients’ social structural knowledge regarding how the visits proceed.

Extracts 3 and 4 are TCM consultations initiated by the doctor with a summons-answer sequence. Since in the majority of cases patients approach the doctor without a summons-answer sequence (73/109 cases), the beginnings of these extracts are noncanonical. As the analysis shows, summonses are produced when patients are not able to discern when it is their turn to approach because the patient registration queue has changed due to the no-shows.
These extracts show that patients in TCM visits assume the position of the current patient by approaching the doctor’s desk and sitting down in the patient’s chair. The patient’s chair is an important artifact since sitting in it constitutes a patient’s status as the current patient.

Past research has shown that in Western acute visits in the UK, doctors produce verbal or embodied invitations to get their patients to sit down (Heath, 1981; Robinson, 1998). However, in most of the TCM cases in my collection, (91/109), patients sit down in the patient’s chair spontaneously, without being invited by the doctor (as we saw in cases 1, 2 & 4 presented above). These differences may be explained by the different physical environments in different medical cultures. The doctor’s office in China is an open space, while in the UK, patients see doctors in their private examining room. Next, I show one case in which the patient is verbally invited by the doctor to sit down (Extract 5), to demonstrate the local contingencies that can make an invitation necessary.

Extract 5 is a continuation of the visit discussed in Extract 3. Lines 11 to 14 of Extract 5 have already been discussed in the analysis of Extract 3. Here the patient fails to approach the doctor’s desk and get into position spontaneously, possibly because the patient registration queue was shifted by absent patients (see Extract 3). The patient begins to approach the doctor’s desk only after the doctor has summoned her by calling her name.

At line 12, the doctor seeks confirmation from the patient of her identity as she is walking towards him. After the patient has delivered the confirmation (line 14), the doctor produces an invitation, asking the patient to sit down in the patient’s chair. As
noted earlier, this type of invitation is rare in TCM encounters – patients predominantly approach the doctor’s desk and sit down spontaneously, without the doctor’s invitation.

**Extract 5**

[WW TCM 7 25 VID0000112:32]

Participants: doctor (DOC), previous patient (PRP), current patient (PAT), other patient (OPT)

011 (0.4)/{(incoming patient approaches, DOC gazes at PAT)}

012 DOC: Shi Fuchenxi| ma.
BE NAME | Q
Are you Fuchenxi?

013 pat: |{(walks into camera with arm extended)}

014 DOC: {(looks at the computer, checking the registration system)}

015 PAT: |A.
|Yes
|Yes.

016 DOC: |{(turns head, glances at the patient)}

017 DOC: Zuo |xialai.
Sit |down
Sit |down.

018 doc: |{(turns head away, averts eye gaze)}

019 pat: |{(sits down in patient’s chair)}/(1.1)

020 doc: |{(looks at the computer, clicking mouse)}

021 OPT: |Duoshao hao xianzai.
|How many numbers now
|What is the current number?

022 pat: |{(looks at the computer screen, adjusts her wrist watch)}

In this extract, the patient does not sit down immediately after she has arrived at the doctor’s desk. Note that as she is walking towards the doctor’s desk, the doctor is gazing at the computer, potentially checking the registration system (line 14). It is possible that the patient treats the doctor’s embodied actions here as an indication of him being involved in another line of activity and that he is not ready to start her visit. Hence, the doctor produces a verbal invitation to prompt her to get into position (line 17). This
indicates that the patient getting into position is achieved collaboratively. The patient is oriented to the doctor’s preparedness.

In this section, I examined five different cases showing different ways in which the beginnings of TCM consultation unfold. These cases show that TCM patient usually spontaneously get into position for their medical consultation. Less frequently, they may be summoned by the doctor as the next patient. In order for patients to recognize the right moment to approach the doctor’s desk, they rely on specific interactional resources: linguistic items in the previous consultation (e.g., the closing implicative “go ahead” and discussion of how to prepare medicine) and doctors’ and patients’ bodily actions (e.g., standing up from the patient’s chair). Cases where patients need to be summoned are less common, occurring only when some of the aforementioned resources are not available for the patients.

Additionally, I have shown how the patient’s action of “getting into position” involves two different components, approaching the doctor’s desk and sitting down in the patient’s chair. In most cases, patients get into position in a smooth, seamless fashion, sitting down spontaneously after arriving at the doctor’s desk. As shown in Extract 5, when this does not happen, the doctor may prompt the patient to get into position by inviting them to sit down.

Another essential component in the opening sequences of TCM visits is securing the patient’s identity. This is the focus of the next section. My analysis suggests that the doctor normally secures the patient’s identity before the patient sits down, or as the patient is sitting down. In rare cases where the doctor checks the patient’s identity after the patient is already seated, the doctor normally delivers the checking in the form of
seeking confirmation from the patient, which may suggest that the doctor already knows who the patient is and is simply making sure that the information is correct.

**Securing the Patient’s Identity**

Securing the patient’s identity is crucial in TCM visits, not only because doctors have to know that they are treating the right patient, but also because of how insurance works in the Chinese medical system. People with government medical insurance normally have a yearly cap, meaning that once they have gone over the maximum reimbursement amount, their healthcare visits have to be self-funded. Hence, it is a routine practice for patients to use insurance that does not belong to them.

In my data, the doctor secures a patient’s identity for different reasons. If the patient is a new patient, the doctor does so to make sure that the patient being seen is the right patient. On the other hand, if the patient is a regular patient or a returning patient, the securing of identity is for insurance purposes, given that the patient may use someone else’s insurance and see the doctor under a different name.

Securing a patient’s identity is a two-step process. First, the doctor retrieves the patient’s information from the patient registration system; second, the doctor confirms that the patient near or at his/her desk is the current patient shown in the system.

The doctor may initiate the identity-securing process before, during, or after the patient sits down in the patient’s chair. In just a few cases (7/109), securing the patient’s identity is omitted because the doctor is able to recognize the patient and thus does not need to confirm their identity.
In this section, I show three cases with different trajectories. In the first case (Extract 6), the doctor secures the patient’s identity before the patient is seated, while in the second case (Extract 7), this task is accomplished after the patient is already seated because of another patient’s interjection. This shows that securing the patient’s identity is often delayed by some local contingencies, such as an intervening patient. The last case in this section (Extract 8) shows how this component may be omitted, when a) the doctor knows who the patient is and b) both the doctor and the patient clearly know that the patient is the legitimate current patient.

Securing Identity Before the Patient Sits Down

In Extract 6, the doctor secures the patient’s identity before the patient sits down in the patient’s chair, as the patient is approaching (line 12). This extract is taken from the same consultation as Extracts 1 and 5. Here the patient is summoned by the doctor because there were two absent patients before her. Note that the doctor secures the patient’s identity first when she arrives at the doctor’s desk (lines 12 to 14), and then invites her to sit down in the patient’s chair (line 15).

Extract 6

Participants: doctor (DOC), current patient (PAT)

010 DOC: [Ranhou:: Fu Chenxi.
[Then:: NAME
[And then Fu Chenxi.

011 (0.4)/{(incoming patient approaches, DOC gazes at PAT)}

012 DOC: Shi Fuchenxi| ma.
BE NAME | Q
Are you Fuchenxi?

013 pat: |{(walks into camera with arm extended)}

014 DOC: {(looks at the computer, checking the registration system)}
As discussed earlier in this chapter (Extracts 1 and 5), this extract begins with the doctor summoning the incoming patient (line 10), and the incoming patient approaching the doctor’s desk upon hearing her name (line 11). The patient in this extract is a university student who studies overseas (information available in ethnographic notes). She has seen the doctor before, but her last visit was about a year ago, the last time that she returned home. This may explain why the doctor, even after seeing her, confirms her identity at line 12, indicating that he is not able to recognize her, possibly because her last visit was a long time ago:

The doctor uses a polar interrogative to seek confirmation from the patient: _Shi Fuchenxi ma_ (“Are you Fuchenxi”?). The design of the doctor’s question conveys a K-epistemic stance (Heritage, 2013), indicating that the information that the doctor is seeking is entirely within the recipient’s domain. This makes it available that although the doctor knows the next patient’s name, he is unable to match the patient’s name with the incoming patient’s face. The patient confirms that she is “Fu Chenxi” (line 15), by giving a positive response to the doctor’s polar question _Shi_ (“Yes”), after which the doctor invites her to sit down in the patient’s chair, confirming her status as the legitimate current patient (line 17).
The fact that the doctor confirms the patient’s identity before inviting her to sit down shows that securing the patient’s identity is an important task that the doctor has to accomplish to make sure that the patient approaching is the next patient in line. In most of my cases, the patient’s identity is confirmed before the patient sits down, or as the patient is sitting down in the patient’s chair (79/109). However, there are cases where the doctor secures the patient’s identity after the patient is already seated. This happens for the following reasons: first, there might be a competing line of activity that the doctor is participating in; second, the doctor may recognize the patient, but the patient’s name and the patient’s face do not match (because the patient is using another person’s insurance). In the next section, I show one example of each of these.

**Securing Identity after Patient Sits Down**

While sometimes the doctor secures the patient’s identity before the patient sits down, or as the patient is sitting down, occasionally the doctor may try to secure the patient’s identity after the patient is already seated in the patient’s chair. In this case, the action of securing the patient’s identity may be construed as late, since the patient’s identity normally needs to be confirmed before he or she sits down (Robinson, 1998). When the patient’s identity is secured late, this may be because there are intervening activities going on. For instance, in the next extract, the doctor does not confirm the incoming patient’s identity until the patient has been sitting in the patient’s chair for 8.3 seconds. This happens because another nearby patient uses the transition between patients as an opportunity to launch inquiries about her own treatment. When the doctor finally checks the patient’s identity, he orients to his checking as repetitive by indicating that he
has asked the patient’s name before. The intervening patient here is a returning patient who was just seen by the doctor. She was sent to the pharmacy, and now she comes back because of some additional concerns regarding how to prepare the prescribed medication.

The beginning of Extract 7 shows the transition from the previous patient to the incoming patient. The intervening patient comes in and launches an inquiry about the “add-on” ingredients that she needs to put in her medicinal soup (line 1). At this point, the incoming patient has already arrived at the doctor’s desk. She sits down in the patient’s chair in the middle of the intervening patient’s turn, treating the intervening patient’s interaction with the doctor as transitory.

The conversation between the doctor and the intervening patient goes on for 22 lines (15 of them omitted). During this discussion, the incoming patient sits quietly in the patient’s chair. The target lines here are lines 29 to 31, where the doctor finally confirms the patient’s identity.

**Extract 7**

**WW_TCM_2016_5_36_TJ2_1_12**

Participants: doctor (DOC), intervening patient (IPT) and current patient (PAT)

001 IPT: |Neili you jiangmi ma. = Hai shi wo ziji [jia. |
|That inside have sticky rice.= Or Be I self [add |
|Is there sticky rice in here? Or do I have to add it myself? |

002 pat: |{({walks into the camera view} |
sits down))|

003 DOC: |Ni ziji |
|You self |
|You add |

004 |ge: ya. |
|add FP |
|it yourself. |

005 IPT: |Duos- Ziji ge duoshao |
|How- Self ad how many |
|How much should I add. |

|{(doctor gives instruction, 15 lines omitted)}|

021 IPT: Ge ji pian jiang. |
|Put several slices of ginger|
Put several slices of ginger.

022 DOC:  En yikuaier.
Mmmh together
Mmmh altogether.

023 IPT:  Gen yihuaier zhu ha.
With together boil FP
Boil them together with (the medicine).

024 DOC:  |Ha hao.
|Okay good
|Okay good.

025 ipt:  |((turns to leave))

026 IPT:  |A xing. Xiexie nin.
|Hmm okay. Thank you
|Hmm okay. Thank you.

027 pat:  |((places hand on the pulse pillow))

028 doc:  ((glances at PAT, |puts hand next to PAT’s wrist))

029 DOC:  |Jiao shenme laizhe.
|Call what again
|What’s your name again?

030 (0.3)

031 PAT:  |Chen Xiulan.
|NAME
|Chen Xiulan.

032 doc:  |((puts hands back on the mouse))

033 (0.2)

034 DOC:  Chen Xiulan shi ma.
NAME       BE  Q
Is it Chen Xiulan.

035 PAT:  |En.
Hm
Hmm

036 (1.2)/((DOC navigates the patient information system))

037 DOC:  |Ni shangtou you liange mei: lai: di:.
|You up have two NEG come FP
|Two people before you did not come.

038 doc:  |((continues to navigate the system))

039 (1.1)

040 DOC:  An shunxu.
According to order
According to the order.
After engaging in detailed discussion of how to prepare the intervening patient’s medicinal soup, the doctor and the intervening patient finally collaboratively close this intervening line of activity at lines 24 to 26, with the intervening patient expressing gratitude and leaving. At line 27, the patient, who has been sitting down in the patient’s chair for a full 8 seconds, places her wrist on the pulse pillow, which indicates that she takes it that her consultation, which was temporarily put on hold by the intervening action, is starting. The doctor, in response, also places his three fingers on the patient’s wrist, officially beginning the pulse-taking activity (see a more detailed analysis in the next section).

At line 29, the doctor confirms the patient’s identity:

```
029  DOC:                  |Jiao shenme laizhe.
          |Call what again
          |What’s your name again?
030       (0.3)
```

The doctor’s turn here asks for a reminder. That he is seeking a reminder is made available by the particle “again” at the turn terminal position, indicating that he knew it previously, but can’t recall it now.

The patient responds to the doctor’s question at line 31 by saying her name:

```
030       (0.3)
031  PAT:      |Chen Xiulan.
          |NAME
          |Chen Xiulan.
032  doc:     |{{puts hands back on the mouse}}
033       (0.2)
034  DOC:     Chen Xiulan shi ma.
          NAME     BE Q
          Is it Chen Xiulan.
035  PAT:     En.
          Hmm
          Hmm.
```
After checking the patient registration information system (lines 32 & 33), the doctor, despite the answer just provided by the patient at line 31, seeks confirmation from the patient that her name is indeed “Chen Xiulan”. This question is likely occasioned by what he sees on the computer screen.

In contrast to prior extracts, the doctor’s action of securing the patient’s identity comes long after the patient’s action of sitting down in the patient’s chair. The doctor secures the patient’s identity relatively late because there is an intervening line of activity (another patient asking questions about her medication) that may have prevented him from doing it earlier (before the patient sits down or as the patient is sitting down). Although the patient has been sitting in the patient’s chair for a long time, she does not place her arm on the wrist pillow until the intervening patient turns around to leave. This indicates that although the incoming patient is already in position for the visit, she treats her visit as temporarily on hold when the doctor is addressing the intervening patient’s concern. When the intervening patient closes her line of action, the patient shows that she understands that her visit is beginning now, readying herself by putting her arm on the pulse pillow.

In Extract 8 the activity of securing the patient’s identity is also implemented after the patient is seated. This may be because the patient is using someone else’s insurance. Because of this, although the doctor knows the patient, he is unfamiliar with the name under which she is registered.

This extract also begins with the closing of the previous patient’s visit. At line 1, the doctor teases the previous patient that she will suffer a lot from her menopause symptoms, as she stands up and turns around to leave (line 3). This tease is receipted with
laughter tokens from the previous patient (line 4). As she leaves, the incoming patient, who has been staying close to the doctor’s desk, walks to the patient’s chair, but she does not sit down in it until invited by the doctor (line 7).

The focus of this segment is lines 12 through 14 where the doctor secures the patient’s identity after the patient is already seated in the patient’s chair. The doctor’s line 12 and the patient’s line 14 make it available for inference that the name the patient is using to register for her visit is not her real name. In this extract, the doctor secures the patient’s identity after she is already seated and positioned to be the current patient, which may appear late. However, in addition to making sure that they are seeing the right patients, TCM doctors also need to verify that they are billing the right insurance, and this is accomplished by cross-checking the patient’s real name, and the name they have used in the registration system.

Extract 8
WW_TCM_2015_TJ_8_3_VID00001_4_01
Participants: doctor (DOC), previous patient (PRP), previous patient’s company (PRC) and current patient (PAT)

001  DOC:  Yige gengnianqi jiu gou ni- gou ni
One menopause just enough you- enough you
Just the menopause that’s enough for you- for you

002          [|he ji bu de le.
[|Drink some pots FRT FP
[|to suffer a lot.

003  prp:   [||((stands up and turns around))

004  PRP:      Heheheheh.

005  pat:   ((walks closer to the patient’s chair))

006          (0.4)

007  DOC:       Ni zuo ba./{( to PAT})
You sit FP
You sit down.

008  PAT:       Dao le?
Arrive FP
It’s my turn?

009  DOC:       ||En.
As shown by the brief gap in line 6, the patient does not immediately sit down after arriving at the doctor’s desk, even after the doctor invites her to do so. She first seeks confirmation from the doctor that it is indeed her turn to be seen after the doctor verbally invites her to sit down:

The patient’s line 8 Dao le (“It’s my turn”) is produced as a question with rising intonation, thus making relevant a confirmation/disconfirmation from the doctor. The patient’s action of seeking confirmation here shows that she treats the doctor’s invitation as unexpected, which indicates that she might not have been monitoring the patient’s registration queue closely.
As the patient is sitting down in response to the doctor’s invitation, she accounts for not immediately sitting down (line 11), claiming that she *Bu ji* (“in no rush”. This account may be remedial, offering an explanation for not sitting down immediately and spontaneously. This indicates that the patient treats her action of not sitting down as accountable, suggesting that she takes it that it is normative for the patient to sit down immediately.

The doctor checks the patient’s identity at line 12, after the patient is already settled in the patient’s chair, by saying her name out loud. Note that the doctor also checks with the patient if registering under this name is only a one-time thing: *Zhei ci shi ba* (“This is for this time, right?”). The doctor’s turn ends with *shi ba* (“right”), which makes relevant a confirming response from the patient. This indicates his expectation that his claim is correct.

In response, the patient’s companion confirms that the name is correct (line 13, *Dui dui* (“Right right”). The patient also instructs the doctor to use it for this particular visit (line 14, *Yong zheige mingzi* “(You should) use this name.”). Referring to the name that she uses for this visit as “this name” instead of “my name” distances the patient from
the name that she is registered under. This further indicates that the name in the registration system is not the patient’s real name.

In this segment, through inviting the patient to sit down in the patient’s chair, the doctor indicates that he recognizes the patient and knows that she is the next to be seen. However, since the patient is possibly registered under a different name, the doctor still secures her identity at line 12 to make sure that the name is the one that the patient wants to use for this visit. This segment demonstrates that when there is a mismatch between the patient and their name in the registration system, the doctor may take the extra step of securing the patient’s identity even after the patient is already in position to be seen.

In both Extracts 7 and 8, the doctor secures the patient’s identity after the patient is already sitting in the patient’s chair. However, this happens for different reasons. In Extract 7, there is an intervening line of activity that may have delayed this task. In Extract 8, the patient is registered under someone else’s name. These cases show that although there is an allocated slot for the activity of securing patient identity, the timing of its occurrence may be shifted in response to local contingencies.

**When Securing Patient’s Identity is Omitted**

Occasionally, the doctor may omit the step of securing the patient’s identity. This activity is likely to be omitted when the doctor and the patient have a long-term relationship and know each other very well, and, importantly, the patient is registered under their own name (see Extract 8 for a counter example). In cases where the patient’s identity does not have to be secured, the doctor apparently is able to recognize the patient. Extract 9 exemplifies this situation.
In Extract 9, there is no summons/answer sequence nor securing of the patient’s identity. The patient spontaneously approaches the doctor’s desk after the previous patient has left, sits down, puts his arm on the pulse pillow and begins to share some news with the doctor.

Two different factors may enable the doctor to skip the task of securing patient identity. First, the relationship between the doctor and the patient in this extract goes beyond the institutional setting. Based on the information available in the ethnographic notes, and their later conversation, it is clear that they have known each other for a long time, and their families used to travel together. Second, the interactional environment in this extract is different from a lot of other cases in the collection. When the doctor is seeing the previous patient, the patient in this extract is the only one waiting in the doctor’s office. He entered the doctor’s office halfway through the previous patient’s visit and has been sitting quietly on an acupuncture table nearby. The opening of this extract unfolds in a smooth and compact fashion – neither the patient nor the doctor does any interactional work to check the patient’s identity, and the patient provides updates on his life immediately after sitting down.

Extract 9

PRP: previous patient; DOC: doctor; PAT: patient; RES: researcher

001   prp:   ((stands |up))

002   DOC:            |Zheliangtian haohao xiuxi a.
|This two days well  rest FP
|Take some rest.

003   PRP:            |Ei    haolei. Ei.
|Okay. Good. Okay
|Okay. Good. Okay.

004   prp:   |((suspends the action of leaving))

005   DOC:            |Xing.
|Okay
|Okay.
At the beginning of this extract, the previous patient is getting ready to leave (line 1) while the doctor is giving her advice about how to recover faster (line 2). When this

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9 This turn is addressed to the researcher. “It” refers to the video camera that the researcher placed on the diagnostic table.

10 A suburban district of the city of Tianjin.
happens, the incoming patient, who has been sitting on one of the acupuncture tables stands up and approaches the doctor’s desk (line 6 & 7). As soon as the previous patient turns around and leaves, the incoming patient sits down in the patient’s chair. As the incoming patient is approaching the doctor’s desk, there is a brief exchange between the doctor and the researcher (me) regarding the location of the camera (lines 8 & 9).

After the patient sits down in the patient’s chair, he immediately places his wrist on the pulse pillow, assuming the pulse-taking position, indicating his readiness to begin the consultation. In the meantime, he reports to some news to the doctor (line 11): Tai duo le. Zhongfeng de (“So many. (People who had) strokes”). The patient’s report here appears to be irrelevant to the ongoing consultation since it is not about his own health status. However, later he expresses concerns about the health status of his own cardiovascular system and requests the doctor to prescribe some TCM medicine that will help him better maintain his health. This suggests that line 11 may be heard as indicating a health-related concern.

The doctor’s acknowledging response to this (line 13) is a little delayed – there is a 0.3 second gap after the patient’s report, during which time the doctor is operating the patient registration system on her computer and locating the patient’s file. After the file is located and opened, the doctor responds to the patient’s report at line 13: “Mm hm”. The doctor’s minimal response here could be construed as a continuer, which indicates that the speaker is aligned as recipient of a multi-unit turn (Schegloff, 1981; Mandelbaum, 2013; Stivers, 2008).

After a brief gap (line 14), the patient continues his telling about people he knows who have had a stroke (line 15 to 21):

015 PAT: Wo jiu zhouweiren si ge.
I just people around me four
Four people that I know (had a stroke).

016 DOC: ( ).

017 PAT: (lai ) lai lia le. Women tongshi- yige
(Come ) come two FP. Our colleague- one
(I have ) already seen two. My colleague

018 xi- zai women nar ganhuo de xiaobudianr
xi- at our there work PRT kid
xi- the kid who works at our place his

019 ta die.
his father
father (had a stroke).

020 (0.2)

021 PAT: Dagang de.
Dagang PRT
(They’re from) Dagang.

The patient’s story, although not about his personal experiences, includes many
details (where people work and live etc.). When discussing one of the stroke victims, the
patient refers to his son as “the kid who works at our place”, which indicates that he takes
it that the doctor may know the person to whom he is referring.

This extract shows that in certain situations, securing patient identity in the
opening sequence may be omitted. Here the patient approaches the doctor’s desk without
being summoned, sits down in the patient’s chair, and puts his wrist on the pulse pillow
without being prompted. This indicates that he takes it that the doctor is ready for him,
and that the doctor can recognize him unproblematically. Throughout the opening
sequence, neither the doctor or the patient tries to confirm the patient’s identity,
suggesting that both patient and doctor understand that this is already known.

As discussed earlier, the doctor relies on the activity of confirming patient identity
to make sure that the patient is the legitimate, current patient, and that the medical
file/insurance information is correct. This extract demonstrates that this component may
be omitted when securing identity is not necessary – when a) the doctor knows who the
patient is; b) the patient knows that he is the next patient and c) the patient also knows that the doctor knows who the patient is. In this case, this is made possible due to relational and environmental factors: the patient has a close relationship with the doctor and the interactional environment is simple, with only one patient waiting in the doctor’s office.

**Initiating Pulse-taking**

So far, I have discussed the core activities in TCM openings in which both the patients and doctors engage in tasks preparatory to dealing with the official medical business. In the data segments I have shown, patients frequently assume the position of being the current patient and display their readiness to start the consultation before the doctor is ready. This kind of preparedness may be normative and considered part of “doing being a good patient” in the TCM setting.

Assuming the position as the current patient involves a series of actions. These actions include approaching the doctor’s desk, sitting down in the patient’s chair, and placing the wrist on the pulse pillow. Since pulse-taking is the first diagnostic activity in TCM encounters, the action of placing the wrist on the pulse pillow displays the patient’s readiness to begin the official business of medical data gathering.

The diagnostic technique of pulse-taking is an important part of many traditional systems of medicine. It is widely used in India, Greece, Mongolia and China (Tang, 2012). In TCM in particular there is a complex knowledge system regarding pulse-taking, including different types of *Mai Xiang* (pulse conditions) that are generally associated with health problems located in different organs. To take a patient’s pulse, the TCM practitioner puts three fingers (index finger, middle finger and ring finger) on the
inner part of the patient’s wrist. Those three fingers are placed on three different locations. Each location has a corresponding organ (see Figure 7).

![Distribution of organs in different locations](image)

**Figure 7 distribution of organs in different locations (Tang, 2012)**

Due to the growing popularity of TCM around the world, many researchers in the medical field are now trying to test the scientific validity of pulse diagnosis (King, Cobbin, Walsh & Ryan, 2002; Zuo, Wang & Zhang, 2014). The next section of this chapter focuses primarily on the interactional function, rather than the diagnostic function, of pulse-taking.

The initiation of pulse-taking is interactionally significant in TCM visits. It marks the transition from the opening sequence, in which the doctor and patient collaboratively prepare for the visit, to the activity of data gathering – the beginning of the official medical business. TCM patients ordinarily treat the beginning of pulse-taking as a green light to launch medically relevant topics.

There are two steps that interactants take collaboratively to initiate pulse-taking. First, the patient lays their hand on the pulse pillow, exposing the inner part of their wrist; second, the doctor places three fingers on the radial artery in the patient’s wrist. There are three different ways for pulse-taking to unfold (see Table 3 for the distribution of cases):

a. Normative cases. The majority of my cases (60/86) are normative cases, since they have the following features: first, the patients place their wrist on the pulse pillow
spontaneously, without being prompted to do so. Second, the timing of the patients’ action of placing their wrist occurs at two possible junctures: either as they are sitting down in the patient’s chair, or immediately after they sit down.

b. Early cases. In 6 out of 86 cases wrist placement occurs early, when patients either have their arms extended as they are approaching the doctor’s desk, or engage in bodily actions that help facilitate the doctor’s access to their wrist, such as rolling up sleeves or adjusting wrist watches, bangles etc. These cases are early relative to the normative cases, since patients assume the position before they even get to the patient’s chair.

c. Late cases. In 11 out 86 cases in my collection, patients have to be prompted by to place their wrist on the pulse pillow. This happens in two different circumstances: first, the patient indicates uncertainty about whether or not it is their turn to be seen; second, other medical or non-medical activities disrupt the normal order of events, such as reading test results or medical images, non-medical talk, etc.

However, when the pulse-taking activity is officially initiated is determined by the doctor. Depending on whether or not they are involved in other activities, such as filling out patient registration form, retrieving patient information or dealing with an intervening patient, the doctors may put their fingers on the patients’ wrists immediately after the they are placed on the pulse pillow, or after their other involvements are closed. Occasionally, patients may even temporarily retract their hands to avoid appearing insistent while the doctors have other involvements. It is worth noting that even when the doctors do not place their fingers on the patients’ wrists immediately, interactants do not
orient to it as problematic or late. Hence, the timing of pulse-taking initiation discussed here involves only the patient’s action of getting ready for the activity.

Table 3: distribution of types of pulse-taking initiation

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early</strong> - Patient assumes position early/engages in preparation</td>
<td>6</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Normative</strong> - Patient assumes position while / immediately after sitting down</td>
<td>69</td>
<td>78%</td>
</tr>
<tr>
<td><strong>Late</strong> - Patient assumes position late, after prompted</td>
<td>11</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Total cases</strong></td>
<td>86</td>
<td>100%</td>
</tr>
</tbody>
</table>

Total cases in data collection =107. 86/107 cases involve pulse-taking.

In this section, I show how pulse-taking is organized differently in each type of case. First, I show canonical, normative cases in which the patient spontaneously approaches the doctor’s desk, sits down in the patient’s chair and places her wrist on the pulse pillow as soon as she sits down. Then I describe a case in which the patient presents their wrist early. I show how patients engage in bodily actions to ready themselves when they are on the way to the doctor’s desk. This happens when the patients fail to approach the desks spontaneously because of some local contingencies. In Extract 11, the patient begins to get ready for pulse-taking when she is still on the way to the doctor’s desk. Her “readying” action is remedial because she has not been monitoring the registration queue closely. Last, I examine two cases that are late, since the patients need to be prompted to place their wrists on the pulse pillow by the doctor. In these two cases, patients' actions of
placing their wrist on the pulse pillow is delayed for different reasons. In Extract 12, the patient, a young adult with ASD (autism spectrum disorders) needs to be reminded by both his father and the doctor to put his wrist on the pulse pillow. In Extract 13, the beginning of pulse-taking occurs late because of an intervening activity.

Transcription symbols:

- > Patient lays wrist on the pulse pillow

*> patient takes other actions to prepare for pulse-taking

=> Doctor places fingers on the patient’s wrist; doctor gets ready for pulse-taking

In over half of my cases (60/107), the patients’ action of laying the wrist on the pulse pillow is spontaneous. This indicates that it is a common understanding among TCM patients that pulse-taking is the first medically relevant activity in their visits. Hence, the beginning of pulse-taking indicates that the doctor and patient have accomplished the transition from the opening sequence to the data gathering activity.

**Normative Cases**

Extract 10 below is a clear case that exemplifies how pulse-taking normatively unfolds. The beginning of this extract shows the previous patient leaving (line 4) after which the current patient sits down in the patient’s chair. Note that as soon as the patient sits down, she rests her wrist on the pulse pillow (line 7), without being prompted by the doctor. Here the patient’s actions of approaching the doctor’s desk, sitting down in the patient’s chair and putting her wrist on the pulse pillow are produced as a continuous series of actions, without being prompted by the doctor in any way. Also, in this extract,
there is a noticeable gap between the patient’s action of laying down her wrist and the
doctor’s action of placing his fingers on the patient’s wrist.

This extract begins with the previous patient leaving. As the previous patient is
walking out of the camera’s view, the incoming patient approaches the doctor’s desk
spontaneously, without being summoned by the doctor. As discussed in the previous
section, the patient here is able to discern the right moment to approach based on verbal,
bodily and social structural resources: she has been standing close to the doctor’s desk
and paying attention to the verbal and bodily actions of the doctor and the previous
patient to discern the right moment to approach. When the incoming patient approaches, the doctor is still navigating the patient registration system, possibly trying to locate the incoming patient’s file.

After the patient’s file is finally located, he seeks confirmation from the patient that her name is “Wang Hongren” (line 7), possibly what the doctor sees in the registration system to secure her identity. After the patient’s identity is confirmed (line 8), the doctor moves his hand from the computer mouse to the patient’s wrist, initiating pulse-taking (line 10), which marks the official beginning of the data gathering phase of the patient’s consultation.

By laying her wrist on the pillow immediately after she sits down and when the doctor is still busy with the preparatory tasks, the patient here displays her understanding that pulse-taking is the next relevant activity in her visit. In this way she also indicates her readiness to begin pulse-taking and transition to the data gathering phase. Also, almost immediately after the pulse-taking begins, the patient proffers a medical topic by delivering an update on her newly adopted health-related habit.

In this extract, pulse-taking, as the first medically relevant activity in TCM visits, occurs after the doctor has accomplished the preparatory tasks that he needs to do before officially starting the medical consultation. However, pulse-taking is a collaborative activity that needs mutual engagement from both parties. We see patients display their readiness by placing their wrist on the pulse pillow without being prompted, showing their orientation towards pulse-taking as the next relevant activity after they sit down. However, pulse-taking is not officially in process until the doctor is also actively
engaged. Here, we see that the doctor, after completing all the preparatory tasks, places his fingers on the patient’s wrist and sets the pulse-taking activity in motion.

As discussed earlier, most TCM patients get into the position of the current patient spontaneously and in a timely fashion, when it is their turn to be seen. Also, as the patients are sitting down or immediately after they sit down, most of the patients place their arms on the wrist pillow to get ready for the pulse-taking activity. This is so pervasive that even children display an orientation towards it by enacting this series of actions: approaching the doctor’s desk, sitting down and placing the wrist on the pulse pillow. In the following extract, the patient, a 4-year-old girl, is in the doctor’s office with her mother. The pair approaches the doctor’s desk as the previous patient’s visit is closing (line 5), and then sits down in the patient’s chair when the previous patient has left (line 12). After the patient is settled (sitting on her mother’s lap, line 17), she spontaneously places her wrist on the pulse pillow (line 21). The patient’s action here shows that she, similar to other patients, understands pulse-taking to be the first medical activity in her visit.

Extract 11

WW_TCM_VID0003_8_7_4_21

Participants: doctor (DOC), previous patient (PRP), patient’s mom (MOM) and current patient (PAT)

003  (0.3)

004  DOC:   Wanshang rang ni ba lai na.
      Evening let your father come pick up
      Ask your father to come here and pick it up later.

005  PAT:       |{(PAT begins to approach with her mother)}

006  PRP:   |Xing.
         |Okay.
         |Okay.

007  prp:   |{(gets up and leaves/PAT and MOM yield)

008  DOC:       |En. Qu ba.
         |Hmm. Go FP
         |Hmm. Go ahead.
Although the patient and her mother here approach the doctor’s desk spontaneously, the mother seeks confirmation from the doctor that they are indeed the next patient to be seen (line 13, Zhangxiuhua. Shi ba. “Zhangxiuhua. Is it”). After
receiving confirmation from the doctor, the patient’s mother, who is sitting in the
patient’s chair, puts the patient on her lap (line 16). After they are settled, the patient
places her wrist on the pulse pillow (line 21), spontaneously assuming the pulse-taking
position. Her mother, upon seeing this, produces a token of approval at line 22 Zheyang
(“just like this”), indicating that what the patient just did (placing her wrist on the wrist
pillow) is the right action for that moment. The mother’s praise here indicates that she
takes a “teaching” stance towards her daughter, praising her for producing the correct
action at the right time. Potentially in response to the mother’s turn in line 22, the doctor
reorients his body to face the patient. He glances at the patient’s hand and moves his hand
closer to the pulse pillow (line 23). This may indicate that the doctor treats the patient’s
action of laying her wrist on the pulse pillow as an invitation and responds to it by getting
ready to start pulse-taking.

At line 24, after the doctor’s change of body orientation and hand movement, the
patient’s mother gives the patient further instructions, asking her to place her hand in the
doctor’s hand. She also provides physical assistance by moving the patient’s arm closer
to the doctor (line 25). The mother’s actions here, both verbal and embodied, show her
orientation towards the doctor’s prior bodily actions (change of body orientation and
hand movement) as displaying readiness to initiate pulse-taking. Hence, by implementing
the verbal action of providing instructions and the bodily action of moving her arm closer
to the doctor, the mother helps the patient to assume the correct position so the activity of
pulse-taking can get underway.

024  MOM:  Ai. |Gei ta gei |ta.
       Right. |Give him give |him
              Right. Give (your hand) to him. Give (your hand) to him.

025  mom:->          |{(moves DAU’s|arm closer to DOC))
The doctor finally places his fingers on the patient’s wrist (line 26), initiating the pulse-taking activity. This marks the official beginning of the data gathering phase in this visit.

In this extract, the patient, a 4-year-old girl clearly displays her understanding that pulse-taking should be the next relevant activity after sitting down by placing her hand on the pulse pillow spontaneously, right after she sat down on her mother’s lap. Her mother displays a similar orientation by first approving the patient’s action, and then providing further instructions to the patient to help her adjust the position of her hand. In addition to displaying readiness to start the medical interview the daughter and her mother’s actions may also be understood as inviting the doctor to partake in the pulse-taking activity. This is accomplished by the daughter getting into the pulse-taking position first, making the inner part of her wrist available to the doctor, as well as the mother praising her and offering her assistance.

The doctor responds to the patient’s and her mother’s actions in an embodied way: he orients his body towards the patient and moves his hand closer to her immediately after the patient’s action of placing her wrist on the pulse pillow. He finally puts three fingers on the patient’s wrist when the patient’s wrist is placed the right way (with a little help from her mother). Through these bodily actions the doctor begins in the activity of pulse-taking, launching the official medical business of data gathering. It is clear that the patient’s mother also treats the doctor’s action as starting data gathering.
She begins presenting a concern as soon as the doctor lays his fingers on the patient’s wrist (line 27, *Ta ke- kesou* (“She cou- coughs”)).

**Early Cases**

There are 6 cases in my collection when the patients begin to get ready for pulse-taking before they arrive at the doctor’s desk. These cases deviate from the norm (more commonly patients ready themselves as they are sitting down or immediately after they sit down). My analysis suggests that patients’ actions of getting ready for pulse-taking preemptively are remedial – they are produced to offset potential “mistakes” made by the patients earlier in the interaction.

Extract 11 below is an example of a case in which the patient presents herself early. The patient in this extract is summoned by the doctor rather than approaching the doctor’s spontaneously (see detailed analysis of this in Extract 3). Earlier in this chapter I discussed how an attentive patient should monitor what is taking place at the doctor’s desk as well as the patient registration queue and approach the doctor’s desk in a prompt fashion when it is their turn to be seen. In this extract, however, the patient walks towards the doctor’s desk after being summoned. Since it is normative for patients to be ready and get into position spontaneously, the fact that the patient needs to be summoned may indicate that she is not being fully attentive by paying close attention to the ongoing interaction at the doctor’s desk. Hence, we see the patient possibly trying to remediate the situation by beginning to extend her arm to assume the pulse-taking position when she is still on her way to the doctor’s desk. Given that the patient engages in actions preparatory for pulse-taking activity before she gets to the doctor’s desk (deviating from the
normative trajectory of pulse-taking), in this case we see the initiation of the pulse-taking activity occurring early.

**Extract 11**

Participants: doctor (DOC), current patient (PAT), other patient (OPT)

010  DOC:        [Ranhou:. Fuchenxi.
[Then::.  NAME
{And then  Fuchenxi.

011  ((incoming patient approaches))

012  DOC:   Shi Fuchenxi| ma.
BE  NAME    | Q
Are you Fuchenxi?

013  *pat:               |((walks into camera view with arm extended))

014  DOC:   ((looks at the computer, checking the registration system))

015  PAT:   |A.
|Yes
|Yes.

016  DOC:   |((turns head, glances at the patient))

017  DOC:   Zuo |xialai.
Sit |down
Sit |down.

018  doc:                   |((turns head away, averts eye gaze))

019  pat:    |((sits down in patient’s chair))

020  doc:                   |((looks at the computer, clicking mouse))

021  OPT:   Duo |shao hao xianzai.
How | many numbers now
What| is the current number?

022  pat:    |((retracts arm, adjusts her wrist watch))

023  pat:    |((adjusts patient’s chair, adjusts watch))/

024  DOC:   Dao le wo ziran hui jiao ni.=
|Arrive PRT I naturally will call you
|When it is your turn, of course I will call you.=

025  pat:    |((puts hand on the wrist pillow))

026  DOC:   =Hao ba. Bie |lao shuo rang wo bang ni=
=Good Q. Don’t |always say let me help you
=Okay?  Don’t always ask me to see the number=

027  doc:                   |((moves the pulse pillow closer))

028  DOC:   =|kan zheige hao. Wo kan bu jian.
=|see this  number. I see NEG see
=|for you. I can’t see it.
In this extract, the patient begins to get ready for the pulse-taking activity as soon as the
doctor summons her by name. As we saw in Extracts 1 and 2, most TCM patients
approach the doctor’s desk and place their wrist on the pulse pillow spontaneously.
However, in this case the patient approaches the doctor’s desk after being summoned,
indicating that she might not have been paying close attention to the patient queue. She
extends her arm to assume the pulse-taking position before she sits down (line 13), as she
is approaching the doctor’s desk. This is possibly designed to indicate her readiness, and
to offset the lack of readiness indicated by needing to be summoned in the first place.
However, just as she is sitting down in the patient’s chair upon the doctor’s invitation, a
nearby patient launches an inquiry about the registration order (line 21). While the nearby
patient’s question is still in progress, the patient partially retracts her already-extended
arm to a bent position, and then begins to adjust her wristwatch by moving it up her arm
(line 22), making her wrist more accessible to the doctor (Lerner & Raymond, 2017;
2021). By retracting her arm and adjusting her wristwatch while the doctor is addressing
the other patient, the current patient avoids appearing overly insistent that pulse-taking should begin, but in occupying herself with adjusting her wristwatch she indicates that she is demonstrably oriented to preparing for the medical interaction by fine-tuning the availability of her wrist. In this way, she indicates her strong orientation to facilitating the onset of pulse-taking. After adjusting her wristwatch for a few seconds, the patient lays her wrist back on the pulse pillow (line 25), assuming the pulse-taking position. This is quickly responded to by the doctor (line 27). He moves the pulse pillow closer to him, possibly to ready it for the pulse-taking activity as he is responding to another patient’s inquiry. In this way, he indicates to the intervening patient that he is about to begin the consultation with the patient in the chair. Finally, at line 26, he puts his fingers on the patient’s wrist, indicating his readiness to attend to the sitting patient while he is in the course of addressing the other patient. The doctor’s medical inquiry, a request for an update Yuejing guo le ma (“Is your menstrual period done”), is delivered at line 22, soon after pulse-taking begins.

In this extract, the patient was summoned by the doctor to be the next patient, which may indicate her inattention to the patient queue. Her action of extending her arm as she approaches rather than upon sitting down may be implemented to remediate this apparent inattention.

**Late Cases**

Although it is normative for patients to get ready spontaneously for pulse-taking, in some cases the patients are prompted either by their companion or the doctor to place their hands on the pulse pillow. In the next section, I show two cases in which this type of
prompting occurs. In the first extract, the patient is prompted by his companions (his parents), possibly due to his health condition; in the second extract, the patient is prompted by the doctor because the patient is uncertain about whether or not it is indeed her turn to be seen.

The patient in Extract 12 is one of the doctor’s regular patients. He is 15 years old and has been diagnosed previously with autism spectrum disorder (ASD) which means that his communicative and epistemic capabilities are limited. Depending on the seriousness of the condition, children and adolescents with ASD may need help from their parents and medical professionals to achieve interactionally the role of a competent patient (Solomon et al., 2016). The patient is in the doctor’s office for a routine checkup, accompanied by both of his parents.

In this extract, the patient does not spontaneously place his wrist on the pulse pillow. Instead, his father explicitly directs the patient to place his wrist on the pulse pillow so he can be ready for the pulse-taking activity.

**Extract 12**

WW_TCM_VID0003_8_7_1_21

Participants: doctor (DOC), patient’s mom(MOM), patient’s dad (DAD) and current patient (PAT)

015 DOC: Lai./((to PAT and his father))

Come

016 doc: ((walks towards desk, [extends hand to take the receipt])

017 DOC: [Ting hao de./((to mom))

[Very good FP

[(You are) doing well?]

018 MOM: Ting hao de.

Very good FP

(We are) doing well.

019 (0.3)/((PAT approaches the doctor’s desk))

020 MOM: Hai nei yang.

|Still that appearance |

| (We are) still the same.

021 pat: |((sits down in the patient’s chair))
This extract begins with the doctor summoning the patient (line 15). The patient’s mother is already standing next to the doctor at this point, with the registration receipt in her hand. The doctor greets the patient’s mom with an inquiry as she takes the registration receipt from the mom’s hand (line 17, (You are) doing well?). The patient approaches the patient’s chair (line 19) and sits down (line 21).

Note that after the patient is seated, he laughs inaudibly with his hands on his lap (line 24). It is clear that the patient is not in position to start the pulse-taking activity, given that his hand is not on the pulse pillow. However, the doctor displays readiness via her embodied actions: her body is oriented towards the patient and her eye gaze is directed at the patient.

11 Here “attacks” refer to the hysterical episodes this patient sometimes has. They are also occasionally accompanied by seizures.
Possibly prompted by the doctor’s display of readiness, the patient’s father verbally directs the patient to put his hand on the pulse pillow (line 26), which receives no uptake from the patient. The father then leans over and grabs his son’s hand and puts it on the pulse pillow (line 28), constructing the patient as incompetent. As soon as the patient’s wrist is in place, the doctor places her three fingers on the patient’s wrist, officially initiating pulse-taking.

Here the patient does not assume the pulse-taking position spontaneously after he is seated in the patient’s chair. However, his father displays a clear orientation towards pulse-taking as the next relevant activity by first asking the patient to place his hand on the pulse pillow, and then manually helping him position it. The patient’s father’s prompt indicates that he takes it this is the next relevant activity, showing that it is normative for patients to place their wrists on the pulse pillow after they are seated. When this is missing (as in this case), other interactants involved in the consultation may pursue it.

In Extract 13, the patient is prompted by the doctor to place her wrist on the pulse pillow. In contrast to the previous extract, the patient here needs to be prompted because she is unsure about whether she is the legitimate next patient. Hence, she needs to ascertain that she is next in line before she can proceed with the visit.

**Extract 13: My turn**

Participants: doctor (DOC), previous patient (PRP), other patient (OPT) and current patient (PAT)

001 prp: ((stands |up, taps the desk))

002 PRP: |Xiexie nin a. |Thank you FP |Thank you.

003 DOC: Qu ba.= qu ba. Go FP.= Go FP GO ahead.= Go ahead.

004 (1.2)
PAT: Dao wo le ba.
Arrive me PRT FP
It is my turn right?

DOC: En./((to another patient))
Hmm
Hmm.

DOC: Shiji ge ren ba. /(to another patient))
Ten QUAN people FP
Around ten people.

Deng |hir a. |Pai dao ni a.
Wait |a while FP. |Queue arrive you FP
Wait for a while. |Wait for your turn.

DOC: |((gazes at PAT,)|taps the pulse pillow))

PAT: |En.
|Mm hm
|Mm hm.

PAT: |((moves left hand closer to the pillow))

DOC: Ren ne?/(to another nearby person))
People Q
Where is the patient?

OPT: Ren zai nar.
Person at there
He’s there.

DOC: Ren |jin lai zuo zher.
People |come in sit here
He should come in and sit here.

DOC: |((points at another chair))

OPT: |Zuo zuo zuo
|Sit sit sit
|Sit sit sit.

DOC: Zenme yang?
How shape
How are you holding up?

PAT: Xianzai hao- haoduo le.
In this extract, the incoming patient enters the camera view after the previous patient’s visit is closed. She then sits down in the patient’s chair (line 5). As she is sitting down, she checks with the doctor whether it is indeed her turn to be seen (line 6, *Dao wo le ba* (“It’s my turn right?”)). It is worth noting that the doctor’s office is exceptionally busy (information available in ethnographic notes). Since the doctor’s desk is surrounded by patients, it is possible that the patient has lost track of the patient registration queue.

The patient’s question is not responded to by the doctor immediately since the doctor is engaged in another line of action, informing a nearby patient about the current situation of the patient queue (lines 7 to 10). When delivering the last part of his turn addressed to the other patient (line 10), the doctor directs his eye gaze towards the incoming patient, who is already sitting in the patient’s chair, and briefly taps the pulse pillow. The patient’s response to this tap indicates that she treats it as a prompt. She responds to it both verbally and bodily, by producing a “Mm hm” at line 12, and then at the same time, moving her left hand towards the pulse pillow. However, this action is quickly corrected by the doctor – he waves his hand briefly, a gesture of disproval in the Chinese culture, possibly indicating to the patient that the patient is trying to put the wrong hand on the pulse pillow (line 14). The patient’s response shows that she treats the doctor’s small hand wave as indicating this. She retracts her left hand, places her bag on the ground, and then switches to put her right hand on the pulse pillow (line 15).

The doctor continues to use his computer after the patient rests her hand on the pulse pillow. He then turns around to check another patient’s status and invites him to
come into his office (line 17-20). Finally, at line 23, the doctor places his fingers on the patient’s hand, and at the same time, shifts his eye gaze towards the patient. At this point, the doctor is fully engaged in the patient’s consultation. Note the doctor’s medical talk, an opening question (line 24, *Zenme yang* (“How are you holding up”)) is delivered in coordination with the beginning of pulse-taking, indicating the transition to the data gathering phase.

In this extract, the patient is unable to discern whether or not it is her turn to be seen. Hence, she does not place her wrist on the pulse pillow spontaneously, as most patients do in my data collection. We see that the doctor produces a subtle gesture (a small tap on the pulse pillow) which is clearly understood by the patient as a prompt and places her wrist on the pulse pillow accordingly.

The next extract is another example in which patient needs to be prompted by the doctor to place his wrist on the pulse pillow. Here, the activity of pulse-taking is delayed by another medical activity, prescription adjustment. Extract 14 begins with the closing of the previous patient’s visit (line 1). The patient, who has been standing next to the doctor’s desk sits down in the chair as she hands over her prescription from last visit to the doctor (line 2). In the meantime, she also presents a problem with the previous prescription (line 4), which is hearable as a request for adjustment. The patient in this extract does not place her wrist on the pulse pillow until prompted by the doctor (line 10). The pulse-taking is delayed because the medical activity of prescription adjustment precedes it.

Extract 14

Participants: doctor (DOC), patient (PAT)
The patient reports a problem regarding the doctor’s prescription from her last visit as she is sitting down (line 2, *Shang ci neige yao(.) shao le* (“I did not get enough medicine last time”) ). She also hands the doctor the physical copy of the prescription, possibly providing the doctor with evidence for her problem. In response, the doctor takes the prescription and reads through it (line 3). The patient extends the report of her
problem at line 4, providing more details about it, possibly pursuing a response from the doctor (Bolden et al, 2012).

In line 5, when the patient’s report is still in progress, the doctor begins to use her computer, possibly in an effort to fix the patient’s prescription’s problem, given that all prescriptions are digitized and stored in the patient registration system. In line 6, the doctor solicits information from the patient about the specific item on the prescription that the patient is trying to fix (*Neige* (“Which one”)), which may be further evidence that the doctor is trying to solve the prescription issue.

After the patient has provided the name of the medication (through a word search, collaboratively completed by the doctor; line 8, *Jiu nin shuo neige zhen- zhen- zhen-* (“Just the one you mentioned. Zhen- zhen- zhen-”)), the doctor reorients her body to face the patient (line 9). She then gently presses the pulse pillow and pushes it towards the patient. This embodied action may be understood as prompting the patient to put her wrist on the pulse pillow.

In response, the patient places her wrist on the pillow (line 11). She also produces an apology, potentially for not placing her wrist on the pillow spontaneously (line 12, *Baoqiao baoqian* (“Sorry sorry”)). Immediately after the doctor puts his fingers on the patient’s wrist, she launches a medical question, requesting an update from the patient on her blood pressure issue (line 14).

In this case, the patient fails to place her wrist on the pulse pillow because of another medically relevant activity. Since the patient needs to accomplish a specific task first (adjusting her prescription), the pulse-taking activity is delayed. Also, the patient, in apologizing for having to be prompted to place her wrist on the pulse pillow, displays an
orientation towards the normativity of patient placing wrist on the pulse pillow without being prompted. That is, the patient’s apology indicates that not having her wrist on the pulse pillow is something problematic and worth apologizing for.

In the previous cases, we saw that patients ordinarily treat pulse-taking as the first medically relevant activity in TCM visits. It is normative for patients to place their wrists on the pulse pillow and get into the pulse-taking position as soon as they sit down. In this case, however, the pulse-taking activity is delayed because the doctor and patient are dealing with a specific task before starting to gather data about the patient’s current health status. Other activities such as blood pressure-taking, or test results-reading may also precede pulse-taking and put pulse-taking on hold.

In this subsection, I have examined three different cases in which patients were prompted either by their companion or by the doctor to place their wrist on the pulse pillow. These “prompts” occur for different reasons: a) in the first case, the patient, despite being a regular patient, needs to be prompted by his parents. The patient’s failure to place his arm on the pillow spontaneously and the parents’ prompting actions construct the patient as an incompetent patient; b) in the second case, a preparatory task, securing patient identity, is accomplished before the doctor and the patient proceed with the normal medical business; c) in the third case, other medical activities precede pulse-taking: the patient reports a problem with her prescription. Given that the canonical order of events at the beginning of the consultation has been disrupted, the patient needs to be prompted when it is time to start pulse-taking. This indicates that the patient takes the initiative when it is the normal organization, but when that is disrupted, the patient appears to take it that the doctor determines what happens when.
In this section, I have outlined three positions in which the pulse-taking activity is initiated. First, it is canonical for the patients to assume the pulse-position by placing their wrist on the pulse pillow as they are sitting down, or immediately after they sit down in the patient’s chair. The first two cases in this section, Extracts 10 and 11, are normative cases. As these two cases show, patients in TCM encounters display a clear orientation towards pulse-taking as the first item on the medical agenda by getting ready for it spontaneously and promptly. As discussed earlier, this may be, part of “doing being an attentive patient” in the TCM visit.

Occasionally, patients may lose track of their place in the registration queue and fail to approach the doctor’s desk spontaneously. In this case, they are summoned by the doctor to begin the visit. We see that in Extract 12, the patient engages in actions preparatory for pulse-taking even before she arrives at the doctor’s desk. These actions which the patients produce to “ready” themselves preemptively are remedial in the sense that they appear to be implemented to offset the earlier lack of readiness.

In some cases, patients may also need to be prompted by the doctor to place their wrist on the pulse pillow. As Extracts 13, 14 and 15 show, this may be occasioned by different circumstances, such as the patient’s limited mental capacity, the patient’s lack of knowledge about the registration queue and other medical activities that shift the normal order of events in the visits. In these cases, the patient’s failure to place his wrist spontaneously and in a timely fashion is treated by the doctor as “officially missing”, hence, a prompt is implemented to pursue it.

*Initiating Medical Talk*
The cases shown so far demonstrate that the initiation of pulse-taking normally marks the official beginning of the data gathering phase in TCM encounters. Data gathering in TCM includes four sub-activities: pulse-taking, observation, concern presentation and history-taking. These four sub-activities can be mapped onto the theoretical system of diagnosis in TCM – pulse-taking is for the diagnostic method of qiè (palpation); observation is for wàng (inspection); concern presentation is for wén (listening) and history taking is for a different wèn (interrogation). When pulse-taking is initiated, patients treat it as a go-ahead to present their problems. Similarly, doctors also only launch medical questioning after they have placed their fingers on the patients’ wrists. In what follows, I show five different cases. Two of the five cases (Extracts 15 & 16) involve the doctor initiating medical talk after placing his or her fingers on the patient’s wrist. These cases show examples of the two most common types of doctor-initiated medical talk: update solicitation and routine medical questions. In the other three cases (Extracts 17, 18 & 19), the patients begin providing medically relevant information after the pulse-taking activity is officially initiated. In two of these cases, the patients present a new medical problem. In the other case, the patient offers an update on her lifestyle choices. These cases show that doctors and patients orient to the existence of at least three types of medical talk initiated by the doctors, and two types of medical talk initiated by the patients. Table 4 shows how these types of medical talk are distributed across the data collection. Note that not all visits involve medical talk. Some of the visits (17/107) are task-oriented, and the patients are there for practical issues such as prescription refills or image/test results reading. These cases are excluded from the
discussion in this chapter since participants do not engage in the pulse-taking activity in these visits.

The five extracts in this section demonstrate two different points. First, they are included to show how medical talk is normally initiated in coordination with the beginning of pulse-taking. That is, both doctors and patients treat the beginning of pulse-taking as an indication that they should proceed to talk about medical problems. However, unlike medical talk initiated by the doctor, which is initiated immediately, patient-initiated medical talk is generally produced a few seconds after the beginning of pulse-taking. This may indicate that at the beginning of the data gathering phase, patients normatively give the doctor the first opportunity to initiate medically relevant talk.

Second, extracts in this section provide examples of different types of medical talk that are normally launched in TCM encounters. Extract 15 shows how the doctor initiates medically-relevant talk by soliciting an update from the patient on their past conditions. Extract 16, on the other hand, demonstrates how the doctor asks routine questions at the beginning of the encounter. Extract 17, 18 and 19 are cases of patient-initiated medical talk. Each case is used to show a different type of medical talk that patients may launch at the beginning of their visits. In Extract 17, the patient presents a new problem after the doctor initiates pulse-taking. Extra 18 shows how instead of a single presenting concern, the patient may present a list of problems to the doctor. Extracts 19 and 20 are show how the patient may offer an update on their past condition and thus begin the official medical business. While in Extract 19, the patient provides an update on her lifestyle changes, the patient is Extract 20 reports lack of improvement after receiving treatment from the doctor.
Transcription symbols:

**Boxed**: doctor lays fingers on the patient’s wrist (beginning pulse-taking);

**Bolded**: doctor/patient delivers medical talk

Table 4 Types of medical talk and distribution

<table>
<thead>
<tr>
<th>Initiation</th>
<th>Types</th>
<th>Number of cases</th>
<th>% within category</th>
<th>% in total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor-initiated (44/109; 40.4%)</td>
<td>Update solicitation</td>
<td>17</td>
<td>38.6%</td>
<td>15.6%</td>
</tr>
<tr>
<td></td>
<td>Problem solicitation</td>
<td>11</td>
<td>22%</td>
<td>10.2%</td>
</tr>
<tr>
<td></td>
<td>Routine questions</td>
<td>16</td>
<td>33.4%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Patient-initiated (48/109, 44.0%)</td>
<td>Updates</td>
<td>9</td>
<td>18.7%</td>
<td>8.3%</td>
</tr>
<tr>
<td></td>
<td>New problem presentation</td>
<td>39</td>
<td>81.3%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Task-focused visits (17/109; 15.6%)</td>
<td>Prescription refill</td>
<td>12</td>
<td>70.6%</td>
<td>11.0%</td>
</tr>
<tr>
<td></td>
<td>Medical image/test result reading</td>
<td>5</td>
<td>29.4%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

**Doctor-initiated Medical Talk: Soliciting Updates from the Patient**

In Extract 15, the doctor initiates talk about the patient’s health precisely as he places his fingers on the patient’s wrist to initiate pulse-taking. Here the medical talk initiated by the doctor is one type of medical talk that sometimes occurs (17/109) at the beginning of TCM visits: solicitations of updates on the patient’s past condition. As soon as the doctor places his fingers on the patient’s wrist, he solicits an update from her on her previous condition of itchy eyes.

*Extract 15*

WW_TCM_2015_4_26_TJ5_9_01

Participants: doctor (DOC), intervening patient: IPT, current patient (PAT)
A xing. Xiexie nin.
Hmm okay. Thank you
Hmm okay. Thank you.

((places hand on the pulse pillow))

((glances at PAT, puts hand next to PAT’s wrist))

Jiao shenme laizhe.
Call what again
What’s your name again?

((places hand on the pulse pillow))

((places hand next to PAT’s wrist))

Chen Xiulan.
NAME
Chen Xiulan.

((puts hands back on the mouse))

((continues to navigate the patient information system))

Ni shangtou you liange mei: lai: di:.
You up have two NEG come FP
Two people before you did not come.

((continues to navigate the patient information system))

An shunxu.
According to order
According to the order.

((reaches for PAT’s hand, adjusts the position OF PAT’s hand))

Yanjing zenme le.
Eyes what FP
How are your eyes.
The first part of this extract was discussed earlier in this chapter (Extract 7). In lines 41 to 56, the patient sits down in the patient’s chair and places her wrist on the pulse pillow. After she is seated, the doctor confirms her identity and navigates through the patient information system, potentially trying to locate her file (lines 52 to 56).

When the patient’s file is successfully located and opened, the doctor changes his body orientation and reaches for the patient’s hand (line 57). He adjusts the position of the patient’s hand slightly and then places three fingers on the patient’s wrist, officially initiating pulse-taking. Note that at the very moment his fingers touch the patient’s wrist, he solicits an update from the patient, about her past problem of itchy eyes (line 58).

The precise timing of the doctor’s turn shows his understanding that the initiation of pulse-taking accomplishes the transition from the opening phase to the data-gathering phase. When the doctor places his/her fingers on the patient’s wrist, the stage of data gathering is officially in progress. This is exactly when the doctor’s action of soliciting an update occurs.

**Doctor-initiated Medical Talk: Routine Questions**

In Extract 16, the doctor launches a question about the patient’s menstrual cycle soon after placing his fingers on the patient’s wrist. Note that the question about the menstrual cycle is one of the routine questions that nearly all female patients get asked (except for post-menopausal women). In this extract, the medical talk is slightly delayed, possibly in response to local contingencies: another patient intervenes into the interaction by asking about the patient registration queue. This segment begins with this question-answer sequence between the doctor and the intervening patient. This extract shows how
the doctor may initiate medical talk by asking a routine question about the patient’s health, and that although the launching of medical talk is normally coordinated with the initiation of pulse-taking, it may also be responsive to local contingencies.

Extract 16

Participants: doctor (DOC); patient (PAT)

016 pat: (sits down in patient’s chair)/(1.1)
017 OPT: Duoshao hao xianzai. How many numbers now
What is the current number?
018 pat: (adjusts her wrist watch)
019 pat: (adjusts patient’s chair, adjusts watch)/(2.7)
020 DOC: Dao le wo ziran hui jiao ni. = Arrive PRT I naturally will call you
When it is your turn, of course I will call you. =
021 pat: (puts hand on the wrist pillow)
022 DOC: Hao ba. Bie lao shuo rang wo bang ni = Good Q. Don’t always say let me help you
=Okay? Don’t always ask me to see the number
023 doc: (moves the wrist pillow closer)
024 DOC: kan zheige hao. Wo kan bu jian. = see this number. I see NEG
=for you. I can’t see it.
025 doc: (places fingers on the patient’s wrist)
026 doc: (shifts eye gaze to the computer screen)/(0.3)
027 DOC: Xianzai. Now
For now.
028 pat: (puts phone in her bag)
029 doc: (shifts eye gaze to the patient)
030 DOC: Neige- Yuejing guo le ma. = Um- Period pass PRT Q
= Um- Is your period done?
031 pat: (closes bag)/(0.2)
032 PAT: Yuejing butiao. Period irregular
(I have an) irregular period.
Here the intervening patient’s request for information is declined by the doctor (lines 22 to 24). The doctor’s preparation to initiate pulse-taking starts at line 23, when he moves the pulse pillow closer to his body. The doctor does this as he is rejecting the intervening patient’s request for him to look at his place in the queue (line 22). Here the doctor has two concurrent involvements (Lerner & Raymond, 2017): on one hand he is responding to the intervening patient’s request; on the other hand, he is preparing to launch the current patient’s pulse-taking activity. The doctor’s dual involvement lasts from lines 20 to 27. For instance, the doctor places his fingers on the patient’s wrist (line 25), but his utterance is addressed to the intervening patient. He also directs his eye gaze at the computer screen (line 26) as he is taking the current patient’s pulse. The official beginning of pulse-taking is at line 25, during the delivery of the last part of the doctor’s turn addressed to the intervening patient. It is possible that the beginning of pulse-taking (the doctor placing three fingers on the patient’s wrist) displays to the intervening patient that the current patient’s consultation is officially in process. At line 29, after the intervening patient has left (ethnographic information), the doctor finally turns his full attention to the current patient by directing his eye gaze to her, and simultaneously launches a routine question about the patient’s menstrual period (line 30):

029  doc:   |((shifts eye gaze to the patient))

030  DOC:  |Neige- Yuejing guo le ma.
|Um-   Period  pass PRT Q
|Um-   Is your period done?

Note that the doctor’s medical question comes soon after he has terminated his other involvement with the intervening patient and becomes fully engaged in the current patient’s consultation. As discussed earlier, the beginning of pulse-taking marks the official beginning of the data gathering phase. In this case, the medical talk begins 0.8
second after the pulse-taking activity is initiated. This small delay may be occasioned by
the intervening line of action.

Patients also display a similar orientation towards the beginning of pulse-taking
by launching medically relevant topics after pulse-taking is initiated. To demonstrate this,
I show three different cases in which patients produce medical talk (problem presentation
and updating) soon after the doctor places his/her finger on the patient’s wrists.
Importantly, there is a noticeable gap between the beginning of pulse-taking, and medical
talk initiated by patients. This is in contrast to the previous cases, in which the doctor is
the one who initiates medical talk, and there is minimal or no gap between the beginning
of pulse-taking, and the initiation of medical talk. This suggests that the patient may be
oriented to the doctor having priority in initiating medical talk at the onset of pulse-
taking, by leaving a brief silence that could provide the doctor with an opportunity to ask
before the patient reports medical information.

Patient-initiated Medical Talk: New Problem Presentation

A major type of medical talk delivered by the patient at this stage in the TCM
consultation is new problem presentation. In extract 18, although the patient presents a
medical concern after the doctor has placed his fingers on her wrist, there is a noticeable
2.1 second gap between the initiation of pulse-taking and the patient’s problem
presentation. This gap could be understood as the patient orienting to the doctor having
priority in initiating medical talk at the onset of pulse-taking. Two points can be made
about this case: first, similar to the doctor-initiated cases, the patient also initiates medical
talk soon after the beginning of pulse-taking. This again shows that doctors and patients
understand pulse-taking to constitute the transition from the opening sequence to the
data-gathering activity, in which medical questioning becomes relevant. Second, the brief
gap between the beginning of pulse-taking and the patient’s initiation of medical talk
suggests that the patient may understand that the doctor should be the one initiating
medical talk. Hence, they only raise their medical problems when the doctor does not
launch medical questioning.

This extract begins with the previous patient standing next to the doctor’s desk,
ready to leave (line 1 to 8). Prior to this, the previous patient’s visit was drawing to a
close, with arrangements for medication pickup already made. In lines 1, the previous
patient seeks confirmation from the doctor that he has another visit scheduled. This is
also when the current patient places her wrist on the pulse pillow, showing that she treats
the previous patient’s question about further arrangement as indicating that her
consultation is about to begin. In lines 7 and 8, the previous patient expresses gratitude to
the doctor, which is receipted with meishir (“no problem”) from the doctor.

The doctor places his fingers on the patient’s wrist at line 9, as the doctor is
closing the previous visit, to initiate pulse-taking. The target lines in this extract are lines
10 and 11, when the patient initiates medical talk after a long gap.

Extract 17
WW_TCM_HDV_0034_2014_8_4_07_21
Participants: doctor (DOC), previous patient (PRP), current patient (PAT)

01  PRP:  Xia libai zai lai.
         Next week again come
         I will come again next week.

02  pat:  ((pat places wrist on pulse pillow))

03  DOC:  Hei xia libai ni yao hao le jiu bu
         Hey next week you if good PRT just NEG
         If you are feeling good next week=

04  prp:  ((turns away to leave))
127

2.1 seconds into the pulse-taking activity, the patient presents a medical problem, that she feels weak all over her body. During this 2.1 second, the doctor is fully engaged in the patient’s consultation: his body is oriented to the patient, his eye gaze is directed at the patient’s face. The patient’s problem presentation is launched near the beginning of pulse-taking, which again shows that the patient orients to the beginning of pulse-taking as constituting the transition from opening to data gathering. However, there is a noticeable gap between the beginning of pulse-taking, and the beginning of the patient’s medical talk. This may be evidence that the patient treats the doctor as having the first opportunity to launch medically relevant topics.

In Extract 18 the medical talk is also initiated by the patient. After pulse-taking begins, the patient presents a list that includes three different medical concerns: her stomach is “acting up”, her throat feels sticky, and her cheeks are swollen. Similar to the
previous extract, there is also a gap, albeit brief (0.7 second), between the initiation of pulse-taking, and the beginning of the patient’s problem presentation.

This extract is discussed earlier (Extract 7) as one of the cases in which the doctor prompts the patient to put his/her wrist on the pulse pillow. The pulse-taking activity in this case begins at line 25, when the doctor places three fingers on the patient’s wrist. 0.7 seconds later, the patient starts to present her medical concerns. From lines 27 to 32, the patient presents three different medical complaints. This series of concerns is delivered by the patient after the beginning of pulse-taking, but not immediately. Here the patient does not initiate medical talk right away, but rather waits momentarily, in this way giving the doctor the first opportunity to start medical talk. When it is clear that the doctor is not
going to do it, the patient begins presenting her medical concerns. However, the gap here is significantly shorter than the previous extract (0.7 vs. 2.1 second).

**Patient-initiated Medical Talk: Updates on a Past Condition**

Another type of patient-initiated medical talk produced after the onset of pulse-taking is an update on the patient’s past condition. In Extract 19, the patient initiates medical talk by delivering an update on her lifestyle changes. Although the patient’s update is also launched after the beginning of pulse-taking, it is not delivered immediately after this. Instead, the patient provides the update when it becomes clear that the doctor is not going to initiate medical talk, 1.1 seconds after the pulse-taking begins.

**Extract 19**

WW_TCM_HDV_0033_2014_8_1_09_02
Participants: doctor (DOC), current patient (PAT)

004-> pat:   ((sits down in patient’s chair, rests her wrist on pillow))
005   doc:   ((clicks mouse)) /(0.8)
          LAST NAME  FIRST NAME.= LAST NAME FIRST NAME
007   PAT:   Dui.
          Right
008   DOC:   (((clicks mouse))/(0.3)
009   PAT:   Wo xianzai ye   beir hao.  Tiantian zaoshang qilai
           Now I am very well too. Every morning get up
           duanlian qi.
           exercise go
           and exercise.
The pulse-taking activity begins at line 10, after the doctor places his fingers on the patient’s wrist. There is a 1.1 second gap after this, during which both the doctor and the patient sit quietly. The doctor has his eye gaze fixed on the patient’s face, while the patient looks down at the desk. At line 12, the patient first delivers a positive assessment of her recent health status, and then an account for it: she has adopted the new health-related habit of exercising regularly (line 12 to 13). Note that the patient only initiates medical talk after the 1.1 seconds, where the doctor sits silently, clearly not about to initiate medical talk. This again provides evidence that the patient treats the initiation of medical talk as within the doctor’s domain. Hence, it may be assumed that immediately after pulse-taking begins, the doctor is allocated the first opportunity to produce medically relevant talk.

In Extract 20, the patient initiates medical talk by providing updates on one of her persistent medical problems. This occurs around 11 seconds after the beginning of the pulse-taking activity. In the first part of the 11 seconds, the doctor is asking questions about the patient’s plan to go back to Australia, where she has been studying as an undergraduate student. After this question-answer sequence is closed, the doctor takes the patient’s pulse quietly for 3.8 seconds. Then the patient delivers an update on the acne on her face, something for which she has been receiving treatment. Here the medical talk is produced later than usual (as shown in the previous two extracts) because the doctor begins doing pulse-taking while a question-answer sequence is already in progress. After this sequence is closed, and after a 3.8 gap, the patient launches a medically relevant topic.
This extract begins with the doctor soliciting information about the patient’s plan
to go back to Australia and continue her study there (ethnographic information) (lines 9
to 12).

Extract 20

Participants: doctor (DOC); current patient (PAT)

009  DOC:  Ni shenme shihou huiqu.
You when time go back
When are you going back.

010  PAT:  Jiuyue di.
September end
The end of September.

012  doc:  |((presses the pulse pillow))

013  pat:  |((places wrist on the pulse pillow))

014  DOC:  Jiu ni yige ren huiqu a.
Just you one person going back FP
You are going back by yourself?

015  doc:  |((doc places fingers on wrist))

016  PAT:  En.
Mm hm
Mm hm.

017  (0.3)

018  PAT:  Jiuyue.
September
September.

019  (0.3)

020  DOC:  A. Jiuyue di ha.
A. September end FP
Oh. The end of September.

021  (3.8)/((pulse-taking))

022  PAT:  Heh. Jiu- Juede lianshang nei |doudou bu xing-
|Heh. Just- think on face that acne NEG okay
Heh. Just- The acne on my face is not better-

023  pat:  |((points to her face))

024  DOC:  Wo |kanjian la.
I |saw FP
I saw that.

025  doc:  |((nods))
At line 12, the doctor presses the pulse pillow in front of the patient, presumably in an effort to prompt the patient to place her wrist on the pulse pillow, given that she did not do so spontaneously. In response, the patient immediately lifts her arm and rests it on the pulse pillow. As the doctor is launching a follow-up question about the patient’s plan to go back to Australia (line 14), he places his three fingers on the patient’s wrist, officially initiating pulse-taking. In lines 16 through 18, the patient gives a confirming response to the doctor’s question at line 14 and reports again that she is leaving for Australia in September (two months later). Then the doctor takes the patient’s pulse silently for almost 4 seconds (line 21). At line 22, the patient breaks the silence and delivers an update on her persistent problem of facial acne, which is not showing improvement:

022  PAT:  .Hheh.Jiu- Juede lianshang nei |doudou bu xing-  
      .Hheh.Just- think on face that |acne NEG okay  
      .Hheh. Just- The acne on my face is not better-

023  pat:                                    |((points to her face))

024  DOC:  Wo |kanjian la.  
      I |saw       FP  
      I saw that.

025  doc:  |((nods))

The patient here updates the doctor on her facial acne by both reporting the problem (line 22) and showing it (line 23). Note that this is a medical problem that is visually accessible to the doctor. For TCM practitioners, it is important for them to be observant given that wàng “(inspection)” is one of the most important diagnostic tools in Chinese medicine. In other words, TCM practitioners are normally held accountable for being able to notice medical signs that the patient manifests. Hence, it might be problematic here that the patient points out an observable medical problem before the
doctor gets to do it, since it may indicate that the doctor fails to notice this medical sign. Additionally, this patient has seen the doctor before about her facial acne. Her lack of improvement may imply that the doctor’s treatment is ineffective, calling the doctor’s expertise into question.

We see the doctor orient to this at line 24 by claiming to have independent access to the medical problem that the patient has just presented: “I saw that.” Here the doctor indicates that he has seen the patient’s problem. In this extract, the patient initiates medical talk by providing an update on her persistent medical problem of facial acne. While in the previous extract, the update is a piece of good news, this update is a report of lack of improvement. Similar to the previous extract, the patient in this extract does not deliver this update until 1.1 after pulse-taking is officially initiated. This may be further evidence that patients understand that the doctor should be the one initiating medical talk. Patients produce medical talk only when the doctor does not do so.

Discussion & Conclusions

Summary of Findings

In this chapter, I have outlined and discussed the essential components of opening sequences in TCM visits. The doctor’s office in TCM clinics is almost always congested, filled with patients waiting to be seen by the doctor. In order to accommodate this complex physical environment, TCM doctors and their patients engage in interactional work to make sure that the consultations go as smoothly and efficiently as possible. Close examination of data shows that TCM patients are aware of the normative structure of TCM visits, and they get ready for their visit without being prompted or reminded by
the doctor. They stay near the doctor’s desk to monitor the interaction occurring at the doctor’s desk and to keep close track of the patient registration queue. This due diligence allows them to approach the doctor’s desk promptly and spontaneously, sit down in the patient’s chair, and place their wrists on the pulse pillow immediately after they are seated. This attentiveness appears to be what is required for TCM visits to unfold smoothly in such a busy, crowded environment.

There are four core activities in TCM openings: initiating the visit, securing patient identity; initiating pulse-taking and launching medical talk. These activities are collaboratively implemented by the interactants to accomplish different tasks. For example, in the activity of initiating the visit the patient gets into position as the next patient leaves. The sequence in which the patient’s identity is secured verifies the patient’s identity so the doctor knows that they are treating the right person using the right insurance. The initiation of pulse-taking is of great interactional significance in TCM encounters because it accomplishes the transition from the opening phase to the data gathering phase. Beginning medical talk is a way for doctors and patients to establish the medical project that they are going to engage in. It is normatively produced in coordination with the initiation of pulse-taking. The openings of TCM visits are normally brief (average 14 seconds). However, as Schegloff (1986) demonstrates, this 14-second period is in fact, a delicate interactional achievement.

First, the summons-answer sequence is not always necessary in initiating TCM visits. Patients diligently monitor the activities at the doctors’ desks, which allows them to approach the doctors and sit down in the patient’s chair at the right time. In cases where there is a summons-answer sequence, there is usually something “disruptive”
going on, such as an unusually crowded office where the patients’ and/or the doctors’ view is obstructed, or no-show patients that disrupt the order of the patient registration queue.

Second, in the activity of securing patient identity, I show that doctors attend to two different tasks: making sure that they are treating the right patient and making sure that they are charging the right insurance. Doctors may check patients’ names and registration numbers before they sit down, as they are sitting down or after they are already seated. In cases where the patients’ identity is secured after they are already seated, there are intervening activities that prevent the doctors from checking the patients’ information before they sit down.

Third, pulse-taking is a TCM-specific medical activity that occurs at the beginning of most TCM visits. Its commencement marks the beginning of official medical business. As demonstrated by my analysis in this chapter, both patients and doctors display a clear orientation towards pulse-taking as the first medically relevant activity. This orientation is demonstrated by patients’ action of getting ready for pulse-taking as they are sitting down in the patient’s chair, or immediately after they are seated. In a few cases where patients needed to be reminded, the doctors simply tap on the pulse pillow without giving any explicit instructions.

Fourth, in TCM encounters, medical talk is normally launched immediately after the doctor places their fingers on the patient’s wrist. Findings from this chapter suggest that patients treat the doctor as someone with the right to initiate medical talk. This is evidenced in the timing of the first medical topic. When doctors initiate the first medical topic, it coincides with the onset of pulse-taking. When the patient initiates medical talk
by either presenting a new concern or providing an update on an old problem, there is a
gap between the doctor’s action of placing fingers on the patient’s wrist, and the
beginning of medical talk.

Findings from this chapter have implications for conversation analytic research on
openings and the overall structural organization of medical encounters. Prior research
has demonstrated that the opening phase of social interactions is of great interactional
significance (Pillet-Shore, 2008; Robinson, 1998; Schegloff, 1968). In the opening
sequence, interactants establish co-presence, construct or enact social relationships and
collaboratively determine the nature of the encounter (Schegloff, 1986; Pillet-Shore,
2018). This is especially the case for medical encounters, where doctors and patients
work together to accomplish a series of institutional tasks that are preliminary to the
official medical business (Robinson, 1998). I find a similar pattern in TCM encounters.
Some of the components in the openings of TCM encounters are very similar to those
identified in the openings of Western primary care visits, given that the institutional tasks
are similar across different cultural settings. For example, before the medical business is
officially initiated, the patients need to sit down in the chair, putting themselves in a
position to be seen by the doctors; their identities need to be secured to make sure that the
doctors are treating the right patients. However, since Chinese hospitals operate
differently than American medical facilities, some of the core components of TCM
consultation openings are context-specific, responsive to the physical environment of and
local contingencies in and norms of TCM visits. For example, the simple actions of
placing wrist on the pulse pillow and pressing the pulse pillow are oriented to by the
patients and doctors as interactionally significant, as pulse-taking is the first medical
activity in TCM consultations that marks the official beginning of data-gathering. It is also worth noting that these differences go beyond managing the medical tasks in a particular physical environment. The openings examined in this chapter enact (and exhibit) a very different kind of relationship between doctors and patients (and other patients) in terms of their rights and responsibilities (what it means to be a “good patient” and a “good doctor”), expectations of privacy, etc. Also, the analysis here in this chapter has implications for the interactional organization of opening sequences of chronic medical visits. The activities in the opening sequences are organized differently because there is not a “doctorable” problem that the patients and doctors are trying to address, instead, we see that many encounters begin with the doctors soliciting updates from the patients or the patients provide updates on their recent health status.

Findings from this chapter have implications for our understanding of the overall structural organization of medical encounters. Robinson (2003) pointed out that in acute care visits, medical consultations are organized into different medical activities that revolve around the main project of solving patients’ new medical problems (p. 30). Since a lot of TCM visits involve chronic care, and are not addressed to resolving new medical issues, the medical activities that occur during a medical consultation may also be different. For example, TCM visits typically do not begin with problem solicitation (Heritage & Robinson 2006) (68/107). Instead, the main goal is for doctors and patients to work together to develop a plan to maintain and improve the patient’s health. Hence, as shown in this chapter, the official medical business may be initiated in different ways in TCM encounters: doctors may request an update from the patient on the patient’s past conditions to determine their current health status or makes an observation of the
patient’s appearance to solicit more medically relevant information. It is also very common for patient to initiate medical talk by volunteering information that is relevant to their health without a verbal prompt from the doctor. These findings extend Robinson (2003)’s discussion about overall structural organization by providing more evidence that the project that doctors and patients collaboratively pursue in a medical consultation determines the core activities involved.
CHAPTER FIVE

Bystander Participation in TCM Consultations

Introduction

Research on the dynamics of patient-provider interaction focuses heavily on dyadic medical interactions in which one doctor and one patient are involved (Robinson, 2003; Robinson & Heritage, 2005; Heritage & Maynard, 2006; Heritage, 2013). Although dyadic interaction is considered the default mode of communication in healthcare settings, certain branches of medicine such as geriatrics and pediatrics are known to include triadic medical consultations that involve a third party (Tates & Meeuwesen, 2001; Stivers, 2007; Ishikawa et al., 2005; Greene et al., 1994). The active role that third parties play in these visits may shape the trajectory of the consultation and influence the outcomes of medical visits. In this chapter, I examine triadic medical consultations in the setting of Traditional Chinese Medicine (TCM). In particular, I focus on a sui generis form of triadic medical interaction that is specific to the TCM context: patient-bystander-provider communication. “Bystander” here means a person who is co-present, but unacquainted with the patient who is being seen by the doctor.

In the context of Western biomedicine, third party participation normally involves only the patient’s companions. However, in TCM visits, we see bystanders who may be complete strangers to the patient also taking part in the consultation. Various characteristics of TCM encounters provide for bystander participation to occur. First of all, the layout of the doctor’s office in China provides a physical setting that makes
bystander participation physically possible, because the doctor’s examination room usually functions as the patient’s waiting room at the same time. When a doctor is seeing a patient, they are surrounded by other patients who are waiting to be seen, as well as those who have accompanied the patients to see the doctor. Additionally, it is not uncommon for Chinese hospitals to place two doctors in the same office. This causes the traffic to double since both doctors’ patients are waiting, and seen, in the same office. Also, Chinese patients have a tendency to visit the doctor in groups, with spouses, friends and coworkers. They usually take turns to consult the physician. While one of them is being seen, the others may join the conversation too. Last, the fact that the interactional organization of TCM consultations is more loosely structured than is typical of Western medical encounters may make these consultations more susceptible to different forms of participation and intervention from interactants other than the doctor and current patient.

This chapter is organized as follows: First, I briefly review research that is relevant to bystander participation, the focus of this chapter; Second, I examine four different cases of bystander participation, in which a complete stranger gets involved in another patient’s medical consultation. The first two cases involve a bystander joining an ongoing medical consultation upon the doctor’s invitation; the other two cases exemplify voluntary interjection by the bystander.

**Literature Review**

In this section, I briefly review three strands of research that are relevant to the current chapter: First, I provide a brief introduction to Goffman’s notion of “bystander” (Goffman, 1981), a term that I use to refer to the interactants who get involved in other
patients’ consultations in this chapter. I will discuss how “bystander” is conceptualized by Goffman and explain my reasoning behind selecting this term.

Second, I review existing literature on triadic medical communication to show that most studies have a primary focus on the involvement of patients’ companions. More research is needed to understand other co-present parties’ (people who are not the patients’ companions) contributions to medical consultations. This is the focus of the current chapter.

Third, I review research related to patient resistance since my analysis indicates that bystander participation is frequently occasioned by patient resistance.

**Goffman and the Notion of Bystanders**

In his work on participation frameworks, Goffman (1981) distinguished between ratified and unratified participants. Ratified participants are legitimate interactants (addressed or unaddressed) within the participation framework of an occasion, while unratified participants are hearers or listeners and overhearers who do not belong officially to the ongoing interaction (p. 9). Bystanders are persons who are unratified participants in a focused interaction (Goffman, 1981, p. 172). Focused interaction (encounter) occurs “when people effectively agree to sustain for a time a single focus of cognitive and visual attention, as in a conversation, a board game, or a joint task sustained by a close face-to-face circle of contributors” (Goffman, 1961, p. 7). However, because of bystanders’ close proximity to the encounter, bystanders have visual and auditory access to what is going on in the interaction. In this chapter, I use the term
“bystanders” to refer to people who are present in the doctor’s office but are not ratified participants in the ongoing consultation.

According to Goffman (1981), bystanders may cross the boundary between ratified and unratted participants and enter a focused interaction. My analytical focus in this chapter is on situations like this, aiming to answer the question “why that now” – why do bystanders get involved in other patients’ visit, and what are they trying to accomplish in doing so?

**Triadic medical communication**

Researchers have long been interested in how a co-present third party may impact the interactional dynamic of medical encounters. Adelman et al. (1987) proposed that there are three (hypothetical) roles that a third party may play in medical interactions: the advocate, the passive participant and the antagonist (p. 731). This means that a third party may work for or against the patient and form a coalition with either the doctor or the patient. How coalitions are formed in triadic medical interactions is shaped by many factors, such as who the third party is (whether the third party is the patient’s companion or another medical professional), the topic being discussed, and the nature of the visit (Greene & Adelman, 2013).

Although the communication dynamic of medical interactions that involve multiple parties have been examined extensively, most existing research on this topic is focused on the role the patient’s companion plays in triadic medical interactions (Clayman & Morris, 2013). According to Laidsaar-Powell et al. (2013) patient’s companions may provide different types of support to the patient, such as logistical
assistance (transportation and physical assistance), informational support (clarifying patient history, remembering information, ensuring patient understanding); emotional support (comforting patients, providing companionship, providing non-verbal support) (p.7). Besides supporting the patients, some companions may also participate to address their own needs (Schilling et al. 2013).

However, how third parties who are not associated with the patient impact the interactional dynamic of TCM encounters remains underexamined. Although this is not common in Western primary care, it is prevalent in Chinese hospitals. As discussed in Chapter 4, doctors’ offices in China also function as the patient’s waiting room. Therefore, it is normal to have strangers present during a patient’s visit. Even in Western countries where patient confidentiality is a greater concern, there may also be other medical professionals present during a patient’s visit, such as medical students, nurses, medical interpreters and social workers (Greene & Adelman, 2013). Hence, it is important to understand how the medical encounters are transformed by these co-present third parties.

Also, few studies about triadic medical interactions offer an emic perspective on this issue by closely examining doctors’ and patients’ interactional practices. Within the field of language and social interaction, researchers have examined triadic medical interaction mainly in pediatric and interpreter-mediated consultations (Bolden, 2000; Clemente, 2009; Hsieh, 2007; Stivers, 2007) and recently, neurological and rheumatological visits (Fioramonte & Vásquez, 2019). Additionally, researchers have now shifted their interest to companion participation in mediated medical consultations (Stommel & Stommel, 2021), revealing how companion involvement is organized in
online environments. However, triadic interaction in alternative medicine remains an underexplored matter, despite the fact that many alternative medical visits involve a third party (Yang, 2018). As demonstrated here, how medical encounters unfold within the context of TCM warrants more scholarly attention. Specifically, how parties other than the patient’s companion shape the trajectory of the TCM visits should be further investigated.

In the next section, I review research on patient resistance in medical encounters. My findings show that bystanders may participate in a TCM consultation when a patient resists the doctor’s diagnosis or treatment recommendation. I review studies that describe patient resistance as an interactional activity and discuss what research has shown about how patient resistance is responded to in medical interactions.

**Patient Resistance in Medical Encounters**

My findings in the current chapter show that bystander participation in TCM encounters is predominantly occasioned by resistance from the patient. In this section, I review research in the field of language and social interaction that focuses on patient resistance towards doctors’ medical opinions. Patient resistance occurs, according to Stivers (2007), when patients produce actions that “obstruct the progress of the course of action that is under way” (p. 81). Most research on patient resistance focuses on practices that patients deploy to resist the doctor’s treatment proposals. Stivers (2005) examined how parents in pediatric visits may either withhold acceptance of or actively resist the doctor’s treatment proposal, and in so doing, occasion a negotiation of the treatment plan with the doctor. Along the same lines, Koenig (2011) observed that patients’ resistance is
a limited form of agency – by resisting the doctors’ treatment proposal, patients “enact rights to choose how and when they endorse the recommendation” (p. 1106). These findings are consistent with what I report in the current chapter. TCM Patients frequently resist the doctor’s medical opinions, and in so doing, try to exert influence on the treatment outcome of the medical visits.

Researchers have also identified different interactional practices of patient resistance in the diagnosis delivery phase of medical visits. Patients may be overt, or implicit about their resistant attempts. While overt resistant moves such as rejecting the doctor’s diagnosis, or proposing an alternative one (Peräkylä, 2002; Stivers, 2007) are easy to identify for both interactants and researchers, tacit patient resistance needs the doctor to draw the implications themselves based on the responses from the patient. Heath (1992) reported that patients in British general practice ordinarily respond minimally to doctors’ diagnostic turns. Therefore, when patients produce extended responses to a diagnosis delivery, such as further descriptions of the symptoms, they “display some kind of misalignment with the doctor’s diagnosis” (Peräkylä, 2002. p. 227). Another way for patients to resist the doctor’s diagnosis is by producing “newsmarks”, which indicate that the diagnosis is news, or surprising, and make relevant a reconfirmation sequence and more information from the doctor (Heritage & Sefi, 1992; Stivers, 2007).

My analysis of TCM encounters shows that in the context of TCM consultations, both doctors’ diagnostic evaluations and treatment recommendations are susceptible to patient resistance, that is, they are very frequently contested by the patients. For instance, similar to their counterparts in Western, primary care, TCM patients use newsmarks
(Heritage & Sefi, 1992, Stivers, 2007) such as “Shi ma (Is it)” and “Zhende ma (Really)” in response to doctors’ diagnosis deliveries. TCM patients also deploy more overt forms of resistance, such as challenges, alternative explanations and lay diagnoses in response to doctors’ medical opinions. A lot of TCM patients’ resistant moves are produced in the service of treatment negotiation, which is consistent with Stivers’ (2007) and Koenig’s (2011) findings. Additionally, TCM patients frequently contest doctors’ medical claims, such as their noticing, observations and speculations, all of which are important resources for TCM doctors to ground their diagnostic evaluations.

Although there is an extensive body of research on how and why patients display resistance, few studies focus specifically on how doctors respond to patient resistance in an effort to counter it and pursue patient acceptance. Stivers (2007) noticed that in the face of patient resistance, doctors either back down and revise their positions, or provide more accounts and evidence to buttress their diagnostic claims. The findings of this chapter advance this line of research by showing how in the face of patient resistance doctors in TCM encounters use a third party (a bystander) to build a stronger case for their diagnostic claims and/or treatment recommendations.

**What is bystander participation?**

Bystander participation in TCM visits involves a nearby person who is unacquainted with the patient joining the patient’s medical consultation. A bystander may be invited by the doctor to join the medical encounter (solicited bystander participation) or may participate spontaneously (voluntary bystander participation).

A total of 47 cases of bystander participation were found across the data collection of 109 cases of TCM visits. Solicited bystander participation is the
predominant type of bystander participation, comprising 87% (41 out of 47) of the collected instances. 6 cases are voluntary bystander participation.

**Table 5 Distribution of two types of bystander participation**

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solicited</td>
<td>41</td>
<td>87%</td>
</tr>
<tr>
<td>Voluntary</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>100%</td>
</tr>
</tbody>
</table>

In this section, I discuss both types of bystander participation by showing two cases of each. I show how bystander participation, either solicited or voluntary, is frequently occasioned by patient resistance – it tends to occur after the patient has displayed resistance towards the doctor’s medical opinions. In the case of solicited bystander participation, the bystander is enlisted by the doctor to fill different roles and accomplish different tasks, in the service of offsetting or addressing patient resistance. In voluntary bystander participation, the bystander spontaneously joins the consultation for a similar reason – to help address patient resistance and move the medical agenda forward. In the next section, I examine two cases of solicited bystander participation. Extract 22 is split into three parts (parts I, II and III) to better explain different forms of bystander participation. I show how doctors assign different roles to the enlisted bystanders: as an illness-free, contrastive case to demonstrate what is wrong with the patient (Extract 1 and part I of Extract 22); as a lay witness to confirm the existence of a clinical manifestation (part II of Extract 22), and finally, as a cured case to attest to the effectiveness of
treatment (part III of Extract 22). In the following section, I begin by introducing solicited bystander participation in different forms.

Solicited bystander participation

Forms of solicited bystander participation

There are three different forms of solicited bystander participation. In each form, the bystander is recruited\textsuperscript{12} by the doctor to fulfill a different role and accomplish a different task:

- *As a comparative case to demonstrate the patient’s problem (28 out of 41 cases).*

  This is the most common role that a bystander is recruited to serve. Normally, when utilized as a comparative case, the bystander does not need to contribute verbally to the consultation. In both Extracts 21 and 22 below, a bystander is enlisted to be part of the interaction as an illness-free, healthy comparative case. The doctor uses the comparison to build a stronger case for their diagnosis after it is resisted initially by the patient.

\textsuperscript{12} According to the framework developed by Kendrick and Drew (2016), recruitment of assistance occurs when interactants are facing practical problems that are “here-and-now” (p. 2). In this dissertation, findings in Chapters 5 and 6 are related to recruitment in the sense that they show how a third party (a bystander or the patient’s companion) may intervene to assist in the patient’s consultation in the face of patient resistance (an interactional trouble). Some of the cases in these chapters are very similar to what Kendrick and Drew proposed, in which a third party is invited by the doctor to offer “here-and-now” assistance, such as testifying to the effectiveness of the doctor’s treatment plan or confirming the existence of the patient’s clinical sign. There are other cases that are different since the troubles in these cases are not tangible or “here-and-now”. For example, the doctor enlists the patient’s companion to help the patient change their lifestyle, which is more “remote” in nature (Steensig & Heinemann, 2014). Therefore, I used the word “enlist” instead of “recruit” to describe the interactants’ actions in these cases where remote assistance is solicited or offered.
• **As a witness to the patient’s clinical manifestation (14 out of 41 cases).** A bystander may also be invited by the doctor to look at the current patient’s clinical manifestation. In this case, the enlisted patient is treated as a witness to help the doctor provide clinical evidence in order to support the doctor’s diagnostic claims or treatment recommendation or lifestyle advice. In Extract 22 below, the bystander is recruited by the doctor to observe a medical sign that the patient manifested.

• **As a cured case to show the effectiveness of a recommended treatment (4 out of 41 cases).** The doctor may enlist a successfully cured patient bystander to provide further support for recommending a particular treatment. Extract 22 shows how a doctor may sometimes deploy a bystander as evidential support for their proposed treatment, given that the bystander had suffered the same condition in the past and was successfully cured by the same treatment.

**Using a Bystander as a Comparative Case**

In TCM encounters, a bystander is most frequently recruited by the doctor as a comparative case to help the doctor build a stronger case for their medical opinions by showing the patient what an illness-free person looks like (28/41 cases). This normally occurs after the patient has displayed resistance to the doctor’s diagnostic evaluation or treatment recommendation. Hence the bystander is utilized by the doctor to build a more convincing case to offset or address patient resistance.

In Extract 21, a bystander is deployed by the doctor as a comparative case to demonstrate the patient’s problematic complexion, after the patient has displayed
resistance towards the doctor’s medical evaluation. The bystander here is a complete stranger to the patient. Her participation in this extract is entirely embodied – she does not contribute verbally to the consultation.

Prior to Extract 21, the doctor has delivered the assessment that the patient’s complexion is “too yellow”, which may indicate some underlying illnesses. This assessment was repeatedly resisted by the patient. Then the doctor and the patient entered the next medical activity, data gathering, where the doctor took the patient’s pulse and, in the meantime, inspected the patient’s physical appearance. Possibly occasioned by inferences drawn from his inspection and pulse-taking, the doctor launched a series of questions about the patient’s sleep quality at the beginning of Extract 1 (lines 1, 4, 8 and 11).

Extract 21 sleep well
WW TCM 2016 5 36 TJ 5 3 21
Participants: doctor (DOC); current patient (PAT)

*> Doctor’s invitation

((doc takes patient’s pulse without talking) ) /((20:00) )
((pulse taking continues throughout this segment))

001   DOC:   Shuijiao [mei shui hao ma.=
Sleep    [NEG sleep good Q
(You) did not sleep well?=

002   PAT:            [Hai-
[Still
[Still-

003   PAT:            =Dui.
=Right
=Right.

004   DOC:   [Ji tian la?
[How many days Q
[For how many days?

005   PAT:            [Zuo-
[Yester
[Yester-

006   (0.2)
PAT: You liangtian le ba.  
Have two days PRT FP
It has been two days maybe.

DOC: Liangtian. =Weishenme. 
Two days. = Why
Two days. = Why is that?

(PAT: Hheheheh. [Jiu-
Hheheheh. [Just
Hheheheh. [Just-

DOC: [You shir ma. 
[Have things Q
[Do you have any problems?

PAT: Hai jiu you dianr xiaoshier ba
Still just have a little small things PRT
I just have some minor problems

DOC: [fanzheng ta jiu a. 
[anyways it just FP
it’s just um-

DOC: [You shir a. 
[Have problems FP
[(You do) have problems.

DOC: Jiu ta bu shuijiao ta jiu zheiyang. 
Just it NEG sleep it just this 
If (you) don’t sleep you will look like this.

DOC: Ni kan duo mingxian na. 
You look how obvious FP
Look how obvious it is.

DOC: [Ta jiu neng daizhe xiangr. 
[It just can have appearance
[It is reflected in your appearance.

PAT: Ou::.
O:th
Oth.

DOC: Jiu zhei lian a ta jiu tebie hui shuohua. 
Just this face PRT it just very can speak 
Just that your face can speak for itself.

DOC: Ni shenme yangr ta yixia jiu gaosu ni le. 
You what shape it once just tell you FP 
It immediately tells you if you are in good shape.

PAT: Ou::.
O:::h
O:::h.
The extract begins with the doctor taking the patient’s pulse without talking. The doctor checks with the patient regarding her sleep quality at line 1: *Shuijiao mei shui hao ma?* (“You did not sleep well?”), which makes relevant a confirmation or disconfirmation from the patient. Formulated as a negative assertion with a question particle, the doctor’s checking is skewed towards a “no” response (confirming the doctor’s speculation that the patient did not sleep well). This turn indicates that he takes
it that the patient has a sleep problem and is now seeking confirmation from the patient that this is the case.

001 DOC: Shuijiao [mei shui hao ma.=
Sleep [NEG sleep good Q
(You)did not sleep well?=  

002 PAT: [Hai-
[Still
[Still-

003 PAT: =Dui.
Right
=Right.

As discussed earlier in this dissertation, because of their knowledge about basic TCM practice, patients are aware that doctors’ diagnostic claims are based on inspection and pulse-taking. Here the doctor’s speculative claim is likely to be based on the data that he has gathered by deploying the invisible diagnostic technique of visual inspection in addition to ongoing pulse-taking. After the patient confirms that she indeed has been experiencing sleep problems (line 3, Dui (“Right”)), the doctor moves on to ask investigative, follow-up questions about the patient’s problem. He starts by soliciting information regarding the duration of the patient’s sleep issue (line 4):

004 DOC: Ji tian la?
[How many days Q
[For how many days?  

005 PAT: Zuo-
[Yester
[Yester-

006 (0.2)

In line 7, the patient claims that the problem has been ongoing for two days, a relative short period of time. In the following line, the doctor continues to investigate the patient’s sleep issue by asking about its cause (line 8).
The doctor repeats the patient’s response (*Liangtian*, “Two days”), which may be understood as a third position receipt.

007 PAT:   *You liangtian le ba.*
          *Have two days PRT FP*
          *It has been two days maybe.*

008 DOC:  *Liangtian. =Weiishenhe.
          Two days   Why*
          *Two days. = Why is that?*

009          (0.4)

The doctor continues his turn, adding another TCU in which he solicits an explanation from the patient regarding the cause of her sleep issue (Bolden & Robinson, 2011). There is no immediate response to this account solicitation (line 9, a 0.4 second gap). The patient’s response to the doctor’s account solicitation starts with some laughter tokens. According to prior studies conducted in the context of medical interactions, laughter tokens in response to the doctor’s questions or advice normally project upcoming disagreement or “discrepancy” between doctor and patient (Haakana, 2001; Ticca, 2013). In this case, the patient’s laughter tokens may be produced to resist the doctor’s project of trying to identify the cause of her sleeping problem by treating it as nonserious or even laughable.

In line 11, the doctor proposes a possible cause of the patient’s condition *You shir ma* (“Do you have any problems”). In response, the patient once again minimizes her sleep problem by downplaying the seriousness of it: *Hai jiu you dianr xiaoshier ba* (“I just have some minor problems”). The mitigator “just” and also the characterization of her problems as “minor” minimize the problem. In this way, while the patient acknowledges that she has problems, she may be understood to be indicating that they may not be the source of her trouble sleeping.

010 PAT:   *Hheheheh. Jiu-
          Hheheheh  Just*
.Heheheh. [Just-

011  DOC:  [You shir ma.
            [Have things Q
            [Do you have any problems?

012  PAT:  Hai jiu you diann xiaoshier ba
            Still just have a little small things PRT
            I just have some minor problems

013          [fanzheng ta jiu a.
            [anyways it just FP
            it’s just um-

014  DOC:  [You shir a.
            [Have problems FP
            [(You do) have problems.

However, at line 14, the doctor only extracts the “problem” part of the patient’s answer: *You shir a* (“(You do) have problems”). The doctor appropriates the patient’s response and uses it to build his case that the patient’s sleep problem is likely caused by the concerns that she has. In lines 15 and 16, the doctor connects the patient’s lack of sleep with her physical appearance and characterizes the patient’s problematic complexion as “obvious”:

015  DOC:  Jiu ta bu shuijiao ta jiu zheiyang.
            Just it NEG sleep  it just this
            If (you) don’t sleep you will look like this.

016  NI kan duo mingxian na.
            You look how obvious FP
            Look how obvious it is.

017  PAT:  Shi[ ma.
            BE [ Q
            Is it?

The doctor’s references to the patient’s complexion are indexical (as “this” in line 15 and “it” in line 16 indicate), showing that the doctor is relying on the patient to be able to understand what it is he is referring to. Also, in characterizing the patient’s problem as “obvious”, the doctor indicates that the problem is universally available – it is obvious to him, and therefore by implication it should be obvious to the patient as well. In producing this characterization, the doctor pushes back against the patient’s earlier effort
to minimize her sleeping problem (lines 8 & 12) and in the meantime, builds up the robustness of his diagnostic claim.

The patient’s response to this, however, is skeptical. She seeks confirmation from the doctor at line 17 (Shi ma (“Is that right?”)) which treats the doctor’s prior turn as surprising and unexpected. Here by seeking confirmation from the doctor, the patient resists the doctor’s effort to shore up his diagnostic claim by formulating the patient’s problem as obvious.

The response from the doctor at line 18 provides further evidence that the patient’s turn is resistant. He continues to pursue acceptance from the patient by strengthening his diagnostic claim that the patient’s complexion indicates that she has sleeping problems (lines 18, 20 & 21):

018 DOC:  [Ta jiu neng daizhe xiangr.  
[It just can have appearance  
[It (lack of sleep) is reflected in your appearance.

019 PAT:  Ou:.  
O:h  
O:h.

020 DOC:  Jiu zhei lian a ta jiu tebie hui shuohua.  
Just this face PRT it just very can speak  
Just that your face can speak for itself.

021 PAT:  Ni shenme yangr ta yixia jiu gaosu ni le.  
You what shape it once just tell you FP  
It immediately tells you if you are in good shape.

022 PAT:  Ou:::  
O::h  
O::h.

Note that from lines 18 to 21, the doctor reiterates his prior claim that the patient’s health status is reflected in the way she looks. He goes from reporting a fact (line 18) to framing the patient’s face as agentive (line 20, 21) – being able to “speak” and “tell” if the patient is in a healthy condition and therefore, proposing a strong connection between the patient’s complexion and her health status.
Despite the doctor’s strong claims, the patient’s resistance to the doctor’s attempts to convince her continues. She responds to the doctor’s explanation with two change-of-state tokens (Heritage, 1984; Xu, 2016), “oh”, at lines 19 and 22, registering the doctor’s turns merely as new information. These responses are resistant, since the doctor is pursuing an agreeing or accepting response to his diagnostic claim.

It is at this point that the doctor draws a bystander, a nearby patient who is unrelated to the patient, into the consultation:

023* DOC: Ni qiao ren nayang./((looks at a nearby patient))
You look other’s like that
Take a look at her (appearance).

024 PAT: .Hehe[heh. Zhe-
 .Hehe[heh. This
 .Hehe[heh. This-

025 DOC: [Bai li touzhe fen.
[White inside reveals pink
[Light skin with a pinkish undertone.

This nearby patient may be considered a bystander in Goffman’s (1981) terms because she a) is not a ratified participant in the patient’s visit; b) has access to the ongoing interaction and c) is perceivable to the other ratified participant (p. 132). By directing the patient to look at the bystander’s face, the doctor admits the bystander into the interaction and changes her status from a bystander to a ratified participant in the ongoing consultation. The doctor is using the recruited bystander to ground his diagnostic claim by displaying on the recruited patient’s body the problem to which the current patient could not have visual access on her own body.

After securing the patient’s attention, the doctor describes the bystander’s complexion as Bai li touzhe fen (“Light with a pinkish undertone” (line 25)). This is the ideal complexion that indicates perfect inner body balance, according to TCM theories. In
describing the bystander’s complexion this way, the doctor leaves the patient to infer what is wrong with her complexion by offering a healthy, contrastive example.

In this extract, bystander involvement occurs after the doctor’s diagnostic claims have been repeatedly resisted by the patient. In the face of persistent patient resistance, the doctor’s recruitment of a bystander is implemented to strengthen his claims and offset patient resistance. The doctor simply describes the bystander’s facial complexion, indicating that the patient should be able to see why her complexion is problematic. The contrast between the bystander and the patient serves as evidence for the doctor’s evaluation that the patient’s complexion is problem-indicative.

However, even after the bystander’s involvement, the patient’s response remains resistant. She contests the doctor’s attempt to compare her with this nearby patient by invoking the age difference between them, characterizing the bystander as a “kid” (line 26 Zh(h)e- zh(h)e- zh(h)ei haizi nianqing (“This- this- this- this kid is still young”)).

This characterization is a clear exaggeration used to resist the doctor’s claim (Drew, 2003) since this so-called “kid” is in her late thirties while the patient is around fifty (information available in ethnographic notes). In characterizing the bystander in this way, the patient indicates that the doctor’s comparison is invalid, since she and the bystander have such a significant age difference. Also, by maximizing and highlighting the age difference between them using this characterization, the patient indicates that the
bystander’s good complexion is because of her young age. This also makes available the inference that the patient’s bad complexion is likely to be age-related (since she is much older than the bystander), which is discrepant with the cause identified by the doctor (sleeping problem). The resistant nature of the patient’s turns is also amplified by the embedded laughter tokens (lines 24 and 27) which treat the doctor’s comparison as non-serious or laughable.

In response to the patient’s resistance, the doctor rejects the patient’s rejection of his comparison, and also dismisses age as the contributing factor to the patient’s complexion. He characterizes the third party as “not young” (line 25), indicating that her good complexion is not a result of her young age. To further dismiss age as a contributing factor, the doctor invokes another third party, a hypothetical older patient who presumably also has a “good complexion” despite their old age (line 30, “As for elderly people I will find you one later that- that- that has good complexion”).

The doctor’s responses here show that he also orients to the patient’s prior turns as suggesting that her problematic complexion is age-related. He invokes a (hypothetical) third party who is older than the patient but still has a good complexion. In providing another contrastive example, the doctor further blocks the patient’s effort to attribute the cause of her problem to her age.
In line 31, the patient finally accepts the doctor’s diagnostic evaluation. She first produces a change-of-state token Ao (“Oh”), treating the doctor’s claim as new information, even though it has been delivered (and resisted) multiple times. She then characterizes her complexion as bu hao (“not good”), which is a weak negative assessment, different from the doctor’s version Ni kan duo mingxian na (“Look how obvious it is”, line 16). The patient’s turn here may be understood as a lukewarm acceptance of the doctor’s claim that the patient’s face is problem-indicative, treating it as surprising. The doctor has been building a case that the patient’s complexion in connected to her sleeping problem since the beginning of this extract. The fact that the patient still orients to the doctor’s assertion as news sequentially deletes the doctor’s prior evaluations and diagnostic claims. The patient is just now accepting the doctor’s assessment that her complexion is bu hao (“not good”), meaning she now acknowledges that it might be problem-indicative.

031 PAT: [Ao wo lianshair bu hao.  
[Oh my face complexion NEG good  
[Oh my complexion is not good.

032 DOC: [Ye you hao de.  
[Also have good FP  
[(Some elderly people) also have good complexion.

033 (0.2)

034 DOC: Xinji duo chang shijian la.  
Heart palpitation how long time FP  
How long have you been experiencing heart palpitations?

After the patient’s begrudging acceptance of the doctor’s evaluation, the doctor at line 34, after a brief gap, moves on to solicit more information regarding another concern that the patient has: Xinji duo chang shijian la (“How long have you been experiencing
heart palpitations”). This indicates that the previous topic which revolved around the patient’s unhealthy complexion, is officially concluded.

In this extract, the patient has displayed resistance towards the doctor’s claim that her bad complexion is sleep-related from the beginning of the interaction. She does this first by producing a newsmark (a token of surprise) in response to the doctor’s explanation (line 17), which treats it as a surprise, and delivering multiple minimal responses to the doctor’s action of pursuing acceptance (lines 19 & 22) through which she withholds acceptance. It is at this point that the doctor draws a bystander into the interaction. Although this bystander does not actively participate in the interaction, her status changes from a bystander to a ratified participant in the ongoing consultation after being enlisted by the doctor. The bystander in this extract serves the function of a visual aide, a healthy contrastive case to convince the patient that her complexion is problematic. After the bystander’s involvement, the patient finally concedes and begrudgingly accepts the doctor’s medical opinion.

A similar pattern is observed in Extract 22. After the patient has presented a concern at the beginning of the segment (lines 1 through 6), the doctor begins the diagnostic process by physically examining the patient (lines 7 & 8) and asking a follow-up question (lines 12 to 14). At line 18, the doctor recommends a TCM massage technique to the patient, which is not explicitly accepted by the patient (change-of-state tokens in lines 21, 26 & 28). Possibly occasioned by the patient’s resistance towards her recommendation, the doctor involves a bystander in the patient’s consultation. The bystander is initially presented by the doctor as an illness-free case to demonstrate the patient’s problem by contrast. She is later invited by the doctor to inspect the patient’s
tongue and to be a lay witness to the patient’s manifested clinical sign. Additionally, since the bystander used to have the same condition as the patient, she is deployed by the doctor as a recovered fellow patient and a testament to treatment effectiveness. After the bystander’s participation, the patient finally accepts the doctor’s diagnostic evaluation as she moves on to discuss the treatment options of this condition. For analytical purposes, I have split Extract 22 into three parts (I, II and III) to show how a bystander is coopted in different ways by the doctor to address patient resistance.

In part I of the extract (lines 1 – 36) a bystander was deployed as a contrastive case to demonstrate the patient’s problem. The doctor’s involvement of the bystander started at line 29. This occurred after the patient displayed slight resistance towards the doctor’s treatment recommendation by producing minimal receipt tokens repeatedly (lines 21, 26 & 28).

Prior to Extract 22, the doctor has evaluated the patient’s health status and delivered her diagnostic conclusion that the patient has a thyroid gland problem (data not shown). The patient acknowledges the doctor’s diagnosis, and then uses it as an opportunity to present a related concern at line 1.

Extract 22-1 Blood stasis part I
TCM_WW_VID0002_8_6_17_21
Participants: doctor (DOC), current patient (PAT)

*> Doctor invitation
~> Bystander participation

001   PAT:   Nin shuo wo jiazhuangxian wo
You  said I thyroid gland I
Now that you’ve mentioned the thyroid gland

002          |zher haoxiang-
|here seems like
|it seems like here-
|{{(touches her left armpit)}}
Under this armpit there seems to be a—((continues to touch her left armpit))

((DOC extends hand to touch the patient’s armpit))

((PAT presses her armpit, DOC looks at it))

((finishes examining the patient))

Mm hm.

After your period is gone it is bad—

It is better.

Maybe it is.

Unclog the three yin.

The Sanyin point on the leg is where the spleen, kidney and liver meridians intersect and is a very powerful point. It can treat many conditions associated with all three organs (Ye, 2007).
N things
whenever you have time.

021 PAT:  |Ao.
|Oh
|Oh.
|((DOC continues to pat her three yin))

022 |(0.3)
|((DOC continues to pat her three yin))

023 DOC:  Qiao qiao.
Pat pat
Just pat.

024 PAT:  (pai) nei ge.
(pat )that one
Pat that.

025 DOC:  Zai |qiao qiao zhei bianr.
Also |pat pat this side
Pat |this side as well.
| |((switches side))

026 PAT:  Ao::.
Oh::.
Oh::.

027 DOC:  |A. Rang ta j- jingluo\textsuperscript{14} tong yi tong.=
|Ah. Let it channel unblock one unblock
|Okay? Try to unblock the channel.
| |((uses hand to illustrate the unblocking))

028 PAT:  [Ao.
[Oh
[Oh.

029 *>>DOC:  [Er q- |ni kan ni-
[Als- |you look you-
[Als- |look at you-
 | |(( points at the bystander))

030 *>>DOC:  Ni kan |ta:
You look |her
(And) look at her.
| |((turns around points at PAX))

031 *>> Mei you. (. ) Cong ni de shetou\textsuperscript{15} kan

\textsuperscript{14} Jingluò (meridian): also called channel network, is a traditional Chinese medicine belief about a path through which the life-energy known as "qi" flows.

\textsuperscript{15} The tongue has many relationships and connections in the body, both to the meridians and the internal organs. It is therefore very useful and important during inspection for confirming TCM diagnosis. It can present strong visual indicators of a person's overall harmony or disharmony.
N have. From your tongue see (She) does not have (it). From your tongue we can

032 *> Ni hai shi you(.) neige (0.2) jiu shi You still BE have that just BE see that you still have that- that

033 *> xueyu: blood stasis

034 PAT: Shi ma. BE FP Is that right.

035 (0.2)

036 DOC: En. Yes Yes.

In lines 1 through 6, the patient presents a new medical concern that she has been feeling a protruding lump under her armpit. The patient presents her concern as occasioned by the doctor’s prior diagnosis that she has problems with her thyroid gland, as indicated by Nin shuo wo jiazhuangxian wo (“Now you’ve mentioned the thyroid gland”), referring back to the doctor’s previously delivered diagnosis (line 1). In this way she may be proposing that this is related to the thyroid condition. Her presentation of the problem is tentative (as “seems” in lines 2 & 3 indicates). While presenting her problem verbally, she also touches her left armpit to show the doctor where the problem is located.

001 PAT: Nin shuo wo jiazhuangxian wo You said I thyroid gland I Now that you’ve mentioned the thyroid gland

002 |zher haoxiang- |here seems like |it seems like here- |{{(.touches her left armpit)}

003 (.)

16 Xueyu (Blood stasis): a concept of pathogenesis, which refers to a pathological product where blood is no longer free-flowing and has lost its normal physiological function (Yan, 1995).
At line 6, after the patient points out where her problem is, the doctor conducts a physical examination of the patient’s armpit as the patient is articulating the actual problem. The patient also feels her own armpit while the doctor is conducting the examination (line 7). After the physical examination is complete, the doctor acknowledges the patient’s problem presentation (line 10, “Mm hm”). She then delivers a follow-up medical inquiry (lines 12 through 14): *Shi yuejing ganjing le jiu buxing- (“After your period is gone is it bad- is it better”).

In line 12 the doctor connects the patient’s lump with her period by asking if it is better after her period, putting the patient in a position to confirm or disconfirm it. The doctor’s line 12 is an assertion produced for agreement with some measures of certainty.
that the patient will agree, as indicated by the declarative syntax of the turn. Here the
doctor checks with the patient the status of her lump after the period is over, and thus
proposes a connection between the patient’s lump and her period. Since a woman’s
estrogen level fluctuates before and after menstruation, the doctor’s turn makes available
the inference that the patient’s lump may be hormonal, which may indicate that no
treatment is required, and also indicates that she takes it that the condition is not related
to the previously diagnosed thyroid condition.

When there is no uptake from the patient, at line 14 the doctor replaces “bad” with
“better”, correcting the speech error that she has initially made. Similar to line 12, line
14 *Jiu hao le* (“It is better”) is also tilted towards making agreement relevant, indicating
that the doctor is confident in this assertion, and puts the patient in a position to either
confirm or disconfirm her theory.

The patient’s response (line 15, *Keneng shi ba* (“Maybe it is”)) to this question is
a tentative confirmation, indicating a level of uncertainty (with the turn initial *keneng*
(“maybe”). Thus, the patient indicates skepticism about the connection that the doctor is
proposing.

014  DOC:  jiu hao le.
        just good FP
        It becomes better.

015  PAT:  Keneng shi ba.
        Maybe BE FP
        Maybe it is.

016  DOC:  |E::n.       [Aa
          |Mm hm::.    [Um
          |Mm hm::.    [Um
          |((waves hand))

017  PAT:  |Mg   dao guo ji [ci:
          |Touch P P a few times
          |Felt it a few times.
The patient in line 17 offers additional information about her lump, indicating that her lump is not an isolated event, but rather a recurrent problem, with the implication that therefore it might not be hormone-related. In providing this additional information, the patient pushes back against the doctor's diagnostic claim that her lump problem may be hormonal.

Starting at line 18, the doctor recommends a TCM massage technique to the patient: *Tong Sanyin* (“Unclog the three-yin”). She instructs the patient to use this commonly known therapeutic massage technique by naming it (line 18), treating the patient as being able to recognize what she is referring to. Note that this recommended technique is not a form of medical intervention. It is a technique known and used by many people even without TCM expertise. In recommending this technique, the doctor
can be heard to be treating the patient’s condition as a non-serious non-medical issue which can be fixed easily by a folk remedy.

When this initial recommendation is met with a brief silence (line 20), the doctor delivers an addition to the prior turn: Mei shir (“whenever you have time”), providing details about when to implement the recommended massage technique. Produced as a continuation of line 18, line 20 is possibly produced by the doctor to pursue an acceptance from the patient by offering another slot for the patient to respond, given that she did not respond initially (silence at line 19).

However, the doctor’s pursuit is still met with patient resistance at line 21: Ao (“Oh”). In producing this change-of-state token (Heritage, 1984), the patient registers the doctor’s prior turns as new information, or something surprising and unexpected. In line 23, the doctor continues giving the patient embodied instructions on how to do the recommended massage technique. This verbal instruction Qiao qiao (“Just pat”) minimizes the effort that the patient needs to put in to following his recommendation, which may be understood as another attempt to solicit the patient’s acceptance. In line 24, the patient repeats the doctor’s instruction (Pai) nei ge (“Pat that”) which makes relevant a confirmation from the doctor, calling into question the doctor’s recommendation.

024 PAT: |(pai) nei ge.| |(pat )that one | |Pat that.| |{(DOC continues to pat her three yin)}|

025 DOC: |Zai qiao qiao zhei bianr.| |Also pat pat this side | |Pat this side as well.| |{(switches to pat her left arm)}|

026 PAT: Ao:: Oh:: Oh::
The doctor’s response at line 25 shows that she understands the patient’s seeking confirmation as potentially skeptical. She switches hands and begins to pat her left arm (line 25), enlarging the scope of the remedy that she is recommending by demonstrating how it can be used on both arms, making it more substantial (and therefore acceptable). However, the doctor’s instruction and demonstration once again receive a change-of-state token in response (line 26, Ao:: (“Oh::”)), again treating the doctor’s recommendation as surprising.

The patient’s resistant move occasions more pursuit from the doctor. In line 27, the doctor first delivers a particle “A17”, which is a common particle that Mandarin speakers use to pursue an absent response. She then further demonstrates how the “Unclog the three-yin” technique works (lines 27) by providing verbal explanation as well as embodied illustration, which once again is receipted with patient resistance (line 28 Ao (“oh”)).

026 PAT: Ao::.
      Oh::.
      Oh::.

027 DOC: |A. Rang ta j- jingluo tong yi tong.=
      |Ah. Let it channel unblock one unblock.
      |Okay? Try to unblock the channel.
      |((uses hand to illustrate the unblocking))

028 PAT: [Ao.
      Oh.
      Oh.

This is when a bystander is enlisted by the doctor to join the ongoing consultation through both embodied and verbal actions (lines 30):

029 *DOC: [Er q- ni kan ni-
      Als- you look you-
      Als- look at you-
      |(( points at the bystander))

17 A is a commonly used article in Mandarin Chinese (Mainland China) to pursue a missing response.
The doctor first points at the patient and directs the patient to look at herself (*ni kan ni-* (“Look at you”), line 29). This is a task that cannot be completed in this environment (the patient cannot look at her own face without a mirror). The doctor then redirects the patient to look at the bystander (*Ni kan ta:* (“And look at her”)) and at the same time, turns around and shifts her eye gaze towards the bystander while producing a pointing gesture. In so doing, the doctor engages in the activity of “showing” (Kidwell & Zimmerman, 2007; Searles, 2017), drawing the patient’s attention to the bystander’s face. The doctor then delivers a diagnostic claim about the bystander’s health status in lines 31 to 32.
In line 31, The doctor reports a negative observation of the bystander’s physical appearance but does not specify what is it that the bystander does not have. She then delivers the diagnosis that in contrast, the patient has a condition called Xueyu ("blood stasis"): Ni hai shi you(.) neige (0.2) jiu shi xueyu ("You still have that- that blood stasis"). Two observations can be made about the doctor’s turn (lines 32 to 33): first, it is inferable that the clinical manifestation of the patient’s problem is located in the patient’s tongue which means that the sign is only observable to the doctor (and others) but not currently perceptually available for the patient. This information is foregrounded in the doctor’s diagnostic claim, since it is structured in a way that Cong ni de shetou kan ("From your tongue we can see…") comes before the diagnosis delivery. The patient’s tongue, something that is not currently visually accessible to the patient herself is formulated as the evidential basis for the doctor’s diagnostic claim. Second, this blood stasis problem is likely to be an old problem, rather than a new one (as the word “still”, and the indexical “that” indicates at line 32). While “still” marks the condition as an ongoing problem, “that” may refer back to the patient’s prior visits where the same condition might have been discussed. In formulating her diagnosis in this way, the doctor builds up a contrast between the bystander (a healthy candidate) and the patient (a patient with blood stasis) by pointing out the differences in the appearance of their tongues.

The bystander’s involvement occurs after the patient has resisted the doctor’s treatment recommendation repeatedly. When the doctor’s multiple attempts to pursue acceptance from the patient do not work, a bystander is enlisted by the doctor as an illness-free, contrastive case to show the patient what is wrong with her. In so doing, the doctor conveys the evidential basis for her diagnostic claim, in the service of
strengthening her case that the patient has the condition of blood stasis, which can be treated by the technique of “unclogging the three-yin”.

However, the patient does not fully accept the doctor’s diagnosis. At line 34, the patient responds to the doctor’s diagnosis delivery with a newsmark: Shi ma (“Is that right”) (Heritage & Sefi, 1992). This newsmark registers the doctor’s turn as new or surprising information and makes relevant further confirmation or explanation from the doctor and in this way conveys the patient’s skepticism over the doctor’s diagnosis. After a 0.2 gap, the doctor provides a confirming response to the patient’s newsmark.

In part I of Extract 22, the bystander was invited by the doctor to join the consultation as an illness-free, contrastive case, in order to establish the patient’s medical problem. This occurred after the patient displayed resistance towards the doctor’s treatment recommendation (the “unclogging the three-yin” massage technique). However, the patient maintained a resistant stance towards the doctor’s recommendation even after the bystander has become part of the interaction. She responded to the doctor’s diagnosis delivery with a newsmark, treating it as new, surprising information. This may explain why in the next section, the doctor invites the bystander to participate for a second time, but to enact a different role: she is recruited as a lay witness to the patient’s clinical manifestation.

**Using a Bystander as a Lay Witness**

In addition to being deployed as a contrastive case, a bystander may also be invited to join another patient’s consultation as a lay witness to the patient’s clinical manifestation (14 out of 41 cases). Earlier in this dissertation, I mentioned how
diagnostic reasoning in TCM can be opaque, since most of the diagnostic evidence that
the doctor relies on cannot be presented to the patients. Clinical manifestation, on the
other hand, is an important and presentable component of the doctor’s diagnostic
evidence. Hence, inviting a third party to testify to the clinical manifestation’s existence
helps the doctor strengthen the case for their diagnosis.

As discussed earlier, there are four diagnostic methods in TCM practice, Wànɡ (inspection), Wén (smell and/or listening), Wèn (interrogation) and Qiè (palpation), with
Wànɡ (inspection) being the most important and frequently deployed. WànɡZhèn (inspection diagnosis) in TCM includes practitioners carefully observing the patient’s
physical appearance and looking for possible signs of health imbalances. When the
doctor delivers his or her diagnosis to the patient, the observed clinical sign is then
presented as the evidential basis for the diagnosis. Although the sign is normally
perceptible to the layperson’s eye, the patient themselves cannot always see it,
particularly if it is a part of their body that is not visually accessible to them. This is when
a third party becomes relevant and consequential for the unfolding consultation – they
may function as a witness to the patient’s problem. In this case, a third party gets enlisted
to help the doctor formulate evidence for his upcoming diagnosis delivery.

In the following section, I focus specifically on lines 38 to 50, where the
bystander who was initially enlisted by the doctor as a contrastive case is invited by the
doctor to look at the patient’s lingual frenulum (where the clinical sign is located). Before
part II of Extract 22, the doctor has delivered two sets of medical opinions, both of which
were resisted by the patient. She first recommended a massage technique in response to
the patient’s report and demonstration that she has felt a lump under her armpit a few
times. The patient resisted the doctor’s treatment recommendation by withholding acceptance and providing additional information on her condition. The doctor then delivered the diagnosis that the patient has the condition of “blood stasis” by drawing the patient’s attention to the differences between her (the patient) and a bystander who does not have this condition. The doctor also provided the clinical evidence for that diagnosis which is located in the patient’s tongue. In response to the doctor’s diagnostic claim, the patient delivers Shi ma (line 34), which may be translated as “Is that right”, making relevant further confirmation from the doctor. By questioning the diagnosis instead of accepting it, the patient’s turn comes off as resisting the doctor’s diagnostic claim.

After the patient’s response, the bystander, who was already used as a contrastive case earlier by the doctor, participates in the consultation by seeking confirmation from the doctor that the patient ye (“also”) has blood stasis (line 37). After providing the confirmation, the doctor recruits the bystander for a second time, this time as a lay witness to the patient’s clinical manifestation (line 38).

Extract 22-2 Blood stasis part II

Participants: doctor (DOC), bystander (PAX); current patient (PAT)

034   PAT:   Shi ma.  
         BE FP  
         Is that right.

036   DOC:   En.  
         Yes
         Yes.

037  -->PAX:   Ta ye you xueyu a.  
            She also has blood stasis FP  
            She also has blood stasis?

038  *-->DOC:   En. Ni kan ta shehidai.  
             Mm hm. You look her frenulum of tongue
Mm hm. Look at her lingual frenulum.¹⁸

| (0.3) |
|doctor shows her own lingual frenulum and points at PAT|)

->PAX: |Wo ne FP |
|What about me? |
|((looks at DOC)) |

(0.2)

DOC: Ni mei you. = Ni hao duo le. You N have You good more FP You don’t have it. You are so much better now.

(Ni) yiqian ye: you. You before also have You also had it before.

(0.3)
|((DOC points at PAT’s tongue)) |

(0.2)
|((DOC casts a glance at the patient’s tongue)) |

PAX: A:h. Oh. Oh.

(0.3)
|((glances at PAX)) |

DOC: |Kan jian le ma. FP FP |
|Have you)seen that? |
|((glances at PAX)) |

(0.2)

PAX: |(Ou) bu duo ha. |
|Oh N much FP |
|Oh not too much(long) right. |
|((looks at PAT’s tongue)) |

DOC: ° (Qi ) yì jì ° - Qi once shortness Once short on Qi-

PAX: Ao:::. [xidai you. Oh:::. Frenulum of tongue have Oh:::. The lingual frenulum shows it.

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¹⁸ Lingual frenulum: a small fold of mucous membrane extending from the floor of the mouth to the midline of the underside of the tongue.

¹⁹ In TCM the concept of qi or chi has two main branches. There is the physical or nourishing portion of qi that makes up the air, water, and food that we take in. The other branch of chi is more insubstantial. It is the vital fluids and the energy itself that flows through our bodies.
By inquiring about the diagnosis (line 37, *Ta ye you xueyu a* (“She also has blood stasis?”)), the bystander creates another slot for the doctor to confirm or provide further information about the patient’s condition. The bystander’s turn here is tilted towards a confirming response, indicating that a “yes” is expected. This turn also leaves available the inference that the bystander might have knowledge of and/or experience with this medical condition, since she incorporates the particle “ye” (also) in her question (“She also has blood stasis”) – which indicates that she, or someone she knows has or had the same condition.

In response, the doctor provides a confirmation (“Mm hm”) (line 38) and then goes on to present the evidence for her diagnosis to the bystander by directing her to take a look at the patient’s lingual frenulum, a small tissue that connects the tongue to the floor of the mouth (*Ni kan ta shexidai* (“Look at her lingual frenulum”), line 38). According to TCM theories, people with blood stasis usually have the clinical manifestation of a pronounced, purplish lingual frenulum. Here the doctor engages in the activity of showing (Kidwell & Zimmerman, 2007; Searles, 2018) and draws the bystander’s attention to the patient’s lingual frenulum, where the clinical sign is supposedly located. Additionally, in the following line, the doctor opens her mouth and shows what her lingual frenulum looks like and in so doing, offers the bystander an example of a healthy-looking lingual frenulum (line 39). In this showing activity, the doctor provides the bystander with two cases, one problematic (the patient) and one healthy (the doctor), so that the bystander can compare and contrast them. If the bystander confirms that she sees some visible differences, she helps the doctor formulate the evidential basis for her diagnostic claim that the patient has blood stasis.
In this segment, the clinical manifestation of a pronounced, purplish lingual frenulum serves as evidentiary support for the doctor’s diagnostic claim. As discussed earlier, since this clinical sign is located in the patient’s mouth and not visually accessible to the patient themselves, having a bystander as a lay witness who can testify to its problematic appearance is helpful or even necessary for the doctor to communicate the diagnostic evidence to the patient. However, to successfully establish the diagnostic evidence, the bystander needs to cooperate with the doctor and acknowledge that she does see the patient’s clinical manifestation. In this case, the bystander only briefly looks at the patient’s mouth, and then solicits an update about her own health status (line 40): Wo ne (“What about me”)? The bystander’s question makes relevant an evaluation of her own health status from the doctor. This question comes after the doctor has already delivered a “no-problem” evaluation of the bystander’s current status (line 31) and used the bystander as an illness-free contrastive example (line 38). It is possible that the bystander’s question is implemented to divert the course of interaction to focus on her, since it makes relevant a response from the doctor.

If we look at what comes before this question, we see that the bystander has already asked a question earlier (line 37 “She has blood stasis too?”). As previously discussed, this question leaves available the inference that the bystander has or had the same condition, or at least is familiar with this condition. It is possible that this earlier question is preliminary to her current question (line 40) about her current health status: the doctor’s diagnostic claim that the patient has blood stasis might have prompted the bystander to solicit an update from the doctor regarding her own blood stasis condition. Although the bystander is enlisted by the doctor as a witness to the patient’s problem, her
question here is self-attentive (Bolden, 2006; Maynard, 2017), not in the service of the patient’s consultation. In this way, her enlisted participation in the patient’s consultation is disruptive and resistant since it does not help with the doctor’s medical agenda.

At lines 42 to 43, the doctor gives a response with multiple turn-constructional units. She first delivers a no-problem diagnosis (Ni mei you (“You don’t have it”)) which could be heard as indicating that the bystander has never suffered from the condition of blood stasis. The second and third parts of the doctor’s turn, a report of improvement (Ni hao duo le (“You are so much better now”)) and a report on the bystander’s past status ((Ni) Yiqian ye you (“You also had it before”)) set up the contrast between the patient’s past problem status, and her current illness-free status. They help remove the possible hearing that the bystander has never had this condition and formulate the bystander as a recovered patient by proposing that the bystander has seen significant improvement “You are so much better now”. Although it does not make explicit the reason for the bystander’s recovery, since the bystander is one of the doctor’s routine patients, it is inferable for us (and the patient) that the patient recovered because of the treatment that she has received from the doctor.

The doctor’s turns at lines 42 to 43 are “Janus-faced”: on one hand, they constitute responses to the bystander’s question about her current health status; on the other hand, they provide information that is potentially relevant to the overhearing patient. Additionally, in giving this no-problem response and a report of improvement, the doctor curtails the bystander’s self-attentive intervention and shifts the focus back onto the patient.
In the ensuing lines, the doctor returns to the patient’s consultation and resumes her activity of showing. She redirects the bystander’s attention to the patient’s tongue, where the clinical sign is presumably located (line 44):

044 |(0.3)
|((DOC points at PAT’s tongue))

045 |(0.2)
|((casts a glance at the patient’s tongue))

046 PAX: A:h.
Oh
Oh.

047 DOC: |Kan jian le ma.
|See FF FF
|Have you seen that?
|((glances at PAX))

The doctor uses a pointing gesture to secure the bystander’s attention and draw her back into the patient’s consultation, reengaging her in the showing activity. In response to the doctor’s pointing gesture, the bystander glances at the patient’s tongue, and then responds with a change-of-state token Ah (“Oh”) (line 46). This “Oh” does not in any way indicate that the bystander has indeed seen the clinical manifestation pointed out by the doctor. In producing this token, the bystander resists the doctor’s effort to use her as a lay witness to the patient’s problem, since she does not confirm or disconfirm the existence of the clinical sign, but rather produces a token that indicates that this is news to her.

In response, the doctor at line 48 pursues a stronger confirming response from the bystander by once again drawing the bystander’s attention to the patient’s tongue, checking with the bystander if she has indeed seen the clinical sign: Kan jian le ma (“(Have you) seen that”? This checking puts the bystander in a position to confirm or disconfirm that the patient is manifesting a clinical sign. It is implemented by the
The bystander’s assessment at line 49 is constructed in a way that is tilted towards a confirming response from the doctor. It corroborates the doctor’s previous claim that the patient is manifesting a clinical sign, but still makes relevant a confirmation from the doctor, orienting to the doctor’s authority in identifying and evaluating clinical signs. Additionally, the assessment is mitigated. We may infer that while the clinical sign does exist and may be visually accessible, it is, however, not very pronounced (“Not too much”) to the bystander’s eyes. The bystander’s turn confirms the existence of the patient’s clinical sign, but also displays the bystander’s reservation about it.

Despite the bystander’s downplayed assessment, the doctor moves on to explicate the medical reasoning behind her diagnostic claim at line 50: Qi yi ji (‘Once short on Qi’). Qi deficiency is one of the common causes of blood stasis (Li, 1988).
turn can be heard as explaining the mechanism behind the patient’s blood stasis condition. The bystander cuts the doctor off at line 51, producing an elongated change-of-state token (\textit{Ao::: (“Oh::::.”)}) and then collaboratively completes (Lerner, 2004) the doctor’s turn (“The lingual frenulum shows it”, line 51). The bystander’s “Oh::::” here is produced differently from her previous “oh”s. It is hearable as a discovery and realization, indicating the bystander’s sudden change of knowledge state. The elongated change-of-state token as well as the collaborative turn completion are produced by the bystander to display her knowledge about this matter, and the fact that she is able to identify the medical sign that the patient is manifesting. In producing her turn in this way, the bystander may be orienting to the reservation that she has previously displayed by producing a downplayed assessment, indicating that she has now seen what the doctor is trying to show. In acknowledging the patient’s clinical manifestation, the bystander assists the doctor in formulating the evidential basis of her diagnostic claim that the patient has the condition of diagnosis.

In this segment, part II of Extract 22, a bystander was recruited by the doctor as a lay witness to the patient’s clinical manifestation, apparently to provide diagnostic evidence and address patient resistance. The bystander in this part of the segment was utilized by the doctor to help formulate the evidential basis for her diagnostic claim that the patient has blood stasis, after the patient has resisted this diagnosis multiple times. In the next section, I discuss the final part of Extract 22, in which the bystander’s identity as a recovered fellow patient is (re)invoked by the doctor, in order to bolster the doctor’s diagnostic claim and treatment recommendation.
Using a Bystander as a Cured Case

A bystander may also be presented as a cured case to testify to the effectiveness of the proposed treatment (4 out of 41 cases). These cases are relatively rare, given that for it to occur the bystander needs to be a fellow patient who used to have the same condition as the patient. To illustrate this form of bystander participation, I examine part III of Extract 2. In the previous parts of this extract, the bystander was recruited by the doctor to join the patient’s consultation. She was first deployed by the doctor as a contrastive case to show what is wrong with the patient (Part I, line 23), then as a lay witness to the patient’s clinical manifestation, in the service of assisting the doctor in formulating the evidential basis for the doctor’s diagnosis (part II, line 38). In this part of the extract, the doctor (re)invokes the bystander’s identity as a fellow patient who used to have the same condition as the patient.

In the next part of the extract (Extract 22 part III), the bystander’s past experience of blood stasis is (re)invoked by the doctor (lines 52 to 56). Compared to the prior report in lines 43 to 44 (see detailed analysis in the previous section), in lines 52 to 56 the doctor makes explicit the connection between the treatment that the bystander received from the doctor (lines 52 to 53, *Ni yiqian mei chi yao shi- ni yiqian you* (“Before you had the medicine you used to have it”)) and the bystander’s current illness-free status (line 56, *Dan ni xianzai mei le* (“But now you don’t have it anymore”)) and thereby presents the bystander as a “before and after (treatment)” case, making available the inference that it is the doctor’s treatment that has successfully cured the bystander. The bystander’s experience then becomes ammunition for the doctor’s diagnostic claim and also paves the way for the upcoming treatment recommendation.
Participants: doctor (DOC), previous patient (PRP), bystander (PAX) and current patient (PAT)

* Doctor’s invitation
~ Bystander participation

051 PAX: Ao:::. [xidai you.
Oh:::. [Frenulum of tongue have
Oh:::. The lingual frenulum shows it.

052 ->DOC: [Ni yiqian mei chi yao shi-
[You before NEG EAT medicine time
Before you had the medicine-

053 ni yiqian you.
you before have
you used to have it.

(0.2)

054

055 PAX: [Ao::.
[Oh
[Oh.

056 ->DOC: [Dan ni xianzai mei le./((turns back))
[But you now N FP
[But now you don’t have it anymore.

(0.3)

057

058 PAT: Zheige xueyu- xueyu zem zhi.
This blood stasis- blood stasis how treat
This blood stasis- How to treat blood stasis.

In the previous part, the bystander has confirmed that the patient is displaying clinical signs of blood stasis (line 51), which helps the doctor establish the evidential basis for her diagnostic claim. After this, the doctor reinvokes the patient’s identity as someone who used to have the same condition as the patient but has since recovered (lines 51, 52 and 55).
The doctor first reports the bystander’s past health status before she received treatment from the doctor (“Before you had the medicine- You used to have it”). “You used to have it” is a report of the patient’s problematic health status in the past, which also makes available for inference that the patient no longer has it (blood stasis) at present.

The doctor then delivers her diagnosis in contrast, indicating that the bystander is now free of blood stasis: “But now you don’t have it anymore”. Note that the doctor’s line 56 is produced as an addition to her previous turns, implemented to pursue a response from the bystander, given one is initially absent (gap at line 54). In producing this report, the doctor explicitly connects the bystander’s recovery from blood stasis to the treatment that she has received from the doctor, formulating her as a “before” and “after” (treatment) case.

Invoking the bystander as a recovered fellow patient implements several actions: first, it addresses patient resistance by showing that the doctor has knowledge and experience of identifying and treating the condition of blood stasis, given that the bystander has already been successfully treated; second, it enhances the bystander’s credibility as a witness to the patient’s problem, since as a fellow patient, she also has
experience and knowledge about the patient’s health condition; additionally, the doctor lays the groundwork for her upcoming treatment proposal by using the bystander’s recovery as evidence for the effectiveness of her treatment in the past.

The patient launches an inquiry about the appropriate treatment for blood stasis: *Zheige xueyu- xueyu zemne zhi* (“This blood stasis- How to treat blood stasis”) (line 58). This question makes relevant a treatment recommendation and explanation from the doctor about how to treat the condition of blood stasis. By asking the doctor about treatment, the patient indicates to the doctor that she is ready to move on to the next medical activity of treatment discussion, therefore, she has de facto accepted the doctor's diagnosis. This acceptance happens after the bystander’s involvement – where she was deployed by the doctor to enact different roles: as an illness-free, contrastive case, as a lay witness to the patient’s clinical manifestation and as a recovered fellow patient. This shows that in the face of patient resistance, a bystander may be enlisted by the doctor to help offset or address patient resistance.

Extract 22 (parts I, II, and III) shows how a bystander is invited by the doctor to accomplish different tasks and enact different roles in another patient’s visit. The patient in this extract had launched multiple resistant moves towards the doctor’s treatment recommendation and diagnosis delivery, including withholding acceptance (minimal responses in lines 19, 21) and responding to the doctor’s claims with change-of-state tokens, and treating the doctor’s diagnosis as surprising or unexpected (lines 21, 26, 28). The role that the bystander in this extract enacted shifts as the consultation unfolds. The doctor utilized the bystander in different ways to offset patient resistance and move the consultation forward.
As demonstrated by Extracts 21 and 22, a bystander may be invited by the doctor to join another patient’s consultation. Solicited bystander participation occurs frequently after the patient has displayed resistance towards the doctor’s medical evaluations (44/47 cases). The bystander may enact different roles in the consultation to help the doctor address patient resistance by building a stronger case for their diagnostic claims and/or treatment recommendations. In the next section, I focus on cases of voluntary bystander participation.

**Voluntary Bystander Participation**

Bystanders may also join another patient’s ongoing consultation “uninvited”. In this section, I show two cases of voluntary bystander participation. In Extract 23, a bystander joins the patient’s consultation to support the doctor’s treatment recommendation and address the patient’s resistance, while in Extract 24, the bystander participates to challenge the doctor’s treatment recommendation by invoking her personal experiences with the proposed treatment. Voluntary bystander participation is not as commonly seen as solicited participation, occurring in only 6 out of 47 cases. This may indicate that interactants do orient to the boundary between ratified and unratified participants (Goffman, 1981).

In Extract 23, a bystander intervenes into the patient’s consultation after the patient resists the doctor’s treatment recommendation repeatedly. This extract shows how a bystander may join the consultation voluntarily to support the doctor’s course of action help the doctor address patient resistance. Prior to this segment, the patient has already launched two medical complaints, one of them being a “bulging disc\(^{20}\)" that has been

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20 A bulging disk occurs when the spongy disks in the spine become compressed. It can lead to a person experiencing pain and mobility issues.
causing chronic pain. The patient also reported that she has been massaging the disc with warm salt bags to help alleviate the pain caused by the bulging disc. This home remedy was endorsed and praised by the doctor.

Extract 23 begins with the patient moving on to present another medical concern: she has been experiencing persistent heel pain (lines 1 & 2). When the doctor recommends that she use the same home remedy (warm salt bag application) to relieve the heel pain (line 3), the patient launches a series of resistant moves. It is after five resistant moves that a nearby bystander intervenes into the ongoing consultation to support the doctor’s recommendation and counter the patient’s claims (lines 14 & 16), after which the patient concedes and accepts the doctor’s recommended treatment.

In lines 1 and 2, the patient presents a new problem: she has been having heel pain for more than one year. In response, the doctor in line 3 recommends the same home remedy (warm salt bag) that the patient has brought up earlier in the interaction to treat her disc pain (lines not included).

Extract 23 Salt bag
WWW_TCM_VID0002_8_6_22_31
Participants: doctor (DOC), bystander (PAX); and current patient (PAT)

~> Bystander participation

01 PAT: Hai you ge zugeng teng. Teng le you: (.n- yi nian duo
Also one heel pain. Pain PRT have(.n- one year more
Also there’s heel pain. The pain has been going on for more

02 [le ba.
[PRT FP
[than a year.

03 DOC: [Na ni ba neige neige yan daizi ca jiaogen shang.
[Then you use that- that salt bag rub heel on
[Then you use that- that salt bag and rub it on your heel.

04 PAT: Er ye guan[yong.
Um also useful
Um. For this too?

05 DOC: [Yiyang guanyong.]
[Same useful]
[It works the same.]

06 PAT: Ou.=
Oh
Oh.=

07 DOC: =Tebie guanyong.
=Very useful
=Works very well.

08 PAT: Zouzou [dao he lian zher dou teng.]
Walk walk [road EXCL even here also painful
(If I) walk for a little bit [here also hurts.
|((points at her ankle))

09 DOC: [Yan dair lian-]
[Salt Bag even]
[Salt bag even-

10 DOC: Yan dair neige fu jiaogen tebie zhi >jiaogen teng<.
Salt bag that apply heel very treat heel pain
Applying a salt bag to the heel really helps with the heel pain.

11 PAT: Wo laotou- laotou shuo wo jing xia zheng.
My old man- old man said I always randomly work
My husband- husband said I always do this kind of random work.

12 (0.3)

13 PAT: Refu:- refu [keyi ma.
Heating pad- heating pad okay Q
Is a heating pad- heating pad okay?

14-> PAX: [Refu shi diedasunshang.=
[Heating pad BE sprain and bruises
[A heating pad is for a sprain and bruises.=

15 PAT: =Ao.
=Oh
=Oh

16-> PAX: Yandair hao.
Salt bag good
A salt bag is good.

17 PAT: A na xing na wo huan dao ( [ ]
PRT then okay then I change to ( [ ]
Oh okay then I will switch to ( [ ]

18 DOC: [Keyi jiezhe neng.
[Can continue do
[(You) can continue.

19 PAT: A xing [xing.
Yep okay [okay
Yep okay [okay.
The patient’s problem presentation in line 1 and 2 is prefaced with *hai* (“also”), indicating that this problem is an addition to the list of problems that the patient has previously presented:

**PAT:** Hai you ge zugen teng. Teng le you: (.).n- yi nian duo
Also one heel pain. Pain PRT have(.).n- one year more
Also there’s heel pain. The pain has been going on for more

**DOC:** [Na ni ba neige- neige yan daizi ca jiaogen shang.
[Then you use that- that salt bag and rub it on your heel.

The patient indicates in her presentation that this heel problem is a persistent and ongoing issue (*Teng le you: (.).n- yi nian duo le ba* (“The pain has been going on for more than one year”)). This may be understood as an account for bringing it up during her visit. In response to the patient’s report of her symptom, the doctor directs the patient to use the same home remedy that she reported using for her bulging disc problem (line 3, *Na ni ba neige- neige yan daizi ca jiaogen shang* (“Then you use that- that- salt bag and rub it on your heel”)).

**DOC:** [Na ni ba neige- neige yan daizi ca jiaogen shang.
[Then you use that- that salt bag and rub it on your heel.

**PAT:** Er ye guan yong.
Um also useful
Um. For this too?

Here the distal deictic term “that” (*neige* in Chinese) refers back to the patient’s prior report of home remedy (lines not included in transcript), indicating that this is the same salt bag referred to earlier in their interaction. In response to the doctor’s recommendation, the patient in line 4 seeks confirmation from the doctor that applying a warm salt bag is an appropriate treatment for her current problem (*Er ye guan yong* (“Um for this too?”)). The patient’s turn has a dispreferred turn shape (it is delayed, as indicated
by the token “Um”, Pomerantz, 1984; Sacks, 1987), making relevant a confirmation or further explanation from the doctor and thus indicates her skepticism and calls the doctor’s recommendation into question.

In response to the patient’s slight resistance, the doctor at line 5 confirms that the treatment will be equally effective for the patient’s heel pain (Yiyang guanyong (“It works the same”)). When this claim is met with a change-of-state token “Oh” from the patient (line 6), the doctor upgrades his assessment of the effectiveness of the treatment from Yiyang guanyong (“It works the same”) to Tebie guanyong (“It works very well”) at line 7. The doctor’s upgrade may be occasioned by the patient’s Ou (“Oh”), which, rather than accepting the doctor’s recommendation, treats the doctor’s claim about treatment effectiveness as merely new information, thereby indicating skepticism.

The patient’s resistance continues in the ensuing lines. In response to the doctor’s upgraded assessment, the patient goes on to provide additional diagnostically relevant information about her heel pain problem (line 8 Zouzou dao he lian zher dou teng (“If I walk for a little while even here hurts”)). As she is delivering this information, the patient also points at her ankle to show the doctor where the pain is located. This information is a new symptom description that is also related to the patient’s heel pain. However, by indicating that the pain gets worse and spreads to her ankle, the patient enlarges the scope of her problem, in this way proposing it as more serious. In upgrading the seriousness of her problem, the patient may be indicating that the treatment recommended by the doctor (the warm salt bag) may not be sufficient. Hence this constitutes further resistance to the doctor’s recommendation.
However, in response to the patient’s resistant report, the doctor does not change his treatment recommendation. He once again claims the effectiveness of the treatment (line 10): *Yan dair neige fu jiaogen tebie zhi >jiaogen teng<* (“Applying a salt bag to the heel really helps with the heel pain”). This claim has two features: first, it is a slight upgrade from his prior claim (line 7 “It works very well”), intensified with “tebie (really)”. Second, he is formulating the treatment recommendation as something that is a general recommendation about the use of a salt bag for heel pain. It is formulated in a way that is not specific to the patient’s problem. In this way he may indicate that this is not simply occasioned by her previous report that she has been using a salt bag for another ailment, but rather something that is effective for the current ailment. The doctor’s claim here provides another opportunity for her to accept it.

However, the patient’s resistance continues. This time the patient uses reported speech from a third party (her husband) to further challenge the legitimacy of the doctor’s recommended treatment:

11 PAT: Wo laotou- laotou shuo wo jing xia zheng. My old man- old man said I always randomly work. My husband- husband said I always do this kind of random work.

The third party being invoked here is the patient’s husband, who, according to the patient, characterized her self-treatment as *xia zheng* (“random work” (line 11). In reporting her husband’s negative characterization, it is possible that the patient is marshaling her husband’s support for this remedy being “random work”, something that she does idiosyncratically at home, and that is therefore not a legitimate medical treatment. In this way she indicates that her skepticism may be shared by others. Additionally, with the “jing (always)” at line 11, the patient uses her husband’s words to convey that this type of
treatment is something that she is prone to or does recurrently, but that is not systematic or reliable. The reported speech here is implemented by the patient to indicate that this is merely a home remedy, which may not be a suitable treatment for the problem that she has just presented. This characterization undermines the legitimacy of the patient’s self-treatment, and by implication of the doctor’s recommendation. As demonstrated by Couper-Kuhlen (2007), interactants sometimes report third party’s speech to substantiate their claims. In this extract, although the patient has not explicitly assessed the doctor’s treatment recommendation, she is bolstering her skepticism towards it here by reporting a negative assessment from her husband.

When the reported speech receives no response from the doctor, the patient at line 13 asks the doctor about a different treatment: *Refu:- refu keyi ma* (“Is a heating pad-heating pad okay (for treating the heel pain)”)*. This question is launched after the doctor has repeatedly advocated for another form of treatment and makes relevant a yes (accepting) or no (declining) response from the doctor. Hence, the patient’s action of checking with the doctor about another treatment option is hearable as proposing it, and thus, resisting the initial treatment that the doctor has recommended. At this point, the patient has repeatedly displayed resistance towards the doctor’s treatment recommendation that she should use warm salt bags to ease her heel pain. She does so by questioning the effectiveness of the treatment (line 4), providing additional information which makes relevant more explanation from the doctor (line 8), reporting a third party’s negative characterization of the treatment (line 11) and finally, nominating an alternative treatment option (line 13). Despite the patient’s several attempts to resist his treatment recommendation, the doctor does not revise his position. He reassures the patient for
several times that this treatment will work (lines 5, 7, 9 and 10), as it does for her other problem. Lines 14 and 16 are the target lines in this extract, in which a bystander, a nearby patient who is unacquainted with the patient spontaneously intervenes into the patient’s consultation.

14-> PAX: [Refu shi diedasunshang. =
          [Heating pad BE sprain and bruises
          [A heating pad is for a sprain and bruises. =

15   PAT: =Ao.
       =Oh
       =Oh

16-> PAX: Yandair hao.
       Salt bag good
       A salt bag is good.

17   PAT: A na xing na wo huan dao ( [ )
       PRT then okay then I change to ( [ )
       Oh okay then I will switch to ( [ )

18   DOC: [Keyi jiezhe neng.
          [Can continue do
          [(You) can continue.

19   PAT: A xing [xing.
       Yep okay [okay
       Yep okay [okay.

At line 14, the bystander interjects into the interaction by responding to the patient’s question about an alternative treatment (line 13, Refu shi diedasunshang (“A heating pad is for a sprain and bruises”)), even though the question is addressed to the doctor.

The bystander rejects the patient’s proposal of using a heating pad to treat her heel pain on the basis of it being an inappropriate treatment for the condition that the patient has. She points out that heating pad is used for conditions like sprains and bruises, rather than chronic pain (which is what the patient has) and thus, rejects the patient’s proposed alternative treatment by challenging its suitability. In addition to rejecting the
patient’s treatment proposal, the bystander also endorses the doctor’s treatment recommendation by positively assessing it (line 16, *Yandair hao* (“A salt bag is good”). The bystander participates in the consultation after the patient’s continual resistance to the doctor’s treatment recommendation. By intervening into the consultation, the bystander supports the doctor’s course of action (recommending treatment) and counters the patient’s course of action towards it (resisting the doctor’s recommended treatment).

At line 17, after the bystander rejects the patient’s alternative treatment and endorses the doctor’s recommendation, the patient concedes, finally accepting the doctor’s recommendation: *A na xing na wo huan dao* (“Oh okay then I will switch to ( )”). “Oh”, a change of state token, registers the bystander’s informing and assessment as new information. The patient accepts the recommended treatment (“okay”) and then indicates that she will implement a change (“then I will switch to”) as a result of what happened just prior (as “then” indicates”).

In this extract, the doctor recommended a treatment which is repeatedly resisted by the patient. Possibly in response to the patient’s serial resistant moves, a nearby patient, who is unacquainted with the current patient, spontaneously joined the ongoing consultation in support of the doctor’s treatment recommendation. She rejected the alternative treatment option proposed by the patient (line 14) and then went on to support the doctor’s recommendation (line 16). Next, the patient accepted the doctor’s recommendation. This extract is different from the previous two extracts because the bystander was not joining the interaction upon the doctor’s invitation, but rather joined it spontaneously. This shows that bystander participation may occur without the doctor’s
prompting, and that a bystander may intervene spontaneously to help the doctor move the medical agenda forward when there is ongoing patient resistance.

In Extracts 21, 22 and 23, the bystanders’ involvement in the patient’s consultation all helps address patient resistance and support the doctor’s course of action. However, in my collection of cases, there are rare occasions on which a bystander voluntarily participates to disaffiliate with the doctor and counter the doctor’s line of action. These cases are uncommon (2/47 cases, approximately 4% of all cases), but still need to be examined. In the next part of this chapter, I show a case of voluntary bystander participation in which the bystander challenges the doctor’s dietary recommendation to the current patient.

This case shows that a bystander may participate in other patients’ consultations for reasons other than supporting the doctor. They may join to counter the doctor’s recommendation and offer their personal experience as evidence. In that case, the resistance that the doctor faces comes from the bystander, rather than the patient.

**Bystander Participation that Counters the Doctor’s Line of Action**

Extract 24 happens during the medical activity of lifestyle discussion. In this extract, the doctor recommends a food item, which is immediately accepted by the patient. However, the bystander joins the interaction to contest the doctor’s dietary advice to the patient by using her personal experience with that particular food item as evidence. In response to the bystander’s challenge, the doctor frames this bystander as an exception whose experience is not applicable to anyone else, and in so doing, dismisses the validity of her challenge. This extract is different from the previous ones because not only is the bystander participation spontaneous, but also self-attentive (Bolden, 2006; Maynard,
2016), meaning that the bystander’s participation is not in the service of the patient’s medical visit, but rather it is used as an opportunity to launch the bystander’s own concern about a certain type of treatment.

Prior to Extract 24, the doctor and the current patient were discussing some possible dietary changes for the patient. In line 1, the patient asks a question about ginger, something that she is currently consuming per the doctor’s recommendation. In line 2, the doctor advises the patient to continue eating ginger in the summer. This piece of dietary advice is immediately accepted by the patient (line 3) but later contested by a bystander (starting from line 6). In contrast to prior extracts, in this extract, the bystander participates to challenge the doctor recommendation, rather than to support it. After an extensive exchange between the doctor and the bystander about the effectiveness of ginger, the bystander eventually backs down and the patient’s consultation resumes.

Extract 24 Ginger

Participants: patient (PAT), doctor (DOC), bystander (PAX, out of camera)

01 PAT: Na neige jiang (.) jin fu hai neng he me. Also that ginger(.) enter hot season still should have FT

02 DOC: Jin fu shi zui yingai chi jiang de. Enter hot season be most should eat ginger FP

03 PAT: >Kebushi me< na tai hao le. Na hai jiezhe chi. >It’s not Q< that so good FP. That still keep on eat

04 DOC: Zui yinggai chi jiang le. Most should eat ginger FP

05 DOC: [Wo jintian zaoshang gei ta- I today morning give her
In the morning I gave her-

06 ~>PAX: [Keshi chi zhei g-
[But eat this
[But eating this-

07 DOC: ((looks at PAX))

08 DOC: [Meitian zaoshang qilai-
[Everyday morning get up-
[Every morning after getting up-

09 ~>PAX: [Chi neige jiang rongyi you neire::.
[It’s very easy to get internal heat eating ginger.

10 DOC: |(0.3)
|((leans forward))

11 DOC: Ni zenme neme te:shu ne./((to PAX))
You how That special FP
How can you be that special.

(0.2)

13 ~>PAX: Er.(.) Wo jiu chi nei [jiang chide
Um. (.) I just eat that[ginger eat
Um. (.) Just after having ginger I

14 DOC: |(0.3)
|[Nin-nin- nin zui teshu.
|You- You- You most special
|You- you- you are the most

15 |le.
|FP
|special one.
|((shifts eye gaze towards PAT))

I eat this ginger[eat FP
After eating ginger I

17 DOC: [Zuotian lai name duo ren.
[Yesterday come that many people
[Yesterday so many people came (to my office).

18 haome chi jiang yige bi yige bai
Wow eat ginger one than one light
Wow everyone who eats ginger was

19 yige bi yige mei.
one than one pretty.
light and pretty.

20 (0.3)

21 DOC: Haoh she ne. [Zhen de.
Good PRT PRT.[Real PRT
All good. Really.

21 Here “bai”, translated as “light” is referring to light complexion. In TCM, light complexion normally indicates healthiness and balance.
Just be blend done juice add honey FP
Just juice it and add honey right.

Right right right
Right right right.

Right

That remedy is very good. After adding honey
it actually no longer upsets your stomach.

Then its strength is also alleviated.

It's not that strong.

Otherwise ginger’s strong taste just=

You enter after soon just sweat sweat FP
Right after you ingest it you start sweating.

This is the most powerful part of ginger.

But after adding honey its power is alleviated.

Much better.

22 Here the strength does not refer to the strength of ginger as medicine, but the taste that may irritate the digestive system.
At line 1, the patient checks with the doctor whether or not she should continue to consume ginger in the hot season (summer): *Na neige jiang (. ) jin fu hai neng he me* (“Also should I still have ginger in the hot season”). Prior to this segment, the doctor and the patient have been discussing some dietary changes that the patient needs to adopt to help her body regain balance (lines not included). The patient prefaces her question with “also”, formulating it as an extension of their previous discussion. The word “still” here indicates that the patient has already been having ginger as a dietary supplement (possibly per the doctor’s recommendation) and is now seeking advice from doctor on
whether she should continue to do so. In TCM, ginger is considered a type of “warming”
food that will raise one’s body temperature. The patient’s question is likely occasioned by
the weather change – the video was recorded in midsummer. Since TCM is all about
balance, having warm food in warm weather may appear odd and against basic TCM
principles. In response to the patient’s question, the doctor makes a strong, intensified
claim about eating ginger in the summer (line 2, Jin fu shi zui yingai chi jiang de (“The
best time to eat ginger is during hot season”)). This claim is extreme (Pomerantz, 1986)
since it characterizes summer (the hot season) as the optimal time to consume ginger,
making available for inference that even in the hot weather, eating ginger will benefit the
patient’s health. The doctor’s line 2 is hearable as a recommendation that the patient
should continue to have ginger as a dietary supplement, despite the warming weather.

The patient’s response at line 3 (>Kebushi me< na tai hao le. Na hai jiezhe chi
(“Absolutely. That’s good. I will keep on having it”)) indicates that she treats the
doctor’s claim as a recommendation and that she is accepting it:

01 PAT: Na neige jiang(.) jin fu hai neng he me.
Also that ginger(.) enter hot season still should have FT.
Also should I still have ginger in the hot season.

02 DOC: Jin fu shi zui yingai chi jiang de.
Enter hot season be most should eat ginger FP.
The best time to eat ginger is during the hot season.

03 PAT: >Kebushi me< na tai hao le. Na hai jiezhe chi.
>It’s not Q< that so good FP. That still keep on eat.
>Absolutely. < That’s good. I will keep on having it.

The patient’s acceptance of the doctor’s recommendation consists of three parts.
She first agrees with the doctor: Kebushi ma “(Absolutely)”’. This expression in
Mandarin Chinese conveys strong agreement. Next the bystander delivers a positive
assessment of the advice given by the doctor na tai hao le (“That’s good”), treating the
doctor’s claim as good news. Also, by describing her future plan in the last part of her turn, the patient indicates that she accepts the doctor’s recommendation and will continue to use ginger as a dietary supplement.

Despite the patient’s acceptance, the doctor continues to strengthen his case for recommending ginger to the patient:

04 DOC: Zui yinggai chi jiang le. 
Most should eat ginger FF. 
Eating ginger is the best option.

05 DOC: [Wo jintian zaoshang gei ta- 
[I today morning give her- 
[In the morning I gave her- 

06 ~>PAX: [Keshi chi zhei g- 
[But eat this- 
[But eating this-

07 DOC: ([looks at PAX))

In line 4, the doctor produces another extreme case formulation, characterizing eating ginger as the most ideal option for the patient (Pomerantz, 1981). By characterizing ginger as the best possible choice for the patient (which is unlikely), the doctor further legitimizes his claim about ginger and adds more ammunition to his recommendation that the patient should continue to eat ginger. Starting from line 5 the doctor begins to describe his daily routine: Wo jintian zaoshang gei ta- (“In the morning I gave her-”). It is possible that the doctor is using his personal experience to further account for his recommendation for it.

The doctor’s line 5 is produced in overlap with the bystander’s turn at line 6: Keshi chi zhei g- (“But eating this-”). The turn initial “But” projects upcoming disagreement and indicates that the bystander is proffering counterevidence to the doctor’s claim that ginger is the best dietary supplement. This attempt to intervene is ignored by the doctor (he glances at the bystander but then relaunches his telling, lines 7
& 8). The doctor’s line 8 is potentially an effort to relaunch his previously abandoned telling (Meitian zaoshang qilai- (“Every morning after getting up”)). His turn starts with “every morning”, which is a modified recycling of his previous turn beginning (line 5, Schegloff, 1987):

07 DOC: ((looks at PAX))
08 DOC: [Meitian zaoshang qilai- [Everyday morning get up [Every morning after getting up-
09 ~> PAX: [Chi nei jiang bener shanghuo::.[Eat that ginger very get internal heat [It’s very easy to get internal heat eating ginger.
10 DOC: |(0.3) ||(leans forward))
11 DOC: Ni zemne neme te:shu ne./((to PAX)) You how That special FP How can you be that special.

The doctor’s rebeginning is once again in overlap with the bystander’s intervening action (line 9) (Lerner, 2019). This time, the bystander counters the doctor’s prior claim about ginger by proposing a problem with ginger as it causes internal heat: Chi nei jiang bener shanghuo::: (“It’s very easy (for you) to get internal heat eating ginger”).

The bystander’s turn here is a strong, intensified claim about the side effect of consuming ginger (as indicated by the intensifier “very”). Since the doctor has clearly conveyed his stance towards ginger consumption, the bystander’s turn here constitutes a counter-informing (Robinson, 2009), which introduces a possible negative effect (internal heat) of ginger consumption and thereby exposes her oppositional stance towards it. Additionally, this turn is formulated as a general claim about ginger, rather than a report of the patient’s personal experience with it. It is possible that this information is also provided as a warning to the overhearing patient about the potential side effects of consuming ginger.
The gap in line 10 indicates that the doctor’s upcoming response is likely to be dispreferred. The doctor also slightly adjusts his sitting position by leaning forward to get closer to the patient. This adjusting action may be used by the doctor to indicate to both the patient and to the bystander that he is currently engaged in the patient’s consultation.

The doctor does not accept or decline the bystander’s counter-informing at line 11. Instead, he undermines the legitimacy of the bystander’s claim by targeting her as a person: *Ni zenme neme te:shu ne* (“How can you be so special”). Two features of this response make it a strong push-back against the bystander’s claim. First, the doctor’s turn, which functions similarly as a wh- interrogative in English, treats the patient’s claim as accountable and thus conveys a challenging stance towards it (Bolden & Robinson, 2007); second, by characterizing the bystander as “special”, the doctor separates and disaggregates (Lerner & Kitzinger, 2007) the bystander from the other patients, or even other people in general. Since the bystander is not like the rest of “normal” people (but rather, is special), her experience with ginger is likely to be unique, and therefore simply not applicable to other patients.

However, in line 13, the bystander continues to offer more specifics details of her personal experience with ginger (*Wo jiu chi nei jiang chide* (“Just after eating ginger I-”)). By offering this information, she continues her challenging stance towards the doctor’s recommendation of ginger by providing more evidence for the potential side effects of consuming ginger:

<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>(0.2)</td>
</tr>
<tr>
<td>13</td>
<td>Er. (.) Wo jiu chi nei [jiang chide</td>
</tr>
<tr>
<td></td>
<td>Um. (.) I just eat that[ginger eat</td>
</tr>
<tr>
<td></td>
<td>Um. (.) Just after having ginger I</td>
</tr>
<tr>
<td>14</td>
<td>DOC:</td>
</tr>
<tr>
<td></td>
<td>[Nin-nin- nin zui teshu.</td>
</tr>
<tr>
<td></td>
<td>[You- You- You most special</td>
</tr>
<tr>
<td></td>
<td>[You- you- you are the most</td>
</tr>
</tbody>
</table>
Two observations can be made about line 13. First, it is prefaced with an “Um”, which indicates upcoming disagreement (Pomerantz, 1984; Schegloff, 2007). Also, the bystander adds the particle “just” in her turn, formulating ginger as the only cause of the problem that she is about to present. This report is about her status after consuming ginger (“after having ginger “). Although it is not complete due to the doctor’s interruption at line 14, it may be implemented as an account for her prior claim that eating ginger causes internal heat. This report is about the patient’s personal experience with ginger, a potential back down from her prior generalized claim about ginger in line 9. When the bystander first mentioned the negative effect of consuming ginger, her turn was formulated as an assertion about a basic fact that can be applied to anyone (Chi nei jiang bener shanghuo:: (“It’s very easy to get internal heat eating ginger”)). This time, the bystander’s claim about ginger is limited to her personal experience. Her turn is produced in overlap with the doctor’s line 14, the interjacent position of the doctor’s turn (Drew, 2009) indicates that the simultaneous talk is competitive and argumentative in nature. Hence, by coming in early, the doctor displays a strong oppositional stance towards the patient’s claim about ginger. Here he again targets the bystander’s personal qualities by characterizing her as “the most special one” (Nin-nin- nin zui teshu(“You are the most special one”)). This characterization is an upgraded assessment from the previous one with a superlative (from “so special” to “the most special one”). In this way the doctor proposes that the patient is atypical. This upgraded characterization is extreme (Pomerantz, 1986) and further separates and disaggregates the bystander from most
patients, and thus undermines the bystander’s claim about ginger by making available for inference that her experience with ginger is unique. Therefore, her negative experience with ginger does not constitute a basis for rejecting ginger as a legitimate dietary supplement for other patients who are not “special”. By implication, this indicates that his recommendation to the current patient stands. Additionally, while launching his turn, the doctor shifts his eye gaze towards the current patient. The eye gaze shift may indicate that the doctor is ready to redirect his attention back to the current patient, whose consultation has been temporarily put on hold during the bystander’s interjection.

Even after the doctor’s strong dismissal, the bystander persists in contesting the doctor’s claim about ginger by once again trying to share her personal experience (line 16: *Wo chi zhe jiang chi de a* (“After having ginger I”)), which is interrupted by the doctor:

\[
16 \rightarrow PAX: \quad Wo \ chi \ zhe \ jiang \ [chi \ de \ a. \\
I \ eat \ this \ ginger \ F \ F \\
After \ eating \ ginger \ I \\
17 \ DOC: \quad [Zuotian \ lai \ name \ duo \ ren. \\
[Yesterday \ come \ that \ many \ people \\
[Yesterday \ so \ many \ people \ came \ (to \ my \ office). \\
18 \ haome \ chi \ jiang \ yige \ bi \ yige \ bai \\
Wow \ eat \ ginger \ one \ than \ one \ light \\
Wow \ everyone \ who \ eats \ ginger \ was \\
19 \ yige \ bi \ yige mei. \\
one \ than \ one \ pretty \\
light \ and \ pretty. \\
20 \ (0.3)
\]

The bystander’s line 16 is a partial repeat of her prior turn at line 13, with “Um” and “just” dropped. This repeat helps the bystander reinvoke her stance towards ginger. Before the bystander finishes, the doctor interrupts again, launching another attempt to discount the patient’s experience and separate the bystander from other patients. He
provides counter-evidence to the bystander’s experience at lines 17-19, reporting that other patients who have consumed ginger have all benefited from it, since they have great complexion: *Zuotian lai name duo ren. Haome chi jiang yige bi yige bai* (“Yesterday so many people came. Wow everyone who eats ginger was light and pretty”).

This report is a clear exaggeration (Drew, 2003) that the doctor uses to strengthen his claim that the patient is different from everyone else. The first part of the doctor’s turn (line 17) highlights the recency of the doctor’s observation (indicated by “yesterday”), as well as the number of samples that the doctor has observed (“so many”), adding more weight and credibility to the doctor’s counterevidence by providing accurate details of his report of observation. In line 18 through 19, the doctor reports his observation of other patients’ appearance after eating ginger, characterizing their complexion as “light and pretty”. In producing this overbuilt report, the doctor makes available for inference that the bystander is an nothing but an outlier whose experience is at odds with his recent observation, and therefore further segregates the bystander from all the other patients.

The doctor’s turn is followed by a gap (line 20), which may indicate further resistance from the bystander. In line 21, the doctor, potentially trying to pursue a response from the bystander, captures the upshot of his previous report by giving an assessment of the collective wellness of all other ginger-eating patients: *Hao zhe ne* (“All good”), and in doing so, he provides another slot for the bystander to respond. He also testifies to the authenticity of his report *Zhen de* (“For real”), in the further pursuit of a response from the bystander.

20          (0.3)

21   DOC:   Hao: zhe ne. [Zhen de. Good PRT PRT. [Real PRT
When the doctor’s pursuit fails (silence at line 22), he returns to the patient’s consultation with a question about her method of preparing ginger (line 23): *Jiu shi da cheng zhir (.) jia fengmi me* (“Just juice it and add ginger right”). This checking is implemented in a way that makes relevant a confirmation or disconfirmation from the patient. Additionally, the “just” at the turn initial position minimizes the complexity of preparing ginger. This checking could be heard in different ways. First, when it is produced for the patient, it could be understood as the doctor’s attempt to move the patient’s consultation forward, since discussion about treatment preparation is the next medically relevant activity after a treatment or dietary item is recommended. It may also be understood as the doctor checking with the patient that she prepares her ginger the right way to make sure that she will not encounter the problem that the bystander encountered. On the other hand, the doctor’s turn may also be understood as “troubleshooting” for the overhearing bystander, trying to offer an alternative explanation for her unpleasant experience with ginger. In producing this checking, the doctor makes available for inference that ginger itself might not be problematic, but the incorrect way of preparing it might be.

So far, the bystander has resisted the doctor’s recommendation that the patient should continue to consume ginger in hot weather. In countering and challenging the doctor’s dietary recommendation, the bystander not only disrupts the patient’s ongoing visit, but also calls into question the doctor’s expertise and authority, since food remedies are traditionally in the doctor’s territory of knowledge. This may explain why the
doctor’s responses are repeatedly dismissive: instead of addressing the bystander’s concern about internal heat, the doctor rejects her claim on the basis of her being “special” and thus inferably different from everyone. In this way, he undermines the legitimacy of the bystander’s counterclaim and dismisses her experience as irrelevant.

Both the patient and the bystander confirm that they are using the correct way to prepare ginger (lines 24 & 25). This provides further evidence that the doctor’s question can be understood to be designed for both the patient and the overhearing bystander:

24   PAT:  Dui  dui d[ui.
       Right right right
       Right right right.

25 ~>PAX:  [Dui:.
           [Right.

Note that they both use dui (“right”) in response to the doctor’s checking. Similar to the American use of “right” (Bolden, Hepburn & Mandelbaum, 2019) the “right” here not only provides confirmation, but also claims independent epistemic access to the matter at hand. Additionally, the patient’s response, a multiple saying “Right right right” treats the doctor’s checking as unnecessary (Stivers, 2004). By responding to the doctor in this way, both the patient and the bystander indicate that they already know the correct way of preparing ginger. In the ensuing lines, the doctor explains in detail why adding honey to ginger may help solve the heat problem (lines 26 to 30):

26   DOC:  Neige- .hh Nei  fangr ting hao de. .hh Jia shang fengmi
       That- .hh that remedy  very good FP..hh add P  honey
       That- that remedy is very good. After adding honey

27           yihou qishi:  a ta jiu bu ciji         wei le.
           After actually  P  it just N irritate stomach FP
           it actually no longer upsets your stomach.

28           Ranhou ne ta n- ta neige liliang ne ye    huanhe le.
           Then   P  it n- it that  strength P also alleviate FP
           Then its strength is also alleviated.

29           meiyou name cho:ng.
I noted earlier that ginger is considered a “warming” food that helps drive away the cold and dampness within the human body. The strength of ginger usually refers to how *xinla* (“hot”) it is – how much heat it may generate within the human body, and importantly, how pungent it tastes. Since ginger has a strong warming effect, according to TCM theories it may upset the patient’s stomach. In the doctor’s response, we see him orienting to both the warming effect of ginger (line 28) and its pungent taste (line 30).

The doctor starts by giving a strong positive assessment of the remedy of adding honey to ginger: *Neige-.hh Nei fangr ting hao de* (“That- that remedy is very good”). He then unpacks what is “good” about this remedy by explaining how it helps to mitigate both the strength and the taste of ginger (lines 27 to 30). The doctor’s explanation has dual functions: on the one hand, it accounts for recommending consuming ginger with honey to the patient by explaining the interaction effect of ginger and honey within the human body; on the other hand, it is responsive to the bystander’s prior claim about ginger causing internal heat, by offering a solution to it. The doctor’s explanation here is another attempt from him to offset the bystander’s resistance towards ginger, offering her another opportunity to accept his recommendation of it.

The bystander’s response to the doctor’s explanation is minimal (line 31): “Mm hm”. Since the doctor’s prior claims make relevant acceptance or rejection from the bystander, this minimal response again constitutes resistance since it merely acknowledges the doctor’s explanation as new information.
The doctor continues to pursue acceptance from the bystander (lines 32 to 33), when he explains how the human body reacts to ginger. He formulates the warming effect of ginger as immediate and strong (line 32, *Ni jin lai yihou mashang jiu chu han la* (“Right after you ingest it you start sweating”)), and then in line 33 frames it as the most powerful effect of ginger (*Zhei jiu shi jiang de neige zui-lihai de difan* “This is the most powerful part of ginger”). The doctor’s lines 32 and 33 confirm what the bystander has claimed earlier (line 9, “It’s very easy to get internal heat eating ginger”).

We see that earlier in the interaction, the doctor has strongly and repeatedly dismissed the bystander’s claim about ginger. However, he does so not by rejecting the claim as false, but by discrediting the bystander. He only confirms what the bystander said was true after offering a solution to the problem. In introducing a solution before acknowledging the legitimacy of the problem, the doctor formulates this side effect of ginger (inducing internal heat) as a solvable problem. In this way, he builds a case in support of his recommendation.

In line 34, the bystander produces “U::m”, which projects more disagreement (Pomerantz, 1984; Schegloff, 2007). The doctor comes in while the bystander’s “U::m” is
still in progress, once again invoking honey as a quick and effective solution to the problem that consuming ginger might cause (Danshi jia le neige mi yihou ta jiu huanhe le. “But after adding honey its power is alleviated”):

34 ~> PAX: E::tn.
   U::mm

35 DOC: [Danshi jia le neige mi yihou ta jiu huanhe le.
   [But add P that honey after it just alleviate FP
   [But after adding honey its power is alleviated.

36 (.)

37 DOC: Hao duo le.
   Good more FP
   Much better.

38~> PAX: En.
   Mm hm
   Mm hm.

While the doctor presents a potential problem in 32 and 33 (ginger causing internal heat), line 35 is offered as a solution to the problem Danshi jia le neige mi yihou ta jiu huanhe le (“But after adding honey its power is alleviated”). Therefore, the side effect of ginger invoked by the bystander should not be an issue since a simple solution is available. In offering this solution, the doctor again dismisses the bystander’s concern because it is an easily solvable problem.

However, the bystander’s response is still lukewarm. She delivers a weak agreement token at line 38 (“Mm hm”). Possibly trying to pursue stronger acceptance, the doctor proposes another candidate solution to the bystander’s problem: consuming less ginger (lines 39 and 40).

39 DOC: Ni yao shi juezhe shuo(.) ta you dian shanghuo
   You if BE think PRT(.) it have little internal heat
   If you think it causes a little internal heat

40 Ni jiu shao: ge dianr shishi.
   You just less put little try
   You just try to put less in it.
Note that by adding *Ni yao shi juezhe shuo* ("If you think") in line 39, the doctor orients to the bystander’s problem with ginger as a perceptual, subjective issue. The doctor’s construction of his turn may indicate that he is skeptical towards the concern presented by the bystander. Also, the *jiu* ("just") in line 40 minimizes the effort that the patient needs to put into solving the problem, again formulating internal heat as a problem that can be solved easily. Similar to some of the doctor’s prior claims this advice leaves available for inference that the bystander’s unpleasant response to ginger is not because of ginger itself, but because of the bystander’s incorrect way of preparing it.

In response, the bystander at line 41 specifies that her problem with ginger is constipation: *bu shi wo yi chi wan jiang wo bu jie dabian* ("No once I eat ginger I do not poop"). Note that she has attempted to report her personal experience with ginger twice before this (lines 13 & 16), but both attempts were abandoned because of the doctor’s interruptions. The bystander’s report here is prefaced with “No”, indicating that she is repairing a misunderstanding in the prior talk (Schegloff, 2001; Raclaw, 2013). Hence, by specifying that her problem with ginger is constipation, rather than intrinsic heat-related, the bystander rejects the doctor’s proposed solutions that adding honey and/or consuming less ginger may solve the problem, since honey only helps with the “strength” of ginger, not its potential side effect of constipation. Therefore, the bystander continues to resist the doctor’s recommendation of ginger by introducing a new problem with it, one that cannot be solved by the doctor’s suggestion.

41 ~>PAX: .hh bu shi wo yi chi wan jiang wo bu jie dabian. .hh N BE I once eat done ginger I N release poop .hh No once I eat ginger I do not poop.

42 DOC: Ao::: Na jiu huai le. Oh. that just bad FP Oh. That’s bad.

43 (1.1)
In line 42, the doctor first registers the bystander’s report as new information (with the change-of-state token “oh”), then offers a negative assessment of the bystander’s situation: Na jiu huai le (“That’s bad”). In so doing, the doctor acknowledges the legitimacy of the bystander’s problem. However, after a gap (line 43), the doctor attributes the cause of the bystander’s constipation problem as particular to her (line 44: Na zhei jiu shi tizhi chayi (“Then this is an individual difference”) and 46: Ta zheige tizhi jiu (.) gen jiang you fanying (“Her body reacts to ginger”), rather than the remedy itself. In this way, he indicates that even if it is true, the claim that the bystander has made about ginger is not relevant to the current patient’s treatment regimen, since it is likely caused by the bystander’s personal characteristics.

The patient, who has been silent the whole time, comes in at line 47 and captures the upshot of the doctor’s claims by delivering her own characterization of the bystander: Ta jiu shi buyiyang (“She is just one of a kind”). “One of a kind” is another way of formulating the bystander as unique, disaggregating her from all the other patients (or even all the other people). In producing this characterization of the bystander, the patient aligns with the doctor’s stance. She agrees with the doctor that the bystander is an
exception, so her personal experience, which is caused by her unique reaction to ginger, is not applicable to other people. In this way, the patient can be understood to be sustaining her acceptance of the doctor’s recommendation, even after the bystander opposes to it. The patient then immediately returns to the official business of her medical visit at line 48 by presenting an additional medical concern, which makes relevant a diagnostic evaluation from the doctor (Wo zhei xigai tebie (jianying)a (“My knee is very rigid”)) and opens a new line of action. In this way, she treats this part of the consultation as over.

In this segment, the resistance to the doctor’s medical opinion comes mainly from the bystander. The bystander’s resistance started with a general claim about one side effect of ginger, conveying her oppositional stance towards using ginger as a dietary supplement. This is built as connected to the doctor’s recommendation for the current patient. The doctor rejected her claim not by disconfirming it, but by characterizing the bystander as being different from everyone else. In so doing, he separated and disaggregates the bystander from other patients. His characterization of the bystander implies that other (normal) patients have no issues with the ginger, and in this way appears to be designed to indicate that the bystander’s counterevidence is not legitimate because she is an exception who is not relevant to the current patient.

This extract is different from the previous cases because the bystander participated to challenge rather than to support the doctor’s line of action. The bystander’s intervention was occasioned by the doctor’s dietary advice to the patient that the patient should continue to consume ginger during the summer. It appears that the bystander used the doctor’s dietary advice as an opportunity to insert herself into the
ongoing consultation to warn the patient about the potential unpleasant experience that is associated with ginger consumption. It is also worth noting that during the bystander’s own consultation (transcript not included), the problem of constipation after eating ginger resurfaces as the one of the bystander’s medical complaints. Hence, it is possible that the bystander is using the doctor’s dietary advice to the current patient as an opportunity to solicit advice from the doctor regarding her own complaint about ginger.

As this extract demonstrates, bystander participation is not always responsive to patient resistance. In some cases, like this one, the bystander may use joining the patient’s consultation as an opportunity to implement self-attentive actions, like presenting concerns about the doctor’s treatment recommendation.

Discussion & Conclusions

Summary of Findings

In this chapter I examined four cases of bystander participation. The first two cases, Extracts 21 and 22, represent the majority of bystander participation cases, where bystander participation is solicited by the doctor. In these cases, the bystanders are recruited to provide additional support for the doctor’s medical opinions when the patient displays resistance towards them. Extracts 23 and 24, on the other hand, are cases where the bystanders voluntarily join another patient’s consultation. These cases are relatively rare (6 out of 47). As Extract 23 shows, bystanders may spontaneously participate in the ongoing interaction to offer support to the doctor, when there is resistance from the patient. Extract 24, on the other hand, is a case where the bystander’s participation
counters the doctor’s line of action. It is self-attentive, in the sense that the bystander uses the doctor’s treatment recommendation as an opportunity to present her own concern.

To conclude, in most cases of bystander participation, the bystander inserts themselves into the consultation to support the doctor’s line of action (40/47). Bystander participation is predominantly occasioned by resistance from the patient. Here by patient resistance, I refer to situations in which the patient withholds acceptance of the doctor’s treatment recommendation and/or diagnosis, or overtly challenges them. In order to pursue acceptance or agreement from the patient, the doctor may enlist a bystander’s help to build a stronger case for their medical opinion (Extracts 21 & 22). Bystander participation may come in different forms. In some cases, bystanders are enlisted by the doctor to serve as an illness-free, comparative case to help demonstrate the patient’s problem (Extract 21 & Extract 22, Part I). In other cases, they may enact a more active role to testify as a witness to the patient’s problem (Extract 22, Part II), or as a recovered fellow patient to show the effectiveness of the doctor’s treatment (Extract 22, Part II & III).

Bystander participation may also be spontaneous, with the bystander endorsing the doctor’s diagnosis and/or treatment proposal (Extract 23). As the last extract (Extract 24) in this chapter indicates, it is also possible that the bystander interjects into the ongoing consultation to contest the doctor’s medical opinions in the pursuit of their own agenda, such as expressing concerns about a particular type of treatment. In the next section, I outline the implications that these findings have for provider-patient interaction, patient participation and multi-party interaction.

_Implications_
First, this chapter contributes to conversation analytic research on patient participation and patient resistance. In the setting of Western primary care, physicians are traditionally believed to be authoritative figures because of their professional knowledge and institutional authority about modern medicine (McKinlay & Marceau, 2002; Starr, 1982). However, in recent years, more scholars are shifting their attention to the important role that patients play in the medical visits (Guadagnoli & Ward, 1998; Halabi et al., 2020). Studies have pointed out that understanding the interactional organization of medical encounters helps us obtain better insight into how and why patient participation comes about (Robinson, 1999; Robinson, 2003; Stivers, 2007). As shown the analysis in this chapter shows, the relational dynamic between doctors and patients is different in the context of TCM. Patients frequently display resistance and slow down the progress of the medical visits. However, as posited by Koenig (2011), patient resistance is an important way for patients to negotiate with doctors and thus to exert agency in the decision-making process.

As shown in this chapter, patient resistance is prevalent in TCM visits, observed in different types of medical activities, such as diagnosis delivery, treatment recommendation and lifestyle discussions. Patients have various ways of displaying resistance towards doctors’ medical opinions. Earlier in this chapter I suggested that more research is needed to understand how doctors respond to patient resistance. Findings from this chapter have expanded our understanding of the interactional practices that doctors may deploy to cope with patient resistance. As findings from this chapter suggest, patient resistance is not something that should be blocked and dismissed, since the doctors’ way of handling patient resistance has potential impact not only on provider-patient
relationships, but also on the health outcomes of medical visits. In this chapter, I have shown that in TCM encounters, doctors engage in extensive case-building to address patients’ concerns in a constructive way, making sure that the patients concur with their diagnoses and treatment recommendations. As extracts from this chapter demonstrate, bystander participation is an important and effective way for doctors to bolster their diagnosis and/or treatment recommendation. This finding can also be applied to other medical context to obtain a better understanding of a) the interactional roles that a co-present third party may play in medical consultations, and b) doctors’ ways of responding to patient resistance and maximizing patient input in the decision-making process.

Second, findings from this chapter offer a unique perspective on multi-party interactions. Goffman (1981) pointed out that social interaction goes beyond dyadic conversations between a speaker and a hearer. Researchers have since examined different aspects of multi-party interactions, such as how interactants organize turn-taking in a multi-party environment (Lerner, 2002, 2019; Stivers & Robinson, 2006), how they design their turns based on their characteristics of the recipients (Goodwin, 1979); how interactants construct and negotiate relationships and collectivities (Lerner, 1993; Mandelbaum, 1987); how interlocuters implement conversational repairs in a multi-party environment (Bolden, 2011) and how interactants interject into on-going interactions (Lerner, 2019; Pillet-Shore, 2008). Additionally, researchers have explored multi-party interactions in a variety of institutional settings, such as pediatric visits (Stivers, 2001); meetings (Ford & Stickle, 2012) and interaction among children (Butler & Wilkinson, 2013).
In this chapter, I focused on one type of multi-party environment: doctor’s office in TCM hospitals. I looked at how and why a co-present third party who is unacquainted with the patient gets involved in another patient’s ongoing visit. Findings from this chapter have implications for interactants’ practices for entering and exiting an episode of focused interaction (Goffman, 1981). Doctors may recruit a bystander into the ongoing consultation by addressing them using verbal and bodily actions. When they do so, the bystander officially becomes a part of the focused interaction. Bystanders may also spontaneously interject themselves into another patient’s visit-in-progress. As shown in this chapter, bystanders do this to implement different actions. Some of them participate in support of the doctor’s line of action, while some others have their own project to pursue.
CHAPTER SIX

COMPANION PARTICIPATION IN TCM VISITS

Introduction

There is a substantial body of research that focuses on companion participation in medical consultations. This phenomenon is frequently observed in medical contexts such as pediatric visits, geriatric visits and oncological visits (Ishikawa et. al., 2005; Stivers, 2005; Street & Gordon, 2008). Researchers have found that companion involvement is relevant to many aspects of health care interactions, such as patients’ participation in the shared decision-making process (Clayman, 2005), patients’ level of satisfaction with received care (Wolff & Rotter, 2008) and patients’ adherence to medical their regimen (DiMatteo, 2006).

Current studies on doctor-companion-patient interaction in Western medicine assume that patients’ companions accompany them to the doctor’s office to provide the assistance that the patients need (Beisecker, 1989; Ishikawa et al., 2005). When they engage in the patients’ medical consultation, companions frequently help facilitate the medical agenda and maximize health outcomes through supportive communication and partnership-building (Street & Gordon, 2007). Companions may either “speak for” or “speak as” the patient but either way they offer medically relevant information to the doctor and actively engage in the decision-making process (Mazer et al., 2004). In other
words, companion participation is predominantly produced to advance the medical agenda. Despite the robust body of literature on companion participation, less scholarly attention has been paid to the interactional organization of companion participation in complementary and alternative medicine (CAM). That is, in CAM consultations, when does companion participation occur, how does it normally interactionally unfold and what does it accomplish.

Since TCM patients mostly visit the doctor’s office in groups, companion participation is very common in this setting, which makes TCM encounter a great site to understand companion participation. 83 of the 109 cases of consultations (76%) that I have examined involve some forms of companion participation. Like the bystander participation that I discussed in the previous chapter, there are two forms of companion participation in TCM: solicited companion participation and voluntary companion participation. A patient’s companion may join the patient’s consultation after being invited by the doctor (solicited participation), or they may do so spontaneously (voluntary participation) (see Table 6 for the distribution of cases).

**Table 6: Distribution of different types of companion participation cases**

<table>
<thead>
<tr>
<th>Type of participation</th>
<th>No. of cases</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solicited</td>
<td>39</td>
<td>47%</td>
</tr>
<tr>
<td>Voluntary</td>
<td>44</td>
<td>53%</td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>100%</td>
</tr>
</tbody>
</table>

In this chapter I show that although TCM companions predominantly enact supportive roles in the patients’ consultation, they may also use their participation as an
opportunity to launch and pursue their own interactional projects, such as convincing the patient to change their unhealthy lifestyle or advocating for a particular kind of treatment. In the previous chapter I discussed cases of bystander participation in TCM encounters, where a co-present third party who is unacquainted with the patient participates in the patient’s visit. In many ways, companion participation in TCM visits is similar to bystander participation. Their involvement also helps the doctor build a stronger case for their diagnosis/treatment recommendation when there is resistance from the patient. For example, like a co-present bystander, the patient’s companion may be enlisted by the doctor to join the patient’s consultation as a lay witness to the patient’s clinical manifestation. However, in this chapter I show that companion participation also has a relational dimension to it, which makes it a more complex phenomenon. That is, in cases of companion participation, relationships categories and category-bound rights and obligations are frequently made relevant and consequential for the interactants. In this chapter, by examining cases of companion participation, I show how participants understand particular actions through an orientation to locally relevant membership categories, and how category membership is invoked in the enactment of particular social actions.

I examine five cases in which a patient’s companion is involved in the patient’s consultation. In the first two cases (Extracts 25 and 26), the companion is invited by the doctor to be part of the consultation. These cases are similar to the cases I presented in the bystander chapter, since the companions are also enlisted and deployed by the doctor to facilitate their medical agenda and accomplish institutional goal. I then show three cases (Extracts 27, 28 & 29) of voluntary companion participation where the patient’s
companion(s) spontaneously joins the patient’s consultation. These cases reveal how patients’ companions use the patients’ resistance as an opportunity to launch and pursue their own interactional projects. While they formulate their observations in such a way as to indicate their relevance to the medical matters under discussion, often they function as “Trojan horses”, raising relational issues in the guise of medical ones.

My findings from this chapter answer the three questions that I raised earlier. First, findings from this chapter address the question of when companion participation occurs. My examination of cases of companion participation shows that companion participation frequently occurs in the environment of patient resistance, when patients withhold acceptance, reject, or challenge the doctor’s diagnosis and/or treatment recommendation. Second, in terms of how companion participation unfolds, I show that companion participation may be solicited or voluntary, and companions may enact different roles in their involvement in the patients’ visits, and their participation may also lead to different outcomes. Third, in response to the question of what companion participation accomplishes, I show that companion involvement not only helps address patient resistance but also generates opportunities for the doctor to provide more medically relevant information to the patient and their companions. Patients’ companions may use their involvement in the patients’ consultation to launch and pursue their own interactional project, which may put the doctors in a position to “pick sides”, meaning that they need to either align with the patients or with their companions. As the extracts in this chapter show (Extracts 27, 28 & 29), doctors may side with the patients, the patients’ companions, or avoid aligning with either party.
Solicited companion participation

In nearly half of the cases in my collection (47% of all cases), companion participation is doctor-initiated. Companions in these cases are invited by the doctor to join the medical consultation. In this section, I discuss two cases of such companion participation in order to show when, how and why solicited companion participation comes about. In Extract 25, the doctor invites the patient’s wife to join the interaction when his lifestyle advice is resisted by the patient. He involves the patient’s wife to help implement his dietary recommendation by invoking her category-bound obligation of preparing food for the family. In Extract 26, the patient’s husband is enlisted by the doctor to help enforce his lifestyle advice to the patient. The husband is enlisted as a role model as well as a supervisor for the patient, in order to help her become more physically active. Both cases of companion participation occur when the patient has displayed resistance towards the doctor’s medical opinions. The companions’ membership in the category of spouse are made resonant, relevant and consequential by the doctor to address patient resistance and pursue acceptance from the patient.

In Extract 25, the patient is a male in his mid 50s. He visits the doctor regularly (weekly or biweekly). In this extract the doctor is giving the patient some lifestyle advice. Specifically, he is trying to convince the patient to adopt healthier dietary habits (eating porridge instead of unhealthy local food), which receives resistance from the patient.

The doctor’s dietary advice is delivered in multiple steps. At the beginning of the extract, the doctor advises the patient to change his diet and avoid unhealthy local food (lines 1-10). This is potentially sensitive advice since the doctor is not from the local area while the patient and his wife are. Asking the patient to stop eating local food may
be understood as an insult to local cuisine by an outsider. The patient does not provide any uptake (lines 4, 6 & 11), possibly orienting to the doctor’s turn as an in-progress multi-unit turn. However, after the doctor’s advice is launched (lines 9, 10 & 12), the patient made several resistant moves (a multiple saying at line 15; minimal acknowledgement token at line 19 and silence at line 21), displaying resistance towards the doctor’s advice. The doctor invites the patient’s wife to participate in the patient’s consultation by first selecting her as a recipient via eye gaze, then ordering her to cook porridge for the patient on a daily basis. Several observations can be made about the wife’s involvement in this extract: first, the wife’s membership in the spousal category is made relevant and consequential after the wife is invited by the doctor to join the consultation. The doctor accomplishes this by ordering the wife to perform the category-bound activity (Sacks, 1992; Schegloff, 2007) of cooking for her husband. In so doing, the doctor implicates the wife in the dietary change that he is proposing. In this way he is proposing this dietary change to a collectivity (husband-and-wife) (Lerner, 1993; Mandelbaum, 1987), rather than to the patient himself. Second, in the face of patient resistance, if the wife sides with the doctor and agrees to change their dietary habits, then the doctor has strong ammunition that his recommendation is a sound one, since the recommendation is as delicate for her as it is for the patient.

**Extract 25: Rice Porridge**

<table>
<thead>
<tr>
<th>DOC</th>
<th>PAT</th>
<th>WIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Doc: Ei chong xianzai kaishi a. Em from now start FP</td>
<td>Em from now on.</td>
</tr>
<tr>
<td>002</td>
<td>(0.2)</td>
<td></td>
</tr>
</tbody>
</table>
Tianjin yinshi.
Tianjin food
Tianjin food.

Although you are Tianjin people
Although you are from Tianjin.

Wo bu:shi bu zunzhong ni.
I N BE N respect you
It’s not that I don’t respect you.

Ei meiyou meiyou.
Um N have N have.
Um not at all not at all.

|Er ni yi:ding cong yinshi shang yao
|Em you definitely from food up should
|Em you definitely should make some changes

Changes- changes a little. Because

You all day like monk alike (0.2) also same
It’s still the same if you act like a monk.

You eat that thing not okay it also same
If you do not eat the right thing it still won’t

bu yangsheng<.
N health maintenance
benefit your health.

Dui./{(nods)}=
Yes
Yes.
=Right FP. Ah
Isn't that right. No?

DOC: Cong xianzai kaishi a, (.)/(shifts eye gaze to WIF))
From now start FP
From now on, one meal everyday

meitian bixu you yi dun shi zhou.
everyday have to have one meal BE porridge
must be rice porridge.

~>WIF: Zhou?
Rice porridge
Rice porridge?

DOC: Ei.
Yep.
Yep.

DOC: Meitian bixu yi dun shi zhou. Ni kan ta,
Everyday must one meal BE porridge. You look him
One meal every day must be porridge. Look at him,

DOC: Ta nei lian shang jiu /(starts to touch PAT'S face)
His that face on just
On his face there

zhei xiao zher.
this small wrinkle
are small wrinkles.

DOC: Jiao ni xifuer chou chou./(turns PAT’s face)
Let your wife look look
Let your wife take a look.

DOC: Ni kan a. (.)/ he guo liang ge yue
You look FP. (.)/ drink P two months
Look at them. After drinking rice porridge

de zhou, (.)/ jiu mei le.
P porridge (.)/ just N FP
for two months, they will be gone.
Prior to this segment, the doctor has delivered the diagnosis that the patient’s body has excessive heat, a common health problem according to TCM theories (lines not included in the transcript). Between line 1 and line 20, we see multiple attempts by the doctor to build a case for his upcoming advice that the patient should change his current, unhealthy diet. This advice is potentially delicate given that the patient and his wife are both from Tianjin, an area that is notorious for having greasy and salty food. In line 1, the doctor initiates a possible recommendation for future conduct: *chong xianzai kaishi a* (“From now on”). Then at line 3, potentially orienting to the delicate nature of his upcoming advice, the doctor simply names Tianjin food, leaving the inferential work for the patient (he needs to determine why Tianjin food is relevant here). In lines 5 and 7, the doctor produces a disclaimer *Jinguan nin shi Tianjin ren.* (0.2) *Wo bu:shi bu zunzhong ni.* (“Although you are from Tianjin. (0.2) I mean no disrespect”). In producing this disclaimer, the doctor frames his upcoming advice as potentially disrespectful. At this point, the patient still needs to draw the inference himself about what is the doctor referring to, since the possible offence is not yet articulated.
The patient’s line 8, *meiyou meiyou* is a common response to apologies. Here indicates that he treats the doctor’s turn at line 5 to 7 as preemptively apologizing to him. Additionally, the patient’s turn here may also be understood as a “go ahead” – indicating to the doctor that he can continue with his dietary advice without worrying about the possible offense.

After the patient’s response in line 8, the doctor continues with his recommendation. He first implements a general recommendation to the patient in lines 9 & 10: *Er ni yi:ding cong yinshi shang yao gai- gaibian yixia* (“Em you definitely should make some changes”), formulating the recommended change as absolutely necessary (as the “definitely indicates”), and not specifying the changes. The doctor then proceeds to provide an account for this recommendation (lines 10 &12): *<Ya:ngsheng jiu cong>* *yinshiqiju kaishi* (“Health maintenance starts from lifestyle choice”). Produced before the delivery of the specific recommendation, this account is formulated as truism, a statement
of basic TCM principles that connects the patient’s health status with his lifestyle choices. It leaves available for inference that the doctor’s upcoming recommendation is going to be about the patient’s lifestyle.

009 DOC:  
[Er ni yi:ding cong yinshi shang yao  
Em you definitely from food up should]  
[Em you definitely should make some changes]

010 gai- gaibian yixia. Yinwei-  
Changes- changes a little. Because-  
to your diet. Because-

011 (0.3)

012 DOC:  
< Yangsheng jiu cong yinshiqiju kaishi.  
< health maintenance just from lifestyle start.  
< health maintenance starts from lifestyle choice.

013 (1.2)

However, the patient provides no immediate response to the recommendation (there is a long 1.2 gap, line 13), indicating that the patient understands that the doctor is taking a multi-unit turn. The doctor continues his multi-unit turn at line 14 and strengthens his case for a change in the patient’s lifestyle choice, presenting it in such a way as to indicate that there is no other alternative: *Yaoburan ni >zenme yangsheng<.* (“Otherwise what else can you do to maintain your health”). In response, the patient delivers a multiple saying (Stivers, 2004) at line 15 (“Right right right”). Although multiple sayings in Mandarin Chinese have not yet been systematically examined, it functions similarly to multiple sayings in the English language. While a standalone “Right” is an agreement token, a triple “right” does work beyond that – it treats the doctor’s extensive case-building as unnecessarily persistent and attempts to put it on hold. So far, the doctor has been trying to build a case for a lifestyle change, but the specific recommendation has not been delivered yet. The patient’s multiple saying at line 15 may be seen as his first resistant attempt.
After the patient’s initial display of resistance, the doctor continues to strengthen his case for a lifestyle change by delivering an extreme case formulation (Pomerantz, 1986): *Nin zhentia:n (0.2) ge:n heshang shide (0.2) ye yiyang* (“It’s still the same even if you act like a monk”). Here acting like a monk is an extreme form of ascetic life – monks usually refrain from sensual experiences. By proposing an extreme circumstance and indicating that there will still be no change to the patient’s current health status under such circumstance, the doctor further bolsters his recommendation that the patient should change his lifestyle. The doctor’s overbuilt case may provide further evidence that he orients to the upcoming dietary advice as delicate: making such a strong case for why it is a good idea to change the patient’s diet may indicate that he understands the advice to be particularly controversial and difficult for the patient.

The patient at line 19 agrees with the doctor’s claim about the importance of lifestyle choices *Dui* (“Yes”). Although this is a confirming response, it is lukewarm at best given that *Dui* (“Yes/right”) in Chinese conveys only weak agreement. Produced
after the doctor’s overbuilt claims, this response may be construed by the doctor as insufficient, and this explains why he again seeks confirmation from the patient in line 20 by launching a tag question that is tilted towards a confirming response:

020  DOC:  =Dui ba. A.
=Right FP. Ah.
   Isn’t that right. No.

021 (0.3)

So far, the doctor has gone to great lengths in attempting to get the patient on board with his dietary advice before delivering the actual recommendation. His question at line 20, a tag question Dui ba (“Isn’t that right”) and a response pursuit A “No”, makes relevant a confirming response from the patient. However, as indicated by the silence in line 21, the patient’s resistance continues, since the 0.3 gap may be seen as a delay indicating upcoming response. He does not respond to the doctor’s question that is clearly designed for an agreeing response.

Starting from line 22, the doctor launches the specific dietary recommendation, which is addressed to the patient’s wife: Cong xianzai kaishi a (“From now on one meal everyday must be rice porridge”). The doctor selects the wife as the recipient by turning his head and directing his eye gaze towards her (line 22).

022  DOC:  .h Cong xianzai kaishi a,(.)/((shifts eye gaze to WIF))
   .h from now     start FP,
   .h From now on one meal everyday

023 meitian bixu you yi dun shi zhou.
   everyday have to have one meal BE porridge.
   must be rice porridge.

024 (1.2)

025 ~>WIF:  Zhou?
   Rice porridge?
   Rice porridge?

026  DOC:  Ei.
   Yep.
In lines 22 to 23, the doctor launches the specific dietary recommendation, ordering the patient’s wife to prepare a specific food item, rice porridge, on a daily basis. This recommendation is formulated as an order (as shown by the word “must”) and conveys a high level of deontic authority (Stevanovic & Peräkylä, 2012). In directing this recommendation to the patient’s wife, the doctor indicates that he takes it that it is she who prepares the food, and/or is responsible for determining what it is the husband eats and thus, invokes her membership in the “wife” category.

There is a long gap at line 24, which may indicate an upcoming dispreferred response from the wife. She then seeks confirmation from the doctor regarding his recommendation at line 25 by repeating the recommended food item: Zhou (“Rice porridge”)? This repeat is delivered with rising intonation, which makes relevant a confirming/disconfirming response from the doctor. Here by partially repeating the doctor’s turn, the patient’s wife indicates that she has an understanding problem, rather than a hearing problem with the doctor’s prior turn. By checking her understanding of the doctor’s recommendation, the wife calls recommendation into question by treating it as unexpected or surprising (Robinson, 2013; Robinson & Kevoe-Feldman, 2010).

In response, the doctor confirms that porridge is the food item that he is recommending (Ei (“Yep”), line 26). Here the Ei can be translated as “Yep” since similar to “Yep”, it also claims that there is nothing more to say. The wife’s question (line 25) and the patient’s confirmation (line 26) may constitute an insert sequence (Schegloff, 2007) between a First Pair Part (FPP) (the doctor’s recommendation) and a Second Pair Part (SPP) (the wife’s acceptance). However, after the doctor has provided a
confirmation to the wife’s question, the wife still withholds acceptance at line 27, which is further evidence that she is resisting the doctor’s recommendation.

Occasioned by the wife’s resistance, the doctor redelivers his recommendation at line 28, *meitian bixu you yi dun shi zhou* (“one meal every day must be porridge”). The doctor produces another multi-unit turn in lines 28 to 34. In line 28 he redelivers his recommendation by producing almost a full repeat of his previous recommendation (lines 22 & 23). In this way, the doctor pursues acceptance from the patient’s wife by providing another slot for her to respond. Additionally, the doctor offers an account for this recommendation immediately after it is delivered – he presents to the wife a clinical sign that the patient is manifesting, which is the basis for his dietary recommendation:

029     | (0.2)
|      | (points at patient)
030  DOC:  | Ta nei lian shang jiu
| His that face on just
| On his face there
| (starts to touch PAT’S face)
031          | zhei xiao zher.
            | this small wrinkle
            | are small wrinkles.

The doctor engages in the activity of showing (Kidwell & Zimmerman, 2007; Searles, 2017) in lines 28 to 34. He draws the wife’s attention to the patient’s face, where his clinical manifestation is located by delivering an imperative (line 28, *Ni kan ta* (“Look at him”)) and producing a pointing gesture (line 29).

Here the doctor is trying to show a clinical sign that the patient is manifesting to the patient’s wife. This showing is potentially occasioned by the wife’s resistance to his dietary recommendation and implemented to pursue acceptance from the wife. The doctor first tells the wife where to look by formulating the location of the clinical sign: *Ta*
*nei lian shang jiu zhei xiao zher* (“On his face there are small wrinkles”) and utilizing the embodied gesture of touching the patient’s cheek (line 30). Here the doctor treats the wife as able to understand why he is calling this to her attention. He leaves the wife to infer the relevance of the clinical sign that he is showing.

When the first round of “showing” (lines 28-31) receives no uptake from either the patient or his wife (0.3 gap in line 32), the doctor orders the patient to turn his face, while manually adjusting the position of the patient’s face slightly so the wrinkles that he is trying to show become more visible to the wife (line 33, *Jiao ni xifuer chou chou* (“Let your wife take a look”)):

032 (0.3)

033 DOC: Jiao ni xifuer chou chou./((turns PAT’s face))
Let your wife look look
Let your wife take a look.

034 Jiu zhei bian zhei xiao zher.((points at the cheek))
Just this side this small wrinkles
The small wrinkles on this side.

035 (0.2)/((wife squints at the patient’s face))

In doing so, the doctor is making the clinical manifestations more perceptually available to the wife (both by giving an order to the patient as well as manually adjusting the patient’s face). In this way the doctor makes another attempt to pursue acceptance from the wife. This showing makes relevant a response from the wife – she needs to either confirm that she indeed sees the wrinkles or deny their existence. Since wrinkles are “impurities” (indications of the patient’s problematic and imbalanced health status), according to TCM theories, if the wife confirms that the wrinkles do exist, her confirmation becomes strong ammunition that shores up the doctor’s case for a dietary change. However, the wife only squints at the patient’s face very briefly (line 35)
without providing any verbal uptake. This may be understood as another resistant attempt because the wife withholds a response to the doctor’s action of showing.

In response to the wife’s tacit yet persistent resistance, the doctor continues to strengthen his case for a dietary change in lines 36 to 37, by making a promise about the effectiveness of rice porridge:

036 DOC: Ni kan a. (. ) he guo liang ge yue
You look FP. (. ) dr ink P two months
Look at them. After drinking rice porridge

037 de zhou, (. ) jiu mei le.
P porridge (. ) just N FP
for two months, they will be gone.

038 (. )

039 DOC: Ta [kan ( )
He [looks ( )
He [looks ( )

The doctor proposes a strong causal connection between consuming rice porridge, and the disappearance of the patient’s wrinkles. This formulation (jiu mei le (“they will be gone”)) conveys a great level of certainty about the effectiveness of rice porridge by formulating the elimination of the patient’s clinical sign as something bound to happen. In producing this promise, the doctor is once again trying to convince the wife to accept his dietary recommendation.

In the following line (line 41), the wife asks a question about the specifics of this proposed dietary change: Sh-shenme zhou (“What kind of rice porridge”). The wife’s turn may indicate that she has accepted doctor’s recommendation since she is seeking specific guidance on how to implement it. After the doctor has provided the instructions (line 41: She:nme zhou dou xing. Shi zhou jiu xing (“No matter what kind. As long as it is rice porridge”), the patient also comes in and provides a minimal acknowledgement token (line 42, “Mm hm”), potentially displaying his acceptance as well. The doctor then
solicits an update from the patient regarding one of his past conditions (line 43, Bozi ne. Bozi zenmeyang le (“How about your neck? How is it?”)). The doctor’s question here may indicate that he treats this line of action (launching dietary recommendation) as officially closed, and they are now moving on to the next activity.

In this extract, the patient’s wife was invited by the doctor to join the consultation after the patient displayed resistance towards the doctor’s general lifestyle recommendation. When the doctor launched his specific dietary advice, the advice was addressed to the wife. In so doing, the doctor made relevant the wife’s membership in the spousal category by invoking her category-bound obligation of meal planning and preparation. In the face of patient resistance, the doctor directed his recommendation to the patient’s wife instead, in an effort to garner support from her. Given that he had received only minimal responses from the patient, garnering more support from the patient’s wife may help him facilitate his dietary recommendation and move the medical agenda forward.

However, the patient’s wife, too, was resistant towards the doctor’s recommendation (indicated by her surprise token and silences at lines 24, 25 & 27). To pursue acceptance from her, the doctor accounted for his dietary advice by enlisting the wife as a purveyor of its solution, rice porridge (lines 22 & 23), as well as a “witness” to the patient’s problem (lines 28, 30, 33 & 34). Additionally, the doctor also promised that
rice porridge will be a guaranteed solution to the patient’s problem (lines 36 to 37). The patient and his wife finally accepted the doctor’s recommendation at lines 40 to 43.

Extract 26 is similar, where the patient’s husband is invited by the doctor to join the patient’s consultation after the patient has displayed resistance to the doctor’s lifestyle advice. While in the first extract, the doctor was successful in obtaining the wife’s support, the doctor’s similar effort in Extract 26 is less successful.

The patient in this extract is a 52-year-old woman. Prior to this extract, she was diagnosed with the condition of excessive dampness and heat. The treatment regimen that the doctor has prescribed for this patient includes TCM medicinal soup and several lifestyle changes, with “fat transformation (weight loss)” being one of them. This lifestyle advice is strongly resisted by the patient. After the patient has made several resistant moves, the doctor invites her husband to join the consultation, ordering him to assist his wife in performing an exercise that he (the doctor) is recommending. In so doing, the doctor invokes the husband’s category-bound obligation of helping his wife to adopt healthy life habits. However, the husband here has two conflicting sets of category-bound rights and obligations. On the one hand, as the patient’s husband, he is responsible for helping his wife live a healthier life; on the other hand, he is also obligated to be a supportive spouse and companion by affiliating with his wife. In this extract, the husband straddles these two sets of obligations by attempting to find a middle ground that both doctor and wife can accept. While in Extract 25, the doctor was successful in getting the companion involved to move his medical agenda forward, Extract 26 shows that the patient’s companions may be reluctant to support the doctor’s line of action when it is in conflict with their other category-bound obligations.
Participants: doctor (DOC), patient (PAT), companion (HUS)

~ Companion participation

DOC: Shiqi zhiyao yi duo de shihou a.=
Dampness only once more PRT when
Once there is a lot of dampness.=

PAT: =En.
=Mm hrm
=Mm hrm.

DOC: Jiu hen rongyi zhaolai hanqi.
Just very easy attract come coldness
It becomes very easy (for you) to attract coldness.

(0.2)

PAT: En
=Mm hrm
=Mm hrm.

DOC: Zhao lai liangqi.
It attracts chill.

PAT: ((nods))

DOC: Ni jiu bi renjia rongyi zhaoliang.
You just compare others easy catch a cold
It is easier for you to catch a cold than others.

PAT: |Sh[i.=
|Be
|Yeah.=

PAT: |((nods))

DOC: Suoyi ni shenshang jiu meiyou
So your body just NEG have
So your body never feels

sha shufu shihou.
what comfortable time
comfortable.

PAT: |Hai.
|Jeez
|Jeez.

PAT: |((turns head away))

DOC: Yihuier zhaolai ge liang.
Sometimes (you) catch a cold.

23 Liangqi (chill) and hanqi (coldness) are the same thing. Hanqi is a more formal expression.
Your body feels sore.

Once you catch a cold.

Then (your) body feels painful.

So it’s either soreness or pain.

And (you) are also very lazy and don’t like to move.

Because moving-

That movement- um-

If one wants to move, (he/she) does not use fat.

(0.2)

(He/she) uses muscles.

That’s right.
Because your muscle too little.

That’s right.

We can or not let that fat transform.

Can we transform the fat a little.

I want to transform it. But I don’t have the ability.

Learn something from that old dude.

You need to exercise every day.

I need your help. .Hheheheh.

When you are at home that- that Mr. Li.

Can you?
The one that you need to be on all fours on the mat.

Just that- um that plank.

I often do it.

This has body NEG PRT exercise
This needs your body to be in good shape.

Give it a try. Give it a try.

If we are free we try to

I at NAME park power walk FP. Exercise FP power walk in Changhong Park every evening. To exercise.
HUS: [Ai. Right. Right.]

PAT: [Bu hao. Heheheheh. NEG good. Heheheheh. (That’s) not good. Heheheheh.]

HUS: [Ni shuo ni yao shi lei le yihou ( ) You say you if BE tired PRT after ( ) If you feel tired ( )]

DOC: [Ni weisha lao You why always Why do you always]

HUS: [Lei le yihou jiu= Tired PRT then just When you feel tired=]

DOC: [Zi renwei bu hao ne Self consider NEG good Q think that you are not good?]

HUS: [=Buyong le. =NEG FF =you don’t have to (powerwalk).]

PAT: Hen [bu hao. Very NEG good Very not good.]

DOC: [Bu yao ba ziji dabai. NEG have let self defeat Don’t let yourself be defeated.]

DOC: [Zhidao me. Know Q You know?]

PAT: Tsk..Hhh. [Bushi wo hen buhao. Zhen de shi hen buhao. Tsk..Hhh. NEG I very unwell. Really BE very unwell Tsk..Hhh. [No I am really not good. I’m really not good.]


PAT: W- w- wo zheiliangtian yi [zhi. W- w- wo these days all the time I- I- I these days I keep on]

DOC: [Guanchangwu ta bu ling. Square dancing it NEG useful Square dancing is no use.]
085~> HUS:  A?
  Huh
  Huh?

086  PAT:  Wo jintian hai- hai- hai haodianr.
  I today also- also- also- better
  Today I feel better.

087  DOC:  En.
  Hmm.
  Hmm.

088  PAT:  Wo zuotian- wo jiu cong yao zher fencheng
  I yesterday- I just from waist here split
  Yesterday I- my waist felt like it was
  liang jier le.
  two parts FP
  split in half.

089  DOC:  Haome ni- ni you bian liangjier le.
  Good you- you again turns two parts FP
  Good lord you- you were split in half again.

090          (0.2)

091  DOC:  Ni- ni gan huo le ma.
  You- you do chores P Q
  Did you do chores.

Prior to this extract, the doctor has delivered a negative evaluation of the patient’s current health status, claiming that the patient’s body has excessive dampness and heat (lines not included in the transcript). He unpacks this evaluation by delivering a multi-unit turn, explaining how that status may impact the patient’s body and cause potential health problems, such as the common cold (lines 1 to 10 below). While the doctor walks the patient through his diagnostic reasoning and explains how dampness and heat may attract cold and cause health problems, the patient produces minimal responses, mostly acknowledgement tokens (lines 2, 5, 7 9 & 10), aligning herself as a recipient of the doctor’s extended explanation.

001  DOC:  Shiqi zhiyao yi duo de shihou a.=
  Dampness only once more PRT when
  Once there is a lot of dampness.=

002  PAT:  =En.
  =Mm mm
  =Mm hmm.
At line 11, the doctor produces an exaggerated claim about the patient’s health status (Drew, 2003, Pomerantz, 1986): Suoyi ni shenshang jiu meiyou sha shufu shihou (“So your body never feels comfortable”). The turn initial “so” indexes an inferential connection between the doctor’s explanation (line 1-10) and his claim about the patient’s current health status (Bolden, 2006). The doctor’s claim is an assertion about the patient’s body and physical experience, something that is within the patient’s domain. On the other hand, the doctor’s claim may be based on his medical knowledge and the data he has gathered by utilizing the four TCM diagnostic methods. Since the patient here has epistemic authority (Heritage, 2013) over her experiences and feelings, she can either confirm or reject the doctor’s claim.
In line 13 and 14 (above), the patient responds to the doctor’s claim with both verbal and embodied actions. She looks away, and at the same time, produces a token of exclamation *Hai* (“jeez”). The patient’s responses here constitute resistance in the following ways: first, she averts her gaze from the doctor’s face, which may project an upcoming dispreferred response (Kendrick & Holler, 2017); second, instead of confirming the doctor’s claim, the patient responds to it with a reaction token *Hai*, treating it as surprising or potentially overdramatic (Wilkinson & Kitzinger, 2006).

The doctor’s ensuing lines further show that he treats the patient’s responses as resistant. Starting from line 15, the doctor delivers another multi-unit turn, explaining how the “chill” attracted by dampness and heat may affect the patient’s body, causing a variety of unpleasant feelings (lines 15 to 17; 20 to 23, see below). This explanation functions as an account for the doctor’s claim that “your body never feels comfortable”. In explaining the diagnostic reasoning behind his prior claim, the doctor pursues a response from the patient by offering her another opportunity to confirm that his claim about her health status is correct.
At line 24, the doctor makes another claim about the patient’s body: *Hai beier lan bu ai dongtan* (“and (you) are also very lazy and don’t like to move”). Similar to the doctor’s prior claim about the patient’s current health status “Your body never feels comfortable” (lines 11 and 12), this claim is also about the patient’s feelings and experiences, something that is within the patient’s domain. Since the patient has primary epistemic right to this issue, she can confirm or disconfirm what the doctor said about her body.

This time, the patient responds immediately with agreement tokens (line 25: *Dui Dui* (“Right right”): nodding at line 26), confirming the doctor’s claim. In line 27, the doctor goes on to explain why the patient always feels lethargic *Yinwei dong zuo ne-* (“Because moving-”). In overlap with the doctor’s explanation, the patient confirms that she indeed feels uncomfortable (line 28, *Hunshen nanshou* “(I feel) uncomfortable all over”). She expands the scope of her uncomfortable feeling to her entire body (“all over”), in this way amplifying her agreement.
In lines 29 to 35, the doctor delivers another multi-unit turn to explain the mechanism behind the patient’s lethargy, connecting it to the patient’s physical condition:

In lines 29 through 33, the doctor establishes the connection between one’s level of physical activity and the amount of muscle they have. Note that this is another general claim, not specifically targeting the patient. By pointing out that being active requires one to use their muscles, the doctor makes available for inference that the patient is not able to “move” (be active) possibly because she does not have enough muscle. This explanation receives a confirming response from the patient (line 34, *Meiyou cuo* (“That’s right”)).

After his general claim is accepted by the patient, in line 35, the doctor adjusts the scope of his claim to specifically target the patient. He articulates the cause of the patient’s lethargy problem: *Yinwei ninde jirou tai shao le* (“Because you have too few
muscles”), which is again immediately confirmed by the patient (line 36, *Meiyou cuo* (“That’s right”)):

035  **DOC:**  
[Because your muscle too little FP  
*Because you have too few muscles.*

036  **PAT:**  **Meiyou cuo.**  
*That’s right.*

At this point, the doctor has successfully established the patient’s problem (feeling uncomfortable constantly; lethargy) and identified the cause of it (not enough muscle mass). In line 37, he launches an inquiry. This inquiry may be implemented to propose a solution to the patient’s problem:

037  **DOC:**  
[Can we transform the fat a little.  
*Can we transform that fat a little.*

The doctor’s turn here is a question that makes relevant an acceptance or rejection from the patient. The doctor refers to the patient as *zan* (“we”), and in so doing, formulates doctor and patient as being on the same team, and therefore on the same side, collaborating in this effort.

The doctor’s proposal is formulated in a mitigated way, with a particle “*xia* (a bit/little)” attached to the verb “*zhuanhua* (transform)”. This particle is used by the doctor to minimize the effort that the patient has to put into adopting this recommended lifestyle change, formulating it as a casual, effortless action (Jiang, 2012). It is possible that the doctor formulates his proposal this way to minimize the effort that the patient needs to make, thus makes the proposal easier for the patient to accept.

At line 38, in response to the doctor’s proposal, the patient delivers a non-type-conforming response (Raymond, 2003). Instead of answering a yes or no, the patient
expresses willingness to accept the doctor’s proposal that she should transform fat (“I want to transform it”), but then claims lack of ability to follow through (Wo xiang rang ta zhuanhua (“But I don’t have the ability- I don’t have the ability personally”)), leaving the doctor to infer that she is rejecting the proposal:

038 PAT:  Wo xiang rang ta zhuanhua.  
I want let it transform.  
But I don’t have that ability-

039 DOC:  
[Gen neige- Gen neige-  
With that- with that  
With that- with that-

040 doc:  
|((points at HUS))

041 PAT:  Wo zishen mei nei nengli.  
I self NEG that ability  
I don’t have that ability personally.

Note that the patient at line 41 claims that she lacks the capability to follow the doctor’s recommendation “personally (by herself)”, leaving available for inference that she may need assistance from others to implement the recommended lifestyle change.

Perhaps in response to the patient’s claim that she is not able to do this by herself, the doctor begins to get the patient’s husband involved at line 39. While the patient’s line 38 is still in progress, the doctor invites the husband to join the consultation by pointing at the husband (who is standing next to the patient) and at the same time, searching for his name. This name-search apparently fails since at line 42, the doctor refers to the patient’s husband using lao ger (“this old dude”), a non-recognitional person reference form (Sacks & Schegloff, 1979).

042 DOC:  
[Gen nei laoger xue yige.  
With that old dude learn one  
Learn something from that old dude.

043 Dei  
|tiantan duanlian.  
Have to [everyday exercise  
(You) need to exercise everyday.

044 PAT:  
Wo zishen mei nei nengli.
In lines 42 and 43, the doctor delivers his specific lifestyle advice. He suggests that the patient should follow her husband’s actions and engage in more physical activity (line 42, *Gen nei laoger xue yige* (“Learn something from that old dude. You need to exercise every day”)). In suggesting that she follow her husband’s example, the doctor frames the husband as a role model whose actions the wife should emulate. The way the doctor refers to the patient’s husband (“that old dude”) suggests familiarity and intimacy, since “laoger 24 (old dude, old brother)” is an address term used only by close friends. By using this address term, the doctor is enacting being close to the patient’s husband, which may be construed as an attempt to draw the husband into a coalition with him. The doctor’s lifestyle advice (line 43, *Dei tiantian duanlian* (“(You) need to exercise everyday”)) makes relevant an acceptance/rejection from the patient. This is a strong piece of advice since the doctor uses the word “need” which indicates that the doctor is recommending something essential to the patient. Produced after the patient has already displayed resistance towards his earlier proposal, this specific advice about how to “transform fat” is another attempt to pursue acceptance from the patient.

While the doctor’s advice is still in progress, the patient at line 44 rejects the doctor’s advice, by repeating her prior response and once again claiming inability to follow through:

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044  PAT:  [Wo zishen mei nei nengli.
[I myself NEG that ability

[I do not have that ability personally.
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**Note:** In Mandarin Chinese, “lao” is a common word used to indicate a high level of intimacy. It is an honorific and not age-related.
The patient’s rejection (line 44, a full repeat of line 41) sustains her resistant stance towards the doctor’s lifestyle advice. Also, she reiterates that she does not have the ability “personally”, separating herself here as someone who is not able to take up this advice. It is possible that this is an appeal for medicinal help rather than a lifestyle change (something that the doctor has previously recommended).

In line 45, the patient explicitly requests the doctor’s help (line 45, Dei xuyao ni bangmang (“I need your help”)). This may indicate that the patient is looking for medical intervention, which can only be implemented by the doctor, rather than a lifestyle change which can be facilitated at home with the help from her husband. This request is also followed by some laughter tokens. Produced after the request is completed, the patient’s laughter tokens may be used to modulate the incipient action (Hepburn et al., 2013), displaying an orientation towards the problematic nature of it (it is a dispreferred response to the doctor’s advice).

The patient’s request is immediately rejected by the doctor at line 46. He first produces a “no”, then once again tries to get the husband involved. He specifies the location where the recommended action should take place Huijia (“when you are at home”), then summons the husband using the address term “Lao Li”:

046 DOC: Bu. Huijia nei shei- Lao Li.
       NEG Go home that that- Old Li
       No. When you are at home that- that Lao Li.

047 HUS: En.
       Yep
       Yep.

048 DOC: Xunlian ni xifur lai yige neige- Zhicheng.
       Train your wife come one that- Support
       Teach your wife to do one of those- support.
This address term, similar to the previous one that the doctor has used to refer to the patient’s husband, enacts closeness and intimacy. As discussed earlier, in selecting this address term, the doctor may be trying to form a coalition with the husband.

The husband responds to the doctor at line 47 (En (‘Yep’)). In lines 48 to 49, the doctor delivers an imperative that is addressed to the patient’s husband, asking him to teach the patient to perform a specific type of exercise activity. Here the doctor does not provide the name of that activity, but instead begins a word search: neige- Zhicheng (“those-support”). Note that although the doctor knows the patient relatively well, he refers to the patient as ni xifur (“your (the husband’s) wife”) when asking for the husband’s help, rather than using the patient’s name. This non-recognitional reference form invokes the husband’s membership in the spousal category. Here the doctor offers a solution to the patient’s prior problem that she does not have the ability to transform her fat alone – since her account for not following the doctor’s advice is that she needs help from others, the doctor here enlists her husband to offer the needed assistance. Additionally, it is the husband’s category-bound obligation to help the patient live a healthy lifestyle. Hence, in asking him to help the patient do a specific exercise, the doctor also invokes the husband’s membership in the spousal category by invoking his category-bound rights and obligations.

In addition to the directive, the doctor also delivers a Hui ma (“can you”) at line 49, which pursues a response, making relevant acceptance/declination from the husband.
This question is met with silence (line 50, no embodied action in the video), which constitutes resistance since it does not provide a response right away, projecting a dispreferred response from the husband.

The doctor then provides another opportunity for the husband to respond by providing a detailed description of the bodily actions involved in the recommended workout (line 51, *Jiu shi neige pa- pa dianzi shang neige* (“The one that you need to be on all fours on the mat”)) (Lerner et al., 2012). By describing what “those support” (line 48) entails, the doctor gives the patient’s husband another opportunity to recognize, and possibly agree to participate in, the proposed exercise activity. This turn is formulated as a reminder, indicating that the doctor takes it the husband is familiar with this exercise.

051   DOC:   Jiu shi nei||ge pa-  pa  dianzi shang neige.
         Just BE tha||t  lie- lie mat on   that
         The one that you need to be on all fours on the mat.

052   pat:               ||((turns head away))

053   PAT:               ||(h:)=(hx::)

At line 53, immediately after the doctor’s explanation is initiated, the patient produces a sigh 25, and at the same time, turns her head away. A stand-alone sigh conveys a negative evaluative stance towards the prior turn (Hoey, 2014). The patient’s sigh is produced in response to the doctor’s prior order directed at her husband (it is produced when the doctor’s explanation is still in progress). Both the patient’s sign, as well as her embodied actions of looking away convey resistant stance towards the doctor’s recommendation. As she is producing the sigh, the patient also turns her head away, temporarily disengaging from the ongoing interaction and in this way, shows her disaffiliative stance towards the doctor’s recommendation.

25 Here the sigh is transcribed according to the symbols developed by Hoey (2014)
Despite the patient’s possible display of resistance, the doctor continues to explain
to the husband what kind of exercise he is asking him to teach the patient, this time by
referring to the exercise using the proper term after a brief word search (line 54):

At line 55, in overlap with the doctor’s turn, the husband offers a candidate
understanding of the exercise that the doctor may be referring to: *Fuwocheng*
(“Pushups”)?, making relevant a confirming/disconfirming response from the doctor.
This apparently wrong candidate term is corrected by the doctor at line 56 when he
repeats the proper name of the exercise: “plank”, accompanied by some bodily gestures
to simulate the movement of plank (line 57).

In response, the husband reports his experience with the plank (line 58, *Jingchang
zuo a* (“I often do it”)). In producing this report, the husband shows that he not only
knows about this exercise, but also has experience practicing it.
Additionally, he goes on to display knowledge about this exercise in the following turns, by pointing out the fact that in order to practice plank, one’s body must be in good condition (lines 62 to 63). He first initiates something that may be on the way to assessment “That’s very-”, abandons it, and then reports his personal experience with plank *Yiqian dou lian guo* (“I have done that before”) potentially as the basis for his claim about plank (line 63, *Zhei yao shen bucuo le liande* (“This needs your body to be in good shape”)).

The husband’s response to the doctor’s order may be construed as resistant, since it leaves available for inference that his wife may not be able to hold a plank per the doctor’s proposal, given that she is, according to the doctor’s own evaluation, not fit enough (line 35, “Because you have too few muscles”). This report may function as an account for not complying with the doctor’s order – the patient lacks the physical strength to hold a plank, therefore the husband is unable to teach her how to do it. By responding to the doctor in this way, the husband here is tacitly aligning with his wife while not overtly disaligning with the doctor’s suggestion.

Despite the husband’s resistance, the doctor insists that the husband should follow his advice, encouraging him to *Shishi* (‘give it a try’ (line 64)).
However, here *shishi* (direct translation “try try”), a case of verbal reduplication in Mandarin Chinese, has an attenuating/diminishing function (Zhao, 1968). By repeating the verb *shi* (try) twice, the doctor downgrades the deontic power conveyed by his order, formulating it in an unassertive way. This formulation is different from his initial order at line 48, where the doctor directs the husband to teach his wife how to do plank. The doctor’s mitigated turn may be orienting to the resistance from the patient (lines 52 & 53) as well as from her husband (line 62 & 63).

064  DOC:   Shishi shishi.  
          Try try Try try  
          Give it a try. Give it a try.

065  pat:   ((corners of mouth |droop))/(0.2)

In response to the doctor’s turn, the patient at line 65 produces the bodily action of turning down the corners of her mouth. This facial expression conveys negative affect towards the doctor’s suggestion. Thus, it may be understood as an embodied display of resistance. At lines 66 to 67, possibly in another attempt to resist the doctor’s suggestion, the patient’s husband reports that they already engage in physical activities regularly:

*Women meitian wanshang yao mei ma shir wo zai changhong gongyuanr kuai zou qi* (‘If we are free we try to power walk in Changhong Park every evening to exercise’). *kuai zou* (“power walking”) is a popular way of exercising among middle-aged Chinese people. It is not as intense as the American version of power walking, and thus generally is considered an appropriate form of exercise for people whose body is not in an ideal condition. By reporting that they are already physically active, the husband indicates that the doctor’s suggestion may be unnecessary since there is no need to adopt a new activity (plank) when they already have an exercise routine.

066  HUS:   |Women meitian wanshang yao mei ma shir
In line 68, the patient’s resistance continues. Here she strongly and explicitly resists both the doctor’s recommendation, as well as her husband’s proposal of an alternative way of exercising, on the basis of not having enough time to exercise (line 68, Wo zhen mei shijian lian (“I really don’t have time to exercise”)). In making this claim, the patient provides an account for not following the doctor’s recommendation and blocks her husband’s attempt to propose an alternative for physical activity – she resists the doctor’s proposal because she does not have time to follow through, not because she lacks the physical strength to do so, as her husband suggested earlier.

While the patient’s turn is still in progress, immediately after she invokes “time” in her account for not doing exercise, the patient’s husband comes in at line 69 to voice his agreement (Ai (“Right”)), once again aligning with the patient.

In line 70, the patient produces a negative assessment of her behavior (line 70, Bu hao (“Not good”)) followed by some laughter tokens (“Hheheheh”).
Note that the subject in the patient’s line 70 is omitted (“not good”). In Mandarin Chinese, this kind of null subject construction normally happens when the mentioning of this subject is at a locally subsequent position so that both parties know what the subject is (Wang, 2000). Produced immediately after the patient’s claim that she does not have time to exercise, line 70 is hearable an assessment of such behavior. This assessment indicates that the patient is aware of the problematic nature of her conduct. The laughter tokens, on the other hand, are potentially produced by the patient to orient to the delicate and problematic nature of her unhealthy lifestyle. Laughter is frequently utilized by patients as an interactional device to acknowledge a delicate situation (Haakana, 2001; Lerner, 2012). These laughter tokens may indicate that the patient is aware that her conduct is problematic, presumably for her health.

In overlap with the patient’s turn at line 70, the patient’s husband further aligns with his wife, partially retracting his previous proposal of an alternative form of exercise (lines 71, 73 and 75 below):
Here the husband back down from his previous report that they powerwalk in the park every day. He suggests that the patient, when “feeling tired”, does not have to powerwalk. The patient’s husband is facing two sets of conflicting obligations. Both are associated with the spousal category (Schegloff, 2007). On the one hand, he needs to help the patient lose weight by adopting healthier life habits (as shown by him offering an alternative exercise routine in lines 66 & 67); on the other hand, he also needs to be a supportive spouse and align with his wife. The husband here is trying to straddle two different category-bound obligations. He proposes a less intense physical activity when the patient initially resists the doctor’s lifestyle recommendation, and then aligns with the patient when her oppositional stance becomes explicit and strong.

So far, the patient has resisted the doctor’s recommendation repeatedly. In the face of her resistance, the doctor invited the patient’s husband to join the consultation in an attempt to enlist him as an ally to help implement the lifestyle change that he has recommended.

However, as the husband’s responses to the doctor indicate, he does not side with the doctor. He tacitly rejects the doctor’s recommendation by indicating that the recommended workout is not suitable for the patient, given that her health status is not ideal (lines 62 & 63); he then moves on to report an alternative, low intensity form of
exercise that they are already doing regularly (lines 66 & 67), which is hearable as proposing an alternative to the doctor’s recommendation; lastly, when the patient overtly rejects the doctor’s recommendation by claiming that she has insufficient time, the husband partially retracts his proposal to side with the patient (line 73 & 75, when the husband excuses the wife from powerwalking under the condition that she “feels tired”).

In lines 72 and 74, the doctor responds to the patient’s negative assessment of her current health-related conduct with what appears to be an account solicitation (Ni weisha lao Zi renwei bu hao ne (“Why do you always think that you are not good?”)). The action being implemented here is a challenge (Bolden & Robinson, 2011): the why interrogative ostensibly solicits an account from the recipient for negatively assessing herself, but at the same time, it conveys that no such account exists (Koshik, 2005). Additionally, the doctor uses “think” in this turn, framing the patient’s negative view as a matter of perception, instead of a realistic assessment. The patient orients the doctor’s turn as a challenge as well by responding to it with an upgraded version of her negative assessment at line 76 (Hen bu hao (“Very not good”)). By upgrading the assessment of her health status with an intensifier (very), the patient sustains her stance towards it, despite the doctor’s challenge.

In lines 77 to 78, in response the patient’s negative assessment, the doctor offers encouragement to the patient (Bu yao ba ziji dabai (“Don’t let yourself be defeated. You know”)). This encouragement indicates that that the patient’s self-assessment should not function as a basis for rejecting the doctor’s recommendation. However, in the following lines, the patient’s resistance continues. She relaunches her negative assessments (line 79,
The first negative assessment that the patient produces in line 70 is about the patient’s problematic conduct (as the null subject structure indicates). In this relaunched assessment, the patient makes it explicit that it is indeed about her problematic conduct, since this time she includes the subject Wo (“I”) in line 79. Her patient’s upgraded negative assessment (line 79 “No I am really not good. I’m really not good”) resists the doctor’s encouragement by indicating that she accepts her current status and has no intention of changing it. In repeating her negative assessment, the patient sustains her resistant stance towards the doctor’s proposal. She admits wrongdoing but indicates no willingness to make any change.

In lines 80 and 81, in overlap with the patient’s turn, the patient’s husband participates again by proposing another alternative form of exercise, square dancing.
Similar to powerwalking, square dancing is particularly popular among middle-aged women and retirees (He, 2014). Compared to the other two alternatives, plank and powerwalking, this form of exercise is a low intensity workout that is less physically demanding. Note that the husband’s proposal is formulated as a multiple saying with appended laughter tokens. In producing this multiple saying, the patient’s husband orients to the ongoing course of action (the doctor making the recommendation and the patient resisting it) as unnecessarily persistent. Possibly the laughter tokens are produced to modulate this incipient action. The husband’s proposal of this option may be understood as another attempt to convince his wife to accept the doctor’s proposal. Square dancing, albeit far less intense than plank, is still a form of exercise which may help the patient gain more muscle.

The patient, upon hearing her husband’s proposal, briefly turns her head to gaze at him. She then goes on to initiate what appears to be an update at line 83: *W- w- wo zheiliangtian yi zhi* (“I- I- I these days I keep on”). *Zheliangtian* (“these days”) indicates that this report that the patient is about to provide is an update on what happened recently. While the patient’s turn is still in progress, the doctor comes in and responds to the husband’s proposal of an alternative form of exercise, dismissing it completely (line 84) on the basis of it being ineffective (*Guanchangwu ta bu ling* (“Square dancing is of no use”)):

083 PAT:  
*W- w- wo zheiliangtian yi [zhi.*  
*W- w- wo these days all[ the time*  
*I- I- I these days I keep[ on*

084 DOC:  
*Guanchangwu ta bu ling.*  
*Square dancing it NEG useful*  
*Square dancing is of no use.*

085 HUS:  
*A?*  
*Huh*  
*Huh?*
The doctor’s initially recommended exercise is “plank”, a high intensity workout that focuses on improving the patient’s isometric strength. What the patient’s husband proposes, on the other hand, is a low intensity, cardio exercise that is not usually performed to gain muscle. The doctor rejects this downgraded alternative by claiming that it is ineffective (line 84). Hence, the husband’s attempt to propose an alternative fails because the solution that he offered is once again rejected by the doctor. At this point, the doctor and the patient are in a “stalemate” where neither party wants to back down. The husband, in an effort to resolve this stalemate, proposes two possible solutions, but both are rejected by the doctor.

At line 86, the patient provides an update on her current status (line 86, Wo jintian hai- hai- hai haodianr (“Today I feel better”)). After this report of improvement is acknowledged by the doctor, the patient then describes how she felt yesterday, which may be heard to be proposing a contrast with how she feels today (line 88 to 89, Wo zuotian- wo jiu cong yao zher fencheng liang jier le (“Yesterday I- my waist feels like it is split in half”)). By reporting her no-problem status first (that she is feeling fine at this moment), the patient is possibly accounting for not bringing up her waist problem earlier. Here the patient complains about having severe waist pain, using an idiomatic expression (“feels like it is split in half”, Drew & Holt, 1988). The patient here is introducing a new medical problem. This problem presentation may be produced to do two different things: first, the severe waist pain may prevent the patient from engaging in physical activities, and thus becomes another account for the patient’s resistance towards the doctor’s proposal; second, this problem presentation initiates a new line of action since it makes
relevant a diagnosis/evaluation from the doctor. It may be a way for the patient to move on from the discussion about exercise.

086 PAT:  Wo jintian hai- hai- hai haodianr.  
I today also- also- also- better  
Today I feel better.

087 DOC:  Eh.  
Hmm

088 PAT:  Wo zuotian- wo jiu cong yao zher fencheng  
I yesterday- I just from waist here split  
Yesterday I- my waist feels like it is  
liang jier le.  
two parts FP  
split in half.

089  
090 DOC:  Haome ni- ni you bian liangjier le.  
Good you- you again turns two parts FP  
Good lord you- you were split in half again.

In response, the doctor first treats the patient’s problem as surprising *Haome ni* (“Good lord”), then teases the patient (Drew, 1987) *ni you bian liangjier le* (“you were split in half again”), indicating that the patient’s medical complaint may be a minor conversational transgression. The “again” in line 90 indicates that this is not the first time that the patient has complained about this waist pain. After teasing the patient, the doctor moves on to solicit more information about the patient’s waist problem (line 92, *Ni- ni gan huo le ma* (“Did you do chores”)) and thus, treats the previous discussion about exercising as concluded.

This extract shows a “failed” case of solicited companion participation. The patient in this extract displayed strong resistance to the doctor’s advice that she should be more physically active. In the face of the patient’s resistance, the doctor enlisted her husband, who is fit and athletic (information available in the ethnographic notes), to help
the patient. However, the husband in this extract did not fully side with the doctor. He indicated reservations about the exercise that the doctor recommended by pointing out that that form of exercise requires the patient’s body to be in a good condition (lines 62 & 63). He also proposed alternative forms of exercise that are less demanding and more age appropriate (lines 66 & 67; lines 80 & 81). Neither the patient nor the doctor accepted the husband’s proposed alternative. It may be argued that the husband, when faced with conflicting sets of obligations (supporting his wife vs. helping his wife obtain a healthier lifestyle), tried to find an alternative that is acceptable to both parties. By enlisting the husband to offer assistance to the patient, the doctor invoked the husband’s membership in the spousal category. Even though helping his wife become healthier is one of the category-bound obligations of being a spouse, the husband is also responsible for supporting his wife. In this extract we see that the husband did try to convince his wife to do more exercise, but he also oriented to his obligation of being supportive by looking for a form of exercise that is acceptable for the patient when she is unwilling to accept the doctor’s proposal.

In both Extracts 25 and 26 of this section, the patients’ spouses were invited by the doctor to participate in the patient’s consultation after the patient has displayed resistance towards the doctor’s recommendation. In Extract 25, the doctor’s recommended lifestyle change involves a special diet, so the patient’s wife was invited presumably as the food provider to help the doctor implement the dietary change. The wife acquiesced and sided with the doctor. In Extract 26, on the other hand, the husband was enlisted to be a role model and a “personal trainer” to help the patient engage in a specific form of physical activity. In both extracts, by implicating the patients’ spouse
into the ongoing consultation, the doctor also made relevant their membership in the spousal category by invoking their category bound obligations (in the first case, preparing food and in the second case, pushing their spouse to adopt a healthy life habit). These two extracts show that when patient compliance is absent, the patient’s companion, who is also partially responsible for the patient’s well-being, may be enlisted to help the doctor move their medical agenda forward. However, as Extract 26 demonstrates, category-bound rights and obligations can be complex within the institutional setting. Interactants may face conflicting rights and obligations that they need to balance, making siding with either party difficult.

In addition to joining the patient’s consultation upon the doctor’s invitation, the patient’s companion may also participate spontaneously. This voluntary companion participation occurs in 53% of my cases (44 out of 83). In the following section, I show that when the patient’s companion voluntarily joins the consultation, they try to accomplish two tasks: they help address patient resistance and support the doctor’s course of action by offering medically relevant information to the doctor; at the same time, they use it as an opportunity to pursue their own interactional projects, such as pushing the patient to adopt/abandon a particular lifestyle habit. Like cases of invited participation, relationship categories and category-bound rights are also frequently invoked when the companions spontaneously join the patients’ consultation.

Voluntary companion participation
Voluntary companion participation occurs when the patient’s companion participates voluntarily in the physician’s interaction with the current patient. Three cases of voluntary companion participation are examined in this section. In the first case (Extract 27), both the patient’s wife and his father-in-law join the patient’s consultation spontaneously in reporting the patient’s health-related “misconduct”, when the patient repeatedly pushes back against the doctor’s recommendation. In the second case (Extract 28), the participating companion is the patient’s wife. She participates voluntarily in her husband’s consultation to support the doctor’s lifestyle advice and offers diagnostically relevant information to the doctor when the doctor’s recommendation is resisted by the patient. However, although the wife’s report is formulated as relevant to the doctor’s diagnosis of the patient’s problem, it in fact functions as a Trojan horse that the wife deploys to implement a different social action (complaining about the husband’s unhealthy life habit). The last case (Extract 29) is a boundary case that does not fit the observed pattern in the following respects: first, the relationship between the patient and her companion is parent-child rather than spousal; second, the patient’s father’s participation in the consultation is not occasioned by patient resistance. Rather, here the father joins in the interaction to make treatment decisions on his daughter’s behalf, after the daughter has displayed a preference for a treatment option of which he does not approve. This extract is included to show how the same kind of phenomenon (voluntary companion participation) may occur for reasons other than patient resistance and in different relationship contexts. The three cases in this section show that when patients’ companions get involved in the patients’ consultations, doctors may be put in the position
to “pick sides”. In response they may either align with the companions or with the patients. They may also try to find a middle ground.

Also, in these three cases, relationship categories and their correspondent rights and obligations are made relevant when the companions participate in the patient’s consultations. In Extract 27, the patient’s companions join the patient’s consultation voluntarily, after the patient has displayed resistance to the doctor’s medical opinion. In this extract, both the patient’s wife and his father-in-law participate in the patient’s consultation to offer medically relevant information that the patient has some unhealthy life habits. However, when the patient is under joint attack from both his companions, the doctor sides with the patient – he rescues the patient by retracting his negative assessment of the patient’s reproductive health and replacing the initial negative evaluation with a positive one. This extract shows that while companions may support the overall medical agenda, they may not always be supportive of the patient’s line of action. The doctor, on the other hand, may choose to align with the patient when the patient and their companions’ views are discrepant.

The patient in this extract is an IT professional in his 30s. He is visiting the doctor for fertility-related concerns – he and his wife have been trying to conceive for over a year but have failed. In this extract the patient is resisting the doctor’s diagnostic claim that he has a condition called “excessive heat”, which may have contributed to his low sperm motility. Companion participation in this extract starts at line 28, when the patient’s wife spontaneously joins the interaction to “snitch” on the patient by reporting his health-related misconduct to the doctor.
The extract begins with the doctor delivering the diagnosis that the patient has low sperm motility (lines 1 to 5):

Extract 27  More rest
[WW TCM VID00003 8 21 1:32]
Participants: doctor (DOC); current patient (PAT); wife (WIF)
~ > companion participation

001:  DOC:  [Erie jiushi shuo(.).hh nide jingzi qishi yaoshi- [Also just say (.).hh your sperms actually if
[Also it is just (.).] Actually if your sperm

002 ((FIL hovers around PAT and DOC)

003  DOC:  Juti shuo ta(.) shuliang (keneng) bu shao. Practically speaking it(.) count (perhaps)N less Practically speaking the count might not be low.

004 (0.2)

005  DOC:  Jiu bu doing. Just N move
Just don’t move

006 (0.2)

007  DOC:  A. [{ } jiu yinwei- Uh. [{ } just because Uh, [{ } It’s because

008  PAT:  [Eh huoli- Huoli bu xing. [Eh activness- Activeness N okay [Em the motility -The motility is not good.

009  DOC:  Huoli bu xing jiu yinwei nide shenti li< Activeness N okay just because your body in The motility is not good only because inside your body

tai re le. too hot FP it’s too hot.

011 (0.7)

012  DOC:  Tai re le ta dou bu ai dong. Too hot FP it all N love move It doesn’t like to move at all if it’s too hot.

013  Xiatian ni ai donghuan ma? Summer you love move FP Do you like to move in summer?

014 (0.3)

015  DOC:  Ni shuo shihua. You say honest words
Be honest.
016  PAT: ( [ ] )

017  DOC: [Xiatian tebie re de tian ni ai donghuan [ma.
        |Summer very hot P weather you love move [FP
        |When it’s really hot in summer do you like to [move.]

018  PAT: [Kending
        |sure
        |of

019  bu ai donghuan.=
      N  love move
course not.=

020  DOC: =Jiu shi. Ni shenti libianr dou- dou zhao:: le.
        =Just BE you body inside all all on fire FP
        =Exactly. The inside of your body is on fire.

021  name de. Ta neng dong [ma.
      That FP. It can move [FP
      Like that. It cannot move.

022  PAT: [En en e::n.
        En en e::n
        |Oh oh o::h.

023  DOC: [[( ] ) wan la.
        [( ] ) done FP
        ( ) done.

024  PAT: [( ] )

025  (0.3)

026  DOC: Dong [ma.
        Understand [FP
        Understand?

027  [((patient nods))]

028  ~>WIF: >Jiu shi< ta zai danwei hai ai kai kongtiao ma de.
            >just BE< he at workplace also love to open AC like
            It’s just that he also likes to use AC at work.

029  PAT: J- Kongtiao dao meiyou jiu jianshao yundongliang.
        J- AC ( ) not have just decrease exercise
        J- It’s not AC. My level of physical activity is decreased.

030  (0.2)

031  PAT ( ) (. ) neige.
      ( ) (. ) that
      ( ) (. ) that.

032  (0.2)

033  DOC: Mei shir.
        N thing
        It’s fine.

034  (.)
273

035 DOC: (Guang jianshao yundongliang.
( ) Exactly decrease level of activity
( ) Exactly the decreased level of activity.

036 PAT: Gongzuo shi ha.
Work BE FP
Work, right.

037 DOC: Dui. Jingchang dei gongzuo. Zhei jiu shi shi-
Right. Often have to work. This just BE e-
Right. Have to work often. This is just e-

038 shidai bing ha.
Disease of the era.

039 ~>FIL: Duo xiuxi zhei [shuimian ha-
More rest this [sleeping FP
(You should) have more rest. This sleep then-

040 PAT: [Shidai- shidai (bi[an le).]
[Era - era (changes FP]
[Era- it’s a different era now.

041 DOC: [Dui: ya:.
[That’s right.

042 shui shui jiao: wa:. ni ni- haohaor de yang yang.
Sleep sleep FP you you- good P heal heal
Sleep a little. You should recuperate.

043-> WIF: Wanshang [shiyidian duo (. ) caineng shui, zaoshang
Night [eleven o’clock more can sleep morning
He doesn’t go to bed until after eleven, gets up

044 [wudian duo jiudei qi.
[5 o’clock more have to get up
around 5 am.

045 DOC: Ni ji sui.
You how old
How old are you.

046 (0.3)

047 PAT: Wo? [I
[Me?

048 DOC: [Ni- ni ji sui |ershiba?
[You- you how old |twenty-eight
[How old are you |twenty-eight?
|((points at PAT))

049 PAT: [Dui.
Right
[Right.

050 DOC: [A.
[P
The doctor’s delivers his evaluation of the patient’s problem in lines 1 to 10, in a "good news” then” bad news” pattern, possibly orienting to the sensitive nature of fertility related issues:

```
001 DOC: [Erqie jiushi shuo(.).hh nide jingzi qishi yaoshi- [Also just say (.).hh your sperms actually if [Also it is just (.). Actually if your sperm

002 [(FIL hovers around PAT and DOC)

003 DOC: Juti shuo ta(.). shuliang (keneng) bu shao. Practically speaking it(.). count (perhaps)N less. Practically speaking the count might not be low.

004 (0.2)


006 (0.2)
```
In this segment the doctor orients to the delicacy of the matter (Lerner, 2013) by reformulating his turn twice (lines 1 and line 3) to foreground the good news (the patient’s sperm count may not be low). The doctor also formulates his diagnosis delivery as delicate by including several tokens that make his turn tentative and mitigated (*jiu* (“just”) and *qishi* (“actually”) at line 1, and *Juti shuo* (“practically speaking”) at line 3). He then delivers the bad news part of his diagnosis in line 5 *Jiu bu do:ng* (“Just don’t move”), minimizing the issue with “just”. The patient provides no uptake of the doctor’s diagnostic turns (gaps in line 4 & 6). Just as the doctor begins to explain the cause of the patient’s problem, the patient comes in at line 7 and formulates the upshot of the doctor’s diagnosis using a medical term (*Eh huoli- Huoli bu xing* (“Em the motility -The motility is not good”)):

007  **DOC:**  A. [()]
    jiu yinwei-
    Uh. [()]
    just because-
    Uh, [()
    It’s because

008  **PAT:**  [Eh huoli- Huoli bu xing.
    [Eh activness- Activeness N okay.
    [Em the motility -The motility is not good.

009  **DOC:**  Huoli bu xing jiu yinwei nide >shenti li<
    Activeness N okay just because your body in
    The motility is not good only because inside your body

010  Tai re le.
    Too hot FP.
    It’s too hot.

Two observations can be made about the patient’s turn here. First, the patient reformulates the doctor’s evaluation using a medical term, and in doing so, displays knowledge about this condition. Second, the patient’s assessment (“the motility is not good”) is a downgrade from the doctor’s initial evaluation that the patient’s sperm is “not moving” (line 5). This downgrade may be the patient’s effort of formulating his problem
as less serious since the doctor’s original claim that the patient’s sperm is “not moving” indicates a serious issue.

Note that in line 9, the doctor adopts the patient’s formulation when he explains the cause of the patient’s problem (Huoli bu xing jiu yinwei nide >shenti li< ("The motility is not good only because inside your body it’s too hot")), showing that he has accepted the patient’s downgraded version of the diagnosis. The doctor attributes the cause of the patient’s problem to the fact that the patient has a lot of heat inside his body – a condition known as “excessive intrinsic heat”26. Also, since intrinsic heat is a common problem among TCM patients, it is possible that the doctor designs his turn this way to indicate that the patient has a curable problem. If the intrinsic heat problem is resolved, the motility problem will also likely be resolved. Note that after this diagnosis is delivered, there is no uptake from the patient (0.7 second gap at line 11), which may indicate upcoming disagreement from the patient. This may explain why the doctor goes on with the explanation to pursue a response from the patient (line 12): (Tai re le ta dou bu ai dong ("It doesn’t like to move at all if it’s too hot")). The doctor’s pursuit may indicate that he is committed to convincing the patient that his sperm motility problem is directly related to or caused by his intrinsic heat condition.

009  DOC:  Huoli bu xing jiu yinwei nide >shenti li<
         Activeness N okay just because your body in
         The motility is not good only because inside your body

010     tai re le.
too hot FP
it’s too hot.

011 (0.7)

012  DOC:  Tai re le ta dou bu ai dong.
          Too hot FP it all N love move
          It doesn’t like to move at all if it’s too hot.

26 Excessive intrinsic heat is a common condition in TCM theory. Patient may experience different symptoms because of it.
This claim is a reformulation of the doctor’s lines 9 & 10. The doctor provides an explanation for the patient’s low sperm motility by proposing a connection between this and his condition of excessive intrinsic heat. At line 13, the doctor asks a question about the patient’s physical activity during the summer, which makes relevant a yes/no response from the patient: *Xiatian ni ai donghuan ma* (“Do you like to move in summer”).

012  DOC:    Tai re le ta dou bu ai   dong.  
            Too hot FP it all N love move  
            It doesn’t like to move at all if it’s too hot.

013          Xiatian ni ai   donghuan ma?  
            Summer you love move   FP  
            Do you like to move in summer?

014          (0.3)

015  DOC:    Ni shuo shi:hua.  
            You say honest words  
            Be honest.

016  PAT:    ( [    )

017  DOC:    [Xiatian tebie re de tian ni ai   donghuan [ma.  
            [Summer very hot P weather you love move [FP  
            [When it’s really hot in summer do you like to [move.

018  PAT:    [Kending  
            [sure  
            [Of

019          bu ai donghuan.=  
            N  love move  
            Course not.=

In asking this question about the patient’s level of physical activity in the summer, the doctor is trying to build up a comparison between the patient’s sperm in a hot environment (his body with excessive intrinsic heat) and the patient in the summer. Just like the patient does not like to move in the summer, his sperm does not want to move inside the patient’s body because of his intrinsic heat problem. Hence, if the patient
admits that he is less physically active in the summer, this establishes the comparison between the patient in summer and the sperm in his body with intrinsic heat.

The patient does not respond to the doctor’s question (0.3 gap at line 14). At line 15, the doctor continues to pursue a response from the patient. He prompts the patient to accept his diagnosis by asking the patient to *Ni shuo shi:hua* (“be honest”). At line 17, the doctor relaunches his question, providing another opportunity for the patient to respond. The doctor’s question this time is intensified: *Xiatian tebie re de tian ni ai donghuan ma* (“When it’s really hot in summer do you like to move”). As noted earlier, the doctor is fishing for a particular kind of response from the patient to help him establish the connection between the patient’s low sperm motility problem and his intrinsic heat issue.

If the patient provides a negative response to the doctor’s question, it becomes strong ammunition for the doctor to build the case that the patient’s condition of excessive intrinsic heat is likely to be the root of the patient’s fertility problem, since the patient’s sperm does not like to move in the patient’s body with excessive heat. At line 19, the patient finally provides a strong, disconfirming response (line 19): *Kending bu ai donghuan* (“Of course not”).

After getting the patient’s response, the doctor continues to strengthen his case that the patient’s low sperm motility is caused by his intrinsic heat problem. In lines 20 to 21. He makes an exaggerated claim (Drew, 2003) connecting the two conditions (*Ni shenti libianr dou- dou zhao:: le* (“The inside of your body is on fire” and “It (the sperm) cannot move”)) to show how serious the patient’s intrinsic heat problem and low sperm motility problem are and that they are related.
The patient’s response, however, continues to be resistant. At line 22, the patient produces a multiple saying (Stivers, 2004): *En en e:n* (“Oh oh o:h”). This multiple saying is resistant given that it treats the doctor’s course of action as unnecessarily persistent.

020   DOC:   =Jiu shi. Ni shenti libianr dou- dou zhaoː le.
              =Just BE you body inside all all on fire FP
              =Exactly. The inside of your body is on fire.

021          name de. Ta neng dong [ma.
            That FP. It can move [FP
            Like that. It cannot move.

022   PAT:                         [En en eːn.
                                              Oh oh oːh.
                                              [Oh oh oːh.

023   DOC:   [{(       )} wan la.
            [{(       )} doːne FP
            [{(       )} done.

024   PAT:   [(                  )

025          (0.3)

026   DOC:   Dong [ma.
            Understand [FP
            Understand?

027          [((patient nods))

The doctor’s response (line 26) to the patient’s multiple saying also shows that he treats the patient’s prior turn (line 22) as resistant. Instead of moving on, he continues to pursue a response from the patient by seeking confirmation from him (line 26, *Dong ma* (“Understand?”)). In response, the patient produces a head nod, a weak confirmation.

So far, the doctor has delivered the diagnosis that the patient has the problem of low sperm motility. He also proposes the cause of the patient’s problem, connecting it to the patient’s health condition of excessive intrinsic heat. However, as the patient’s responses to the doctor’s diagnosis and explanation indicate, he is resistant towards the
doctor’s course of action. This is when the patient’s wife comes in. She provides information about the patient’s (unhealthy) lifestyle habit (line 28):

028 WIF: >Jiu shi< ta zai danwei hai ai kai kongtiao ma de. >just BE< he at workplace also love to open AC like >It’s just< also he likes to use AC at work.

The patient’s wife reports that her husband likes to use the air conditioner (AC) at work. Using AC in the summer, while normal in Western countries, is considered a bad lifestyle choice among many people in China. According to TCM theories, AC offers an “artificial” and “unnatural” way to change the surrounding temperature. According to the beliefs of many TCM experts it disrupts the natural balance of the human body. The use of AC is especially problematic for patients with excessive intrinsic heat (such as the patient), since it may cause the condition of “*Waihaineire* (cold in the exterior, hot in the interior)”, throwing the body out of balance. The patient’s wife assists the doctor in identifying the cause of the patient’s problem by reporting a wrongdoing (Bergen & Stivers, 2013) that may have contributed to the patient’s problem. The wife’s participation comes after the patient has repeatedly displayed resistance to the doctor’s diagnostic claims. In providing this diagnostic information, the patient’s wife offers a candidate explanation for her husband’s problem, which involves a problematic life habit.

The patient immediately rejects his wife’s explanation (line 29 below). He offers his own candidate explanation for his problem in the same turn, attributing the cause of his health condition to a decreased level of physical activity *J- Kongtiao dao meiyou jiu jianshao yundongliang* (“J- It’s not AC. My level of physical activity is decreased”):

029 PAT:  J- Kongtiao dao meiyou jiu jianshao yundongliang.  J- AC ( ) not have just decrease exercise .  J- It’s not AC. My level of physical activity is decreased

030  (0.2)
Here the patient reports a lifestyle change that may have impacted his health negatively and caused the excessive intrinsic heat problem: he has not been as physically active as before (line 26). This explanation, which is an alternative to his wife’s explanation, is accepted by the doctor. The doctor first gives a “no problem” response (line 33, It’s fine), then strongly agrees with the patient by producing an “exactly” prefaced partial repeat of the patient’s explanation (line 35, Guang jianshao yundongliang (“Exactly the decreased level of activity”)), indicating that he wholeheartedly accepts the patient’s explanation that lack of physical activity is the culprit behind the patient’s sperm motility problem. In this way the doctor sides with the patient in rejecting her proposed cause and accepting the patient’s.
The patient, at line 36, invokes his work as a possible explanation for his lack of physical activity (he is an IT specialist) by simply naming it, leaving available the inference that it is his job that prevents him from being physically active. The patient also seeks confirmation from the doctor (line 36, Shi ba (“Right”)), which indicates that he takes it that the doctor should be able to understand what he is talking about by mentioning work. The doctor agrees with the patient at line 37 (Dui (“Right”)). He exposes the patient’s unarticulated explanation for not being able to be more physically active (Jingchang dei gongzuo (“Have to work often”)) and then provides a strong, negative characterization of work: Zhei jiu shi shi- shi:dai bing ha (“This is just e-disease of the era”) (line 38). The doctor’s characterization indicates that he agrees with the patient and accepts the patient’s explanation that sedentary work is the root cause of the patient’s health problem, and that the patient is not unusual or exceptional in experiencing this. Again here, the doctor seems to side with the patient rather than with his wife.

By implying that his work is preventing him from partaking in physical activity, the patient minimizes his responsibility in this matter because work is something that is out of his control. It is an alternative explanation to the patient’s wife’s (overusing AC at work), which is something that is in the patient’s control. Here the patient is attributing the cause of his health problem to something that he is not personally responsible for, and thereby exonerates himself. Additionally, in proposing this alternative explanation, the patient also resists his wife’s explanation.

This is when the patient’s father-in-law also participates in the consultation (line 39 and 42). He offers lifestyle advice to the patient, which could also be understood as a
possible explanation for the patient’s health problem *Duo xiuxi zhe shuimian ha*- (“(You should) have more rest. That sleep then-”) (line 39):

The father-in-law at line 39 advises the patient to “have more rest”, and then raises an issue with the patient’s sleeping (*shuimian ha* (“This sleep then-”)), which leaves available for inference that the patient has not been resting enough, possibly due to lack of sleep. This could be understood as an alternative explanation for the patient’s fertility issue. Insufficient sleep is a serious, sanctionable “offence” in TCM since according to TCM theories, human organs have their own biological cycle. They are only able to recover and recuperate at night after the person has entered deep sleep. Hence, sleep deprivation may have a negative impact on people’s body by jeopardizing the health of their organs.

The father-in-law’s advice is met with agreement from the doctor (lines 41 to 42 *Dui: ya:. shui shui jiao: wa:. ni ni- haohaor de yang yang* (“That’s right. Sleep a little. You should recuperate”)). Note that the doctor asks the patient to “Sleep a little”,
minimizing the seriousness of the patient’s sleep issue. At line 43, the patient’s wife participates in the consultation again to offer additional information about the patient’s poor sleeping habits (Wanshang shiyidian duo (.) caineng shui, zaoshang udian duo jiudei qi (“He doesn’t go to bed until after eleven, gets up around 5 am’’)). The wife’s report is a more specific report about the patient’s sleeping deprivation problem. The wife’s report makes available for the inference that the patient is only sleeping 6 hours a day, far less than the amount of sleep that a healthy adult needs according to TCM theory (7-9 hours). While the father-in-law’s advice makes available for inference that the patient has not been getting enough sleep, the wife’s report provides more specific details about the severity of the problem.

Note that the patient’s wife has already participated in the consultation once (line 28). She engages in discussion about the patient’s lifestyle by providing alternative explanations for the patient’s health condition. However, similar to her previous report of the patient’s habit of using AC at work, this report also receives no uptake from the doctor.

In line 45, the doctor asks the patient his age (line 45, Ni ji sui (“How old are you”)). The patient initiates repair at line 47, seeking confirmation from the doctor that he is indeed asking for his (the patient’s) age Wo (“Me?”). The patient’s repair initiation indicates that he does not have a hearing problem, but an understanding one. It is possible that the patient has an understanding problem because this question seems out of place. The patient’s repair initiation indicates that he does not treat it as relevant to the ongoing activity since questions about the patient’s age are usually launched at the beginning of the data-gathering phase. Note that the patient here is seeing the doctor for his fertility
problem, which is sometimes age-related. This question may be the doctor’s attempt to further investigate the patient’s problem, proposing another alternative candidate for the source of it.

In overlap with the patient’s repair initiation (line 47), the doctor repeats his question, then speculates that the patient is 28 years old (line 48 *Ni-ni ji sui ershiba* ("How old are you twenty-eight?")). This speculated age is first confirmed, but later corrected by the patient (line 49, *A* ("Yeh"); line 51, *Sanshier* ("Thirty-two")).

The doctor gives a mitigated positive assessment of the patient’s overall health condition at line 54, after the patient has revealed his actual age: *Sanshier qishi zhei*
qingkuang ye ting hao de ha (“This condition is not bad for thirty-two, actually”). Here zhei qingkuang (“this condition”) refers to the patient’s current fertility issue. In producing this positive assessment, the doctor revises his initial evaluation that the patient’s low sperm motility problem is serious. The turn-terminal “actually” also indicates that the doctor’s position regarding the patient’s fertility health has shifted, and that the new evaluation is different from his previous one (Clift, 2001). Note that the doctor reevaluates the patient’s condition after getting information about the patient’s age, indicating that the patient’s age may be a contributing factor to his current status.

The doctor’s reevaluation comes after both patient’s companions participated in the consultation. Since they have provided information about the patient’s bad lifestyle habits, it is possible that the doctor here attempts to rescue the patient by providing a positive assessment of the patient’s reproductive health.

The doctor then proceeds to offer lifestyle advice to the patient (line 58): Jiu shi yao tiaoyang (“(You) just need to take care of your body”). The jiu (“just”) at the turn initial position minimizes the effort that the patient needs to make to follow the doctor’s advice and remediate his health status. This advice is a panacea – it addresses all the previous concerns launched by the patient, his wife, and his father-in-law without targeting any specific issue. In delivering his recommendation in this way, the doctor avoids siding with either party.

In addition to the general lifestyle recommendation that the patient should take care of his body, the doctor also prescribes a medical test (sperm motility test) for the patient (line 60). With the treatment recommendation and the patient’s acceptance of it, the ongoing activity that revolves around the patient’s fertility issue is officially closed.
This condition is not bad for thirty-two actually.

Hmm

Just BE have to condition
(You) just need to take care of your body.

Next week you should go for testing at People’s Hospital.

Okay okay
Okay okay.

In this extract, the patient’s companions participated in the interaction to report the patient’s health-related misconduct. As shown in this extract, the patients’ companions do not always align with the patients and support their line of action. They may contribute to the overall medical agenda by offering medically relevant information to the doctor. The doctor, on the other hand, sided with the patient when he is under “joint attack” from both of his companions.

Extract 28 also involves the patient’s companion participating voluntarily in the ongoing medical consultation. Here the patient’s wife spontaneously intervenes into the interaction after her husband has displayed resistance towards the doctor’s diagnostic claim and lifestyle advice. The wife participates to indicate to the doctor that as the patient’s wife, she has fulfilled her category-bound obligation of attending to the patient’s health by telling the patient to do the right thing (learn to swim). Also, this extract shows that when the patient’s companion offers medically relevant information to the doctor, they may use that as an opportunity to implement a different social action, such as
convincing the patient to abandon particular health-related conduct (in this case, cellphone overuse). Hence, these reports of medically relevant information function as “Trojan horses”– while they are delivered as reports of information ostensibly to help the doctor diagnose/treat the patient’s problem, they are also vehicles for the companions to implement their own interactional project.

The patient in Extract 28 is a male in his late 50s. He works as a bus driver and sees the doctor on a regular basis. Prior to this segment, the patient launched a medical complaint that the soles of his feet were in great pain (lines not included). At line 18, the doctor delivers her diagnosis that the patient has problems with both his lumbar and cervical vertebrae. The patient resists the doctor’s diagnostic claim by providing additional symptom descriptions that misalign with the doctor’s diagnosis. Following the diagnosis delivery, the doctor also recommends a “treatment” that may help relieve the patient’s problem: swimming. However, the patient shows reluctance and resistance to following the doctor’s advice. The patient’s wife’s first attempt to intervene at line 45 is not responded to by the doctor, while at lines 67 and 68, she tries to intervene again by offering a candidate explanation for the patient’s health problem.

**Extract 28 Cellphone**

Participants: patient (PAT), doctor (DOC), patient’s wife (WIF, out of camera)

-> Companion participation

018   **DOC:** Yaozhui, jingzhui (. ) dou you wenti.  
    Lumbar vertebrae, cervical vertebrae all have problems
    There are problems with both lumbar and cervical vertebrae.
    (0.3)

019 020 **DOC:** Jiu shi y[ao:-
    Just Be waist
    Just the waist-

021 **PAT:** [Shi (.)] shi shi.
    [BE (.)] BE shi
[Yes (.) yes yes.]

022 DOC:  Jiu shi yao san si- san si neige defang. =
Just BE waist three four three four that place
Just near the third and fourth vertebrae. =

023 PAT:  =A:o.
=Oh
=Oh.

024 (0.2)

025 DOC:  Xiao jiaodou jiu shi (.) n- liu qi:.
The little toe just BE (.) n- sixth seventh
The little toe is the sixth and the seventh (vertebrae).

026 (1.1)

027 PAT:  Jiu shi zai neige::: xiao jiaodou gen neige (.)
Just BE at that little toe and that (.)
Just between the little toe and that (.)

er jiaodou: (0.2) jiu shi neige zhijian neige.
second toe (0.2) just BE that between that.
the second toe.

029 (0.2) /((takes off shoes, points at foot))

030 PAT:  You you [you you ge wo-
Have have have have a dent
There’s there’s there’s there’s a dent-

031 DOC:  [((points to her back))

032 PAT:  Ei [dui:.
Em [right
Em [right.

033 DOC:  [(

034 PAT:  Nin shuo zhei ge (.).hh wo- wo yaoshi kai
You say this one .hh I- I if drive
Now that you’ve mentioned this (.).hh If I drive

>zhe kai zhe che< wo jiu dei zhei yangr.
>P drive P car< I just have to this appearance
>the car< I just have to do this.

036 (0.3)/((PAT straightens his back))

037 PAT:  Zhei yao dei tingting zhe.
This waist have to straighten FP
I have to keep my back straight.

038 DOC:  En/((nods slightly))
Hmm.
Hmm.

039 PAT:  Ting wan le yihou dei ci:- huanhuan.
Straighten up done FP afterwards have to ci:- take a break
Then I have to take a break after straightening up.
Can you swim?

P: Bu hui.
N can
[I can’t.

P: Yao hui youyong xi:ng le.
If can swim okay FP
I wish I could swim.

WIF: Wo shuo rang ta xue
[I said let him learn
[I asked him to learn

D: Xue youyong. Wayong.
[Learn swim. Breaststroke
[Learn to swim. Breaststroke.

P: Yao hui yongyong xi:ng le.
If can swim okay FP
I wish I could swim.

D: (yao ). Ei. You wayong.
[(if ). Yep. Swim Breaststroke

P: (Qishi yao< chang da yumaoqiu ye xing.
Ac> Actually if< often play badminton also okay
Ac> Actually if< you often play badminton it is also good.

D: Er:. Yumaoqiu bu xing.
E:mm. Badminton N okay
E:mm. Badminton is not okay.

P: Ah?
Huh?

058  
DOC:  Yumaoqiu bu xing.
Badminton N okay
Badminton is not okay.

059  
PAT:  "Shi ma".
"BE Q".
"Really".

060  
( )

061  
DOC:  Lian- (.) yangwoqizuo.
Practice- sit-up
Do sit-ups.

062  
PAT:  A::o.
O::h.

063  
(0.4)/((PAT nods, looks away))

064  
DOC:  Lian yangwoqizuo.
Practice sit-ups
Do sit-ups.

065  
(0.2)

066  
PAT:  "Yangwoqizuo".
"Sit-ups".
"Sit-ups".

067  
(0.3)

068-> WIF:  Ni shuo gen ta na neige  shouji  ta- bu likai a:.
You say with he bring that cellphone he- N leave FP
Is it related to him always using his cellphone.

069  
zhiyao  zai jia, (0.3) yizhi[wuli-]
As long as at home, (0.3) always in room-
As long as he’s at home, (0.3) he’s always in his room-

070  
DOC:
[Nei- Zhuyi dia:nr.
[That- caution a little.
[That- be careful.

071  
Nei- neige Ma Caiming na bu tiantian iPad
That- that NAME that N everyday iPad
That- that Mai Caiming uses iPad everyday

072  
( )

073  
DOC:  Em. /{(points at the recorder)} >shenme shenme shenme shenme<
Em.  >what what what<
Em.  >that that that<

074  
nige zheige shouji. (.) Yitiandaowan jiu shenme
that this cellphone Day and night just what
that that cellphone. Day and night just that

075  
mai dongxi a  kan [na].
buy things FP Look[ FP
buying things, browsing.

076~> WIF:  Bu xian zhe.
            N   idle FP
            Restless.

077  DOC:  [Neige huangbanbianxing le.
          [That macular degeneration FP
          [That (he) has macular degeneration.

078~> WIF:  ° Ta  jiu zheiyang. °
            [ He just like this
            [ He’s also like this.

079          (0.2)

080  PAT:  A dui.
          Um right
          Um right

081          (0.2)

082  DOC:  Huangban liekoːŋ.
          Macular hole
          Macular hole.

083  PAT:  ( )

084  DOC:  [Zai lie- zai lie guo da jinr jiu=-
          [More tear- more rip over big strength just
          [If it tears up more=-

085  PAT:  [Zhei jiu shi;  la.
          [This just lose FP
          [He will lose (sight) then.

086          =[((DOC uses one hand to cover her left eye))]=

087  DOC:  =Shiming le.
          =Go blind FP
          =(he’ll) go blind.

088  PAT:  Dui. Shi.
          Right Yes
          Right. Yes.

089          (0.2)

090  PAT:  Shiming zheige.
          Go Blind this one
          It causes blindness.

091          (0.2)

092  PAT:  Shouji   [jiu shi zheiyang.
          Cellphone [just be this look
          Cellphone [is just like this.

093~> WIF:  [Bie waːnr le ba ni jiu.
          [Don’t play P P you just
          [You should stop using it.
In this segment, the patient’s chief complaint is that he had been experiencing great pain in the soles of his feet. Prior to this segment, the patient produces an extensive telling about how his feet are constantly in pain. Based on the information provided by the patient, the doctor delivers a diagnostic evaluation (line 18): *Yaozhui jingzhui (.) dou you wenti* (‘There are problems with both lumbar and cervical vertebrae’), attributing the cause of the patient’s pain to issues with his spine. The doctor’s initial diagnosis delivery is formulated as a plain assertion (Peräkylä, 1998), meaning that the diagnosis is delivered as a straightforward statement without further explanation.

The patient’s resistance may start as early as line 19, when he does not provide any uptake to the doctor’s diagnosis delivery. At line 20, possibly occasioned by the patient’s silence, the doctor pursues a response from the patient by replacing the specialist terms in the initial diagnosis delivery (she substitutes the professional terms
“lumbar and cervical vertebrae”) with a vernacular one (“waist”), treating the patient’s silence as caused by a problem of understanding (cf. Kitzinger & Mandelbaum, 2013), and thereby providing another opportunity for the patient to respond. The patient comes in overlap with the doctor’s turn with a “multiple saying” (Stivers, 2004) (line 21, “Yes (. ) yes yes”), orienting to the doctor’s course of action as unnecessarily persistent. Here by responding to the doctor’s explanation in this way, the patient may be indicating to the doctor that there is no need to further explain her diagnosis.

However, doctor continues with her explanation of how the patient’s pain in the sole of his feet is related to the lower part of his spine. She switches back to professional medical terminology at line 22 (Jiu shi yao san si- san si neige defan (“Just near the third and fourth vertebrae”)) when specifying the exact location of the patient’s problem. This explanation is met with a simple change of state token “oh” (Heritage, 1984), registering the explanation as new information.

The doctor’s explanation continues in line 25. This explanation is met with a long silence (line 26), which may indicate that the patient treats the doctor as in the process of delivering a multi-unit-turn:

024          (0.2)

025   DOC:   Xiao jiaodou jiu shi (. ) n- liu qi:.  
Little toe   just BE (. ) n- sixth seventh  
The little toe is the sixth and the seventh.

026          (1.1)

After the gap, the patient provides further details about where his pain is located (Jiu shi zai neige::: xiao jiaodou gen neige (. ) er jiaodou: jiu shi neige zhijian neige (“Just between the little toe and that (. ) the second toe”)) at line 27-28. He also takes his socks off and points at the location of his pain (line 29), which is near the little toe on his
left foot. Given that the doctor has just delivered the diagnosis that the patient’s problem is located between the “third and fourth vertebrae” and also explains that the little toe is associated with the sixth and seventh vertebrae, the patient’s location description (his pain is adjacent to the little toe) misaligns with the doctor’s diagnosis, since based on where it is located, the patient’s pain is more likely to be caused by problems with his sixth and seventh vertebrae.

The patient then goes on to present a new symptom: there is also a dent located between his little toe and the second toe, which should also be, according to the doctor’s prior turn, related to the patient’s problems with his sixth and the seventh vertebrae.

In overlap with the patient’s symptom description, the doctor points at her lower back (line 31). It appears that the doctor is trying to show the patient where his problem is located, in addition to explicating it verbally. In so doing, the doctor may be displaying knowledge about the patient’s problem and showing that she is able to identify the location of the patient’s issue. It is worth noting that where the doctor is pointing at is between the third and fourth cervical vertebrae (the upper part of her spine), which is consistent with her previous diagnosis.
The physician’s pointing gesture returns to her previous diagnosis that the patient has problems with both cervical and lumbar vertebrae because it connects the problem that the patient tries to present to the diagnosis that the doctor has already delivered, indicating that the “dent” that the patient is showing is another clinical manifestation of the patient’s spine problem. This action receives a hesitant agreeing response from the patient at line 32 (Ei dui (“Em right’’)). This agreement has a dispreferred turn shape (as the “Em” indicates) which indicates that although the patient agrees with the doctor, he is not embracing it whole-heartedly. In the ensuing lines, the patient presents a new symptom (lines 34-37 & line 39).

The patient formulates the beginning of his symptom presentation (line 34, Nin shuo zhe ge (.).hh wo- wo yaoshi kai (“Now that you have mentioned this’’)) in a way that indicates this symptom presentation is occasioned by the doctor’s prior diagnosis. The patient, a bus driver who works long hours, describes a series of bodily actions that he has to do after driving for a long time (lines 34 to 39):

034 PAT: Nin shuo zhe ge (.).hh wo- wo yaoshi kai
You say this one .hh I- I if drive
Now that you’ve mentioned this (.).hh If I drive

035 >zhe kai zhe che< wo jiu dei zhei yangr.
>P drive P bus< I just have to this appearance
>the bus< I just have to do this.

036 (0.3)/{(PAT straightens his back)}

037 PAT: Zhei yao dei tingting zhe.
This waist have to straighten FP
I have to straighten up my back.

038 DOC: En/{(nods slightly)}
Hmm.
The patient’s description of his actions is accomplished by him using both verbal (lines 34 & 35; line 37, line 39) and embodied actions (line 36). Although the patient does not articulate what symptom prompts him to perform this series of bodily actions, it is inferable that the symptom is located near the patient’s waist, given that from his bodily demonstration we can tell that he is adjusting his posture to relax the muscles near his waist.

The doctor responds to the patient’s report in line 40 with an inquiry, asking if the patient can swim (Hui youyong me (“Can you swim”)). This question makes relevant a confirming/disconfirming response from the patient. Note that at this point, the doctor has already delivered a diagnosis that the patient has problems with his lumbar as well as cervical vertebrae. Here by checking if the patient has the ability to swim, the doctor’s question may be understood as preliminary to her upcoming treatment recommendation.
The first part of the patient’s line 41 (\textit{Zaish- (“On the oth-“)}) appears to a continuation of his previous problem description. This description is abandoned, and then in the same line, the patient initiates repair by producing an open class repair initiator A: (“Hu:h?”) (Drew, 1997).

The patient’s repair initiation is treated as caused by a hearing problem, since the doctor responds to it with a full repeat (line 42, \textit{Hui youyong me (“Can you swim”)}). The patient delivers a negative response to the doctor’s question (line 43, “I can’t”). This claim of inability blocks the incipient advice—since the patient lacks the skill to follow the advice, then swimming will not be a feasible way of improving his health. In response to the patient’s negative response, the doctor lowers her head and looks away (line 44), temporarily disengaging from her interaction with the patient. As Kendrick and Holler (2017) show, gaze aversion predominantly projects dispreferred responses.

In line 45, the patient indicates willingness to swim, but inability to remediate this situation: \textit{Yao hui youyong xi:ng le (“I wish I could swim”)}. In producing this response, the patient treats swimming as a legitimate form of exercise, but one that he cannot take up because he lacks the required skill.

The patient’s wife joins the interaction at line 46. Her turn is produced in overlap with the patient’s response: \textit{Wo shuo rang ta xue (“I asked him to learn ”)} and invokes a past interaction between the patient and his wife about swimming. This report conveys that the wife is on board with or knowledgeable about swimming is helpful for the patient’s health situation. Additionally, in reporting that she has previously advised her husband to learn to swim, the wife makes available for inference that: a) unlike her husband, the wife recognizes the health value of swimming and b) the wife has fulfilled
her category-bound obligation to monitor her husband’s health, advocating for a healthy lifestyle by asking her husband to adopt a healthy life habit.

As previous research shows, husband and wife constitute a collectivity (Lerner, 2009; Lerner & Kitzinger, 2007, Mandelbaum, 1987). It may be the wife’s category-bound obligation (Schegloff, 2007) to take care of the husband and encourage him to live a healthy life. Here, by implying that the patient has previously displayed resistance to her lifestyle advice, the wife shows that she has fulfilled her obligation as a wife, and the husband is the one who is responsible for his current health status. Additionally, this indicates that the wife is aligning with the doctor regarding swimming. Like the doctor, the wife considers swimming a good way to help the patient improve his health.

At line 47, the doctor continues with her lifestyle recommendation. She produces a directive Xue youyong (“Learn to swim”), ordering the patient to learn swimming since he has previously indicated that he is unable to do so, and then nominates a specific swimming style that the patient should master: “Breaststroke”. This order makes relevant an acceptance/rejection from the patient. Delivered after the patient’s claim of not having the ability to swim, this order indicates that the doctor, despite resistance from the patient, is sustaining her stance that the patient should swim to improve his health.

After a brief gap, this order receives another tacit rejection (line 49, Yao hui yongyong xìng le (“I wish I could swim”)) from the patient. Note that this turn is a full repeat of the patient’s turn at line 45. In producing this full repeat, the patient once again expresses willingness to follow the doctor’s recommendation but implies inability to do so. This response constitutes resistance to the doctor’s order that the patient should learn
to swim, and by implication the doctor’s recommendation that the patient should use swimming as way to relieve his back problem.

In line 52, the patient appears to be nominating an alternative to swimming (>Qishi yao< chang- (“>Actually< if you often-”)). The turn initial “actually”, along with the gap (line 51) that precedes it, indicates that the patient’s turn is a dispreferred action (Clift, 2001) that disaligns with the doctor’s recommendation.

While the patient’s turn is still in progress, the doctor, challenges the patient (line 53): “Then what is to be done.” This turn is interruptive and potentially argumentative, since its placement is “interjacent” (Drew, 2009), when the patient is only halfway through his turn at line 52. Although formulated as a question, this Mandarin Chinese expression (Na zenme ban) does not usually make relevant a response. It is frequently
deployed by interlocutors to show that there is no good solution to the problem at hand. Here, the doctor is indicating that with the patient’s inability to follow her order (Xue youyong (“learn to swim”)), there may be no other way to fix his problem. However, the patient’s response at line 54 treats the doctor’s challenge as a genuine inquiry. He nominates an alternative to swimming (playing badminton): Qishi yao chang- Qi- Qishi yao< chang da yumaoqiu ye xing (“Actually, if you often play badminton, it is also good”). Note that the patient’s turn here is prefaced with the linguistic item “actually”, which indicates that he is providing information that contradicts or counters the doctor’s claim that swimming is the only option (Clift, 2001).

The doctor rejects the patient’s alternative candidate by delivering a negative assessment of the proposed activity at line 55: Er::: Yumaoqiu bu xing (“E:::m badminton is not okay”).

055  DOC:  Er::: Yumaoqiu bu xing.  
        E:::m. Badminton N okay 
        E:::m. Badminton is not okay.

056  

057  PAT:  Ah?  
        Huh  
        Huh?

058  DOC:  Yumaoqiu bu xing.  
        Badminton N okay  
        Badminton is not okay.

059  PAT:  °Shi ma°.  
        °BE Q°  
        °Really°.

060  (.)

The features of this turn (“E:::m”, and its mitigated formulation) indicate that it is a dispreferred response to the patient’s proposal. After a gap, which projects upcoming disagreement, the patient responds to the doctor’s rejection of his alternative candidate
with an open class initiator (“Huh?” Drew, 1997). In response, the doctor at line 58 repeats her prior turn (line 55) treating the patient as having a hearing problem.

The patient at line 59, delivers a quiet Shi ma (“Really”) in response to the doctor’s repeat. This token, according to Heritage and Sefi (1992), works as a newsmark that generates sequence expansion since it invites further confirmation or even explanation from the doctor. In producing this newsmark, the patient displays skepticism towards the doctor’s claim about badminton.

The doctor does not provide a confirming or disconfirming response to the patient’s newsmark. Instead, after a brief gap (line 60), the doctor offers an alternative activity at line 61: *Lian- (.) yangwoqizuo* (“Do sit-ups”).

Here the doctor produces a simple imperative and orders the patient to do sit-ups in lieu of swimming, making relevant an acceptance or rejection from the patient. Unlike swimming, doing sit-ups does not require special skills, hence the patient should be able to comply with this order. The patient’s response, however, is a simple change-of-state token A::o (“O::h”) (line 62), registering the doctor’s turn as new information, rather than
an order that needs to be either accepted or rejected. Additionally, the patient disengages from his interaction with the doctor by averting his eye gaze after a slight nod (line 63). This juxtaposition of verbal and bodily actions constitutes further resistance to the doctor’s order.

Potentially trying to pursue an acceptance (Pomerantz, 1984), the doctor at line 64 repeats her recommendation (Lian yangwoqizuo (“Do sit-ups’’)). The patient’s response is delayed (0.2 gap at line 65). He then quietly repeats the doctor’s turn (line 66 °Yangwoqizuo° (“°Sit-ups °’’)). This partial repeat conveys the patient’s potential skepticism towards the doctor’s recommendation, since it makes relevant confirmation, or even more explanation from the doctor (Robinson, 2013; Robinson & Kevoe-Feldman, 2010).

060            (.)
061   DOC:   Lian- (.) yangwoqizuo.
Practice- sit-up
Do sit-ups.
062   PAT:   A::o.
O::h
O::h.
063          (0.4)/{(PAT nods, looks away))
064   DOC:   Lian yangwoqizuo.
Practice sit-ups
Do    sit-ups.
065            (0.2)
066   PAT:   °Yangwoqizuo°.
°Sit-ups°.
°Sit-ups°.
067            (0.3)

So far, the patient has launched multiple attempts to resist the doctor’s lifestyle recommendation. He rejects the doctor’s initial recommendation that he should swim by claiming inability to follow the recommendation since he does not have the required skill.
He also proposed an alternative exercise in lieu of the one recommended by the doctor, which is quickly rejected by the doctor. The doctor then proposes her own alternative, another type of exercise, which is again resisted by the patient.

After a gap (line 67), the patient’s wife enters the consultation by asking a question (line 68, *Ni shuo gen ta na neige shouji ta- bu likai a*: (“Is it related to him always using his cellphone”). Here the wife formulates the patient’s cellphone overuse as a potential cause of his health problem.

The wife’s claim about the patient’s cellphone use at line 69 is exaggerated (Drew, 2003). She maximizes the amount of time that the patient spends on his phone: *zhiyao zai jia, (0.3) yizhi wuli-* (“As long as he’s at home, He’s always in his room”), suggesting that the only thing the patient does at home is using his phone. In describing the patient’s cellphone use in this hyperbolic way, the wife indicates that what she reports might be a serious problem that needs intervention. Here the wife uses the current environment of ongoing patient resistance to raise a concern about the patient’s health-related conduct. It is not obviously related to the patient’s presenting problem, although it is formulated as though it is. In this way, the wife’s alternative explanation functions as a Trojan horse – it appears to be a report of diagnostically relevant information but is in fact a vehicle for her to pursue her own agenda by raising another issue as though it were related to this one.
In line 70, the doctor responds to the wife’s report by acknowledging it as a legitimate concern. She first cautions the patient against excessive cellphone use (line 70, *Nei- Zhuyi dia:nr* (“That- be careful”), then invokes a third party who supposedly had the same habit and has ended up with a serious condition (lines 71 to 75, 76).

At line 76, the patient’s wife participates in the doctor’s telling by characterizing the third party’s action described by the doctor as “Restless”. She then connects this story to the patient’s behavior *°Ta jiu zheiyang* ° (“He is also like this”) (line 78), after the doctor has indicated that it is indeed a medical issue by reporting that the other patient has macular degeneration (line 77). In so doing, the wife indicates that her husband and the third party have similar issues when it comes to cellphone use.
The patient, after a short gap, begrudgingly agrees with the doctor (line 80 "A dui ("Um right")). This turn is delayed, indicating that the patient is slightly resistant towards the doctor’s cautionary tale. This may be why the doctor continues to pursue a response at line 82 by reporting a possible prognosis of the third party’s condition: Huangban lieko:ng ("Macular hole"). A macular hole is the worst prognosis of macular degeneration. While macular degeneration may cause sight loss, a macular hole will likely lead to blindness. By reporting this possible outcome of the third party’s cellphone use, the doctor adds more weight to her cautionary story about overusing electronic devices, and thus leaves available for inference that the patient should change his behavior due to its potential negative impact on the patient’s health.

The patient, however, displays independent knowledge about this condition (and its prognosis) at line 85 by collaboratively completing the doctor’s turn: Zhei jiu shi: la ("He will lose his (sight) then"). In so doing, the patient indicates that he is fully aware of the severity of macular degeneration. By displaying knowledge about this illness and how it may progress, the patient treats the doctor’s informing as unnecessary.
The patient’s resistance continues in lines 88 and 89. He once again agrees with the doctor (line 88, *Dui. Shi* (“Right. Yes”)) after the doctor reports the possible prognosis of the third party’s condition (line 87), and then once again indicates that he is already aware of that by redelivering the prognosis (line 90, *Shiming zheige* (“It causes blindness”)), exerting epistemic independence. He also connects the third party’s eye problem to his habit of excessive cellphone use (line 92, *Shouji jiu shi zhei yangr* (“Cellphone is just like this”)):

The patient’s turns here further show that he is informed about the potential problems caused by excessive cellphone use, meaning that the doctor’s warning and her cautionary tale are unnecessary.

The patient’s wife comes in at line 93 and explicitly advises the patient to stop using his cellphone: *Bie wa:nr le ba ni jiu* (“You should stop using it (the cellphone)”).
This advice is hearable as responsive to the prior talk between the doctor and patient about how excessive cellphone use may cause blindness. Note that the patient’s problem of excessive cellphone use was raised by his wife at line 68, after the patient repeatedly resisted the doctor’s lifestyle advice that the patient should learn to swim. Although it was initially introduced as a candidate explanation for the patient’s health problem of back pain, the doctor’s response does not treat it as such. Instead, the doctor orients to it as a separate concern and informs the patient about another health condition that may be a result of cellphone overuse by sharing a story of a third party. In doing so, the doctor implicitly cautions the patient against his excessive phone use, given that it may lead to serious health problems. However, the doctor’s course of action again receives resistance from the patient. He gives weak, half-hearted agreement tokens (line 80), and displays independent knowledge about the condition, treating the doctor’s warning and story as unnecessary. This is when the wife participates again, by explicitly launching the lifestyle advice: line 93, \textit{Bie wa:nr le ba ni jiu} (“You should stop using it (the cellphone)”).

In response to the wife’s advice, the husband indicates tentative acceptance (line 94, \textit{Wo xiangxiang} (“I will think about it”)), after which the doctor returns to the patient’s prior medical problem of waist pain (line 95, \textit{Neige- neige- Yao ye bushi bu neng hao} (“The waist problem can be improved”)). At this point, the discussion about the husband’s cellphone use appears to be concluded.

| 093–> WIF: | Bie wa:nr le ba ni jiu. |
|  | [Don’t play P P you just] |
|  | [You should stop using it]. |

| 094 HUS: | Wo xiangxiang. |
|  | I think think. |
|  | I will think about it. |

| 095 DOC: | Neige- neige- Yao ye bushi bu neng hao. |
|  | Um- Um- waist also NEG NEG can improve. |
|  | The waist problem can be improved. |
In this extract, the wife sided with the doctor when the doctor advises the patient to learn to swim (line 45) and reported that she has also advised the patient to do so. In so doing, she enacted being a good wife who takes proper care of her husband’s health by giving him the right advice. Later, she offered a candidate explanation for her husband’s problem which is a “veiled” complaint about her husband’s excessive cellphone use. When the doctor warned the patient against excessive cellphone use by telling the story of a common acquaintance, the wife participated again, suggesting that the patient should change his bad life habit. This extract is different from the Extracts 25 and 26 since the companion’s participation in this extract is voluntary. The patient’s wife joined the patient’s consultation uninvited to side with the doctor after the patient has displayed resistance towards the doctor’s advice. In this case, the patient’s wife raised a domestic concern (her husband’s excessive cell phone use) that is ostensibly unrelated to the patient’s problem with his waist as though it is in fact related. In this way, she exploited the patient’s resistance to the doctor’s recommendations to insert an unrelated concern as though it is related.

In the first section of this chapter, I examined four cases of companion participation in TCM encounters, all occurring in the environment of patient resistance. In the two cases of solicited companion participation, the patients’ companions were enlisted by the doctor to join the consultation and assist the doctor in implementing the lifestyle changes that they recommend. However, the doctor’s attempt to enlist the companion as their ally may not always succeed, as Extract 26 shows. In the two cases of voluntary companion participation the companions spontaneously joined the consultation.
The companions in these two cases use the contention between the doctor and patient as an opportunity to offer information about the patient’s unhealthy life habits.

**A Boundary Case**

The extracts that I have shown so far are all cases in which the patients’ companions are their spouses (in Extract 27 the father-in-law is also involved). However, companion participation also occurs within other types of relationships. In Extract 29, the patient’s father voluntarily intervenes into his adult child’s consultation. Unlike the previous extracts, the patient in this extract does not display resistance throughout the interaction. Her father, however, intervenes in the interaction to challenge the patient when she chooses one treatment option over another. The patient’s father here is “doing being a father” by engaging in the category-bound activity of making decisions for his child, since in Chinese culture parents are absolute authoritative figures, even after their children have entered adulthood (Ho, 1994).

The patient here is a female in her mid 20s. She is seeing the doctor for the acute problem of an upper respiratory infection. The segment is from the treatment recommendation phase of the patient’s visit. At the beginning of the segment, the doctor offers two treatment options for the patient (line 1, “(You) want to have medicinal soup or you want premade medicine”). The patient’s father intervenes into the interaction at line 5, after the patient has indicated that she is inclined to choose the premade option.

**Extract 29: Coughing**

Participants: doctor (DOC); current patient (PAT); patient’s father (FAT)

~> Companion participation

001 DOC: Xiang chi dianr tangyao xiang lai dianr
        Want eat a little medicinal soup want come a little
(You) want to have medicinal soup or you want chengyao.
premade medicine premade medicine.

PAT: Chengyao duo shi ba.
Premade medicine more BE Q
There is more premade medicine available, right?

Mg[hhhm mgh.

~FAT: |[Bu xing.
|[NEG okay
|[(That’s) not okay.
|((Gazes at the patient))

Ta yao xi |neige- cheng yao bu xing.
She wants west |that- premade medicine NEG okay
It is not okay for her to ask for west- premade medicine.
|((gazes at the doctor))

PAT: Wo ma zhuyuan wo zenme he. = Mei ren
Mom is in the hospital how can I take (the soup).

gai wo ao.
give me
No one will decoct (the soup) for me.

~FAT: Zher z|uo. Zher ao.
Here make. Here decoct
(We’ll) make it here. (We’ll) decoct it here.
|((points at the door))

(0.3)

|>At here decoct<. At here boil
|>(We’ll) decoct it here.< Boil it here.
| ((gazes at the doctor))

(1.2)

~FAT: Neige tangyang shihe. zai- you
That medicinal soup suitable. also- also
The medicinal soup is more suitable. Also- also

~
zhide kuai.
treat fast
it treats (the condition) faster.

(4.4)

DOC: Shui- laoniang zhu nar le.
Who- mother lives where FP
Who- where is your mother staying at.

(0.2)

PAT: Zhu neige-:
Live that
She is staying at that-


021 DOC: En. Oh Oh.

023 ~>FAT: He tangyao dai dai zher jian. Zai zher jian. Drink medicinal soup at- at here fry. At here fry Have medicinal soup. (We) boil it here. boil it here.

025 PAT: Zhei neng he neige:- (0.2) Huoxiangzhengqi ma. This can drink that- (0.2) NAME Q. Can (I) drink that Huoxiangzhengqi for this?

026 (.)

027 DOC: Hmm::::::. Hmm::::::. Hmm::::::.

028 (0.3)

029 DOC: Zai lai yidianr (.). chengyao ba. Also come a little (.). premade medicine FP (I’ll) also prescribe a little (.). premade medicine okay.


032 DOC: Dou gei ni kai san fu a. All give you prescribe three packets okay I will prescribe three packets of each (medicine) okay.

033 PAT: Xing. Okay Okay.

034 DOC: Zai gei ni dai jian a.= Also give you substitute boil okay I will also (ask the pharmacy to) boil it for you.=

035 FAT: =Ei. =Okay. =Okay.

In lines 1 and 2, the doctor offers two treatment options to the patient, putting her in the position of choosing between them: the traditional medicinal soup, which requires
boiling or decocting; or premade TCM tablets/pills. Although many people nowadays use premade TCM medicine since it is much more convenient, it is still widely believed that medicinal soup is the ideal and effective way of taking TCM medication. In response, the patient checks the availability of one of the two options, premade medicine, which could be understood as preliminary to choosing it (line 3, *Chengyao duo shi ba* (“There is more premade medicine available, right?”)).

Immediately after the patient launches her inquiry, her father comes in to reject the patient’s choice (line 5 *Bu xing. Ta yao xi neige- cheng yao bu xing* (“(That’s) not okay. It is not okay for her to ask for west- premade medicine”)). His rejection is addressed to the patient, as his body orientation and eye gaze show.

The father’s rejection (line 5, *Bu xing* (“Not okay”)) displays disapproval, treating the patient’s inquiry about the premade medicine as preliminary to her choosing this particular treatment option. At line 6, the father shifts his eye gaze to the doctor, and then
unpacks what he meant by “not okay”, exposing what was implied by the patient’s inquiry about the availability of premade medicine— that she is going to choose premade medicine over medicinal soup (“It is not okay for her to ask for west- premade medicine”).

The patient, in response, offers an account for choosing premade medicine at line 7 & 8:

007  PAT:  Wo ma zhuyuan wo zenme he. = Mei ren
My mom hospitalized I how drink.= NEG people
Mom is in the hospital how can I take (the soup).

008          gei wo ao.
give me
No one will decoct (the soup) for me.

Here the patient presents a practical problem which may prevent her from choosing the medicinal soup: her mother is currently hospitalized. In presenting this problem, the patient provides an account for choosing premade medicine and thus rejects her father’s rejection of her choice. Medicinal soup, although generally considered the optimal treatment option, requires the patient to prepare it properly. Decocting TCM medicinal soup is a complicated process that may take a long time (4 to 6 hours) and requires a certain level of knowledge about TCM. From the patient’s turn here, we may infer that her mother is normally the one who decocts the medicinal soup and is likely the only one in the family with the required expertise. Hence, the fact that the patient’s mother is staying in the hospital renders medicinal soup an unrealistic choice.

In response, the patient’s father again rejects the patient’s choice of premade medicine. He does so by offering a candidate solution to the practical problem proposed by the patient at line 9. He proposes that they make the medicinal soup in the hospital pharmacy instead of at home. Since the problem raised by the patient can be solved by
the father’s plan, the patient’s account for choosing premade medicine is no longer valid.

The father’s proposal implicates the doctor as well, given that she is the one who needs to write the prescription if the patient needs the pharmacy-prepared medicinal soup.

Note that here the father produces a proposal for a joint future action (see Tomasello, 2008 p. 72) that involves all three parties in the consultation. He uses the pronoun “we” to speak on behalf of the patient by including her with himself in a collectivity (Lerner, 1993), making a decision on the patient’s behalf. The way that the patient’s father formulates his turn (line 9 Zher zuo. Zher ao (“We’ll make it here. We’ll decoct here’’)) conveys a high level of deontic authority (Stevanovic & Peräkylä, 2012). In formulating his turn this way, the patient’s father enacts being a parent who has the category bound right to make decisions for his children. However, the proposal for medicinal soup still needs to be accepted by the doctor, since she is the one making the ultimate treatment decision.

There is no uptake from either the doctor or the patient (gap at line 10). This may explain why the father in line 11 repeats his prior turn with slight lexical changes making it available for response again: >Zai zher ao<. Zai zher jian. (“>We’ll decoct it here. < Boil it here’’). This time he also shifts his eye gaze towards the doctor, selecting her as the recipient, possibly in an effort to pursue a response from her. Note that jian (boil) and ao (decoct) are two verbs that describe the same kind of action. However, compared to
“boil”, “decoct” requires more time and effort. By replacing “decoct” with “boil”, the father orients to the practicalities of making medicinal soup at the hospital’s pharmacy and the fact that it may be a “lesser” choice compared to medicinal soup that is decocted. This lexical change, along with the eye gaze shift, may be understood as another attempt from the father to pursue acceptance from the doctor.

However, the father’s second attempt to pursue acceptance still receives no response (gap at line 12) from the other interactants. In the ensuing lines, the patient’s father accounts for choosing the medicinal soup over the premade medicine (lines 13 & 14):

012 (1.2)
013 FAT: Neige tangyang shihe. zai- you
That medicinal soup suitable. also- also
The medicinal soup is more suitable. Aso- also

014 zhide kuai.
treat fast
it treats (the condition) faster.

The father presents two accounts for choosing the medicinal soup: first it is more suitable for the patient’s condition; second, it offers quick relief for the patient’s ailment. In producing these accounts, the father strengthens his case for choosing the medicinal soup, offering another opportunity for the other parties to accept his suggestion.

The father’s claims are once again met with a long silence (the long gap at line 15, 4.4 seconds). Since his request for the medicinal soup is not addressed to anyone specific, the lack of uptake may indicate dispreferred responses from both the patient and the doctor. At line 16, the doctor asks a follow-up question about the patient’s mother’s hospital stay Shui- laoniang zhu nar le (“Who- where is your mother staying at”). This question is addressed to the patient, as the person reference “your mother” indicates. In
response, the patient provides information on the location of the hospital that her mother is staying at, as well as the reason for her hospital stay (lines 18 to 20 (Ji dan). Yixianyan ("(Ji dan hospital). Pancreatitis").

016  DOC: Shui- laoniang zhu nar le.  
Who- mother lives where FP  
Who- where is your mother staying at.

017          (0.2)

018  PAT: Zhu neige-:  
Live that  
She’s staying at that-.

019          (0.2)

020  PAT: (Ji dan). Yixianyan.  
(NAME). Pancreatitis  
(Ji dan hospital). Pancreatitis.

021  DOC: En.  
Oh  
Oh.

022          (4.3)

This exchange is followed by another long gap (line 22, 4.3 seconds). So far, there has been no verbal or embodied responses from either the doctor or the patient to the patient’s father’s earlier proposal that they will choose medicinal soup as treatment and decoct the soup in the hospital pharmacy. At line 23, the father once again proposes that the patient choose the medicinal soup as her treatment: He tangyao dai- dai zher jian. Zai zher jian ("Take medicinal soup. (We) boil it here. boil it here"), creating another opportunity for the doctor (and the patient) to accept it.

Drink medicinal soup at- at here fry. At here fry  
Take medicinal soup. (We) boil it here. boil it here.

024          (2.8)

025  PAT: Zhei neng he neige:- (0.2) Huoxiangzhengqi ma.  
This can drink that- (0.2) NAME  
Can (I) drink that Huoxiangzhengqi for this?

026          (.)

027  DOC: Mnhmm:::. 
From the father’s multiple attempts to pursue a response, it is clear that he is persistent in pursing his course of action of deciding how the patient should take her medicine. However, as the following line (line 24, 2.8 second gap) shows, acceptance is not provided right away. Instead, the patient launches an inquiry about a particular type of premade TCM medicine, “HuoXiangZhengQi\textsuperscript{27}”. This turn may be understood as preliminary to requesting this specific type of medicine, which indicates that despite her father’s strong opposition, the patient still does not acquiesce to his demand. The doctor does not respond to the patient’s inquiry explicitly. She produces an information receipt “Mmhm::”(line 27), then goes on to announce her (partial) treatment plan at line 29: \textit{Zai lai yidianr (.) chengyao ba (“(I’ll) also prescribe a little (.) premade medicine okay”)}

The doctor’s turn is prefaced with “also” which indicates that the premade medicine that she is prescribing for the patient is an addition to the treatment plan. Since medicinal soup and premade TCM are the only two available options, the doctor’s turn here leaves available for inference that medicinal soup is also part of the treatment plan. Hence, the doctor’s announcement of treatment is hearable as accepting both the patient’s and the father’s treatment requests.

The patient’s father, upon hearing the doctor’s announcement, immediately responds with agreement tokens (line 30, Ei. Dui (“Yeah, right”)), indicating that he agrees with the doctor’s treatment recommendation. In lines 32 to 34, after writing down

\textsuperscript{27}HuoXiangZhengQi is a widely used, over the counter premade TCM medicine. It is used to treat many different TCM conditions, resolve the exterior and transform dampness, rectify Qi and harmonize the center.
the prescription, the doctor provides details of her prescribed treatment for the patient, including the quantity of the medicinal soup packets (line 32 *Dou gei ni kai san fu a* (“I will prescribe three packets of each (medicine) okay”)); and the method of preparing the medicine (line 34, *Zai gei ni dai jian a* (“I will also (ask the pharmacy to) boil for you”)).

Note that up to this point, the doctor has not provided any verbal response to the patient’s father. Other cases of companion participation I have shown in this section all involve more active participation from the companion, in which the doctor responds to or addresses the companion in different ways. However, the doctor’s turns addressed to the patient (lines 29, 32 and 34) show that she has been paying attention to what the father was saying. She acquiesces to the father’s request by offering a compromised solution. Since the patient and her father do not agree with each other regarding the treatment options, the doctor proposes a middle ground by also accommodating the patient’s need and prescribing her some premade TCM medicine in addition to the medicinal soup.
This extract shows that the patient’s companion may invoke their membership in a relationship category to participate in the shared decision-making process. In this sense, they are not supporting the patient, but rather, acting on the patient’s behalf. In this case, the doctor needs to manage with whom to side. In this extract, the doctor found a middle ground by catering to the needs of both parties (prescribing two different kinds of medication) and avoid explicitly aligning with either party.

**Conclusions and Implications**

**Summary of Findings**

In this chapter, I have explored patient companion participation in the context of TCM encounters. Two types of companion participation have been identified. In the first type, the patient’s companions are recruited by the doctor to join the medical consultation. Solicited companion participation predominantly occurs after the patient has displayed resistance towards the doctor’s diagnostic evaluation and/or treatment recommendation. The companions are enlisted by the doctor to accomplish different tasks, such as to help implement the lifestyle change that the doctor has recommended (Extracts 25 & 26), or to serve as a witness to the patient’s clinical manifestation (Extract 1). In getting the patient’s companions involved in the patient’s medical visit, the doctor makes the relationship category that the companion belongs to salient, invoking the category-bound rights and obligations. For example, in Extracts 25 and 26, the doctor makes relevant the companion’s category-bound obligations of preparing meals for the family (Extract 25) and helping the patient to live a healthier life (Extract 25 and 26). In cases of solicited companion participation, the patient’s companions are deployed by the
doctor to offset or address patient resistance, to make sure that the medical agenda can move forward.

Voluntary companion participation may not always be in the service of solving the patients’ presenting concern, but rather, vehicles for the companions to implement other social actions. Patients’ companions may voluntarily join the patient’s consultation to offer medically relevant information to the doctor. Although these reports of information are formulated as relevant to the ongoing diagnostic activity, they may sometimes function as a way for companions to pursue their own agenda, such as pushing the patient to change their unhealthy life habits (Extracts 27 & 28). In response to the companions’ spontaneous participation, the doctors may align with the companion and convince the patient to change their health-related behavior (Extract 28), or side with the patient and treats the information offered by the companions as less relevant (Extract 27). These findings show how flexible and fluid relationship categories are in the institutional setting. Category-bound rights and obligations are frequently intertwined with context-specific institutional tasks and goals.

Additionally, the last case in this chapter shows another way that voluntary companion participation may unfold. In Extract 29, the patient’s father participates to make decisions for his adult child, and in so doing, enacts being a father by fulfilling his category-bound right of speaking for his child. This extract shows how voluntary companion participation may also be used by companions to invoke their membership in a particular relationship category and in so doing, participate in the decision-making process.

Implications
Past research on companion participation put a lot of emphasis on the supportive role that patient’s companions play in triadic (or tetradic) interaction. Cases in this chapter show that companions’ participation in the context of TCM visits goes beyond simply offering assistance and support for the patient. Findings from this chapter have implications for the following areas of research: first, although patient resistance has received meaningful scholarly attention (Koenig, 2011; Stivers, 2005, 2007), most studies focus primarily on the patients’ ways of displaying resistance. This chapter, however, offers some insight into the doctors’ responses to patient resistance by describing one of the practices that doctors may use to address patient resistance. This adds to our current understanding of how doctors respond to patient resistance to make sure that the medical agenda moves forward.

Findings from this chapter also shed light on the body of research on membership categorization (Sacks, 1992; Schegloff, 2007; Stokoe, 2012; Whitehead, 2009; 2020) and collectivities (Kangasharju, 1996; Lerner, 1993). As shown by the cases discussed here, in the face of patient resistance to diagnosis/treatment recommendation, TCM doctors may deploy relationship categories in the service of facilitating the medical agenda and obtaining institutional goals. They make the companions’ category-bound rights and obligations salient when trying to get the patients’ companions involved in the patients’ medical visits. This shows the complicated, intertwined relationship between the relational dimension and the institutional dimension of interaction.

Finally, discoveries in this chapter expand current literature on companions’ participation in medical visits. As discussed at the beginning of the chapter, the scope of research on companion participation needs to be further expanded. Most studies focus on
specific medical contexts, such as geriatric visits, pediatric visits, and oncological visits (Ishikawa et. al., 2005; Stivers, 2005; Street & Gordon, 2008). The current study examines companion participation in the context of complementary and alternative medicine, a setting that is currently underexplored. Studies on companion participation have found that active companion participation may have a positive impact on the patient’s medical consultation by increasing patient satisfaction and encouraging shared decision making (Hobbs et al., 2015; Wolff & Roter, 2011). Findings from this chapter reveal that within the context of TCM visits, companion participation generates more opportunities for doctors to explain their medical decisions and offer medically relevant information. However, as the last case in this chapter demonstrates, with the patient’s companion participating in the decision-making process, the patient’s voice may be weakened.
CHAPTER SEVEN
CONCLUSIONS

This dissertation examined medical interactions in the TCM context from a conversation analytic perspective, focusing on three different interactional phenomena in TCM encounters: their opening sequences, bystander participation, and companion involvement. There are three parts to this chapter. First, I summarize the major findings of the dissertation. Next, I discuss how these findings contribute to our understanding of various topics in the realms of patient-provider communication and conversation analysis. Finally, I outline some of the limitations of this dissertation, and propose several lines of future research to advance our understanding of medical interactions in TCM visits.

Summary of Findings

In this dissertation, I focused on three different aspects of TCM visits. In the first analytic chapter (Chapter 4), I examined the interactional organization of the opening sequences. Four components of TCM opening sequences were outlined: initiating TCM encounters; securing patient identity; beginning pulse-taking and launching medical talk. By examining each component, I showed how they are implemented to accomplish different institutional and interactional tasks that are preliminary to dealing with the official medical business of health maintenance.

In the first component of TCM encounter openings, doctors and patients establish copresence and “ready” themselves for the upcoming consultation. Since most patients
are already in the doctor’s office, establishing copresence involves patients walking towards the doctor’s desk and sitting down in the patient’s chair.

The second component of securing patient identity involves doctors checking patients’ names, registration numbers and insurance information. In TCM hospitals, insurance information is managed by the doctors. In cases where the patient is using some else’s insurance, doctors need to make sure that they are billing the right insurance. Since patients are seen according to the order of the patient registration queue, doctors also need to check patients’ registration numbers to make sure that they are seeing the right patient.

The third component, initiating pulse-taking, is unique to TCM visits. Pulse-taking is predominantly the first medically relevant activity in most TCM encounters. Patients frequently engage in actions that ready themselves for pulse-taking, such as putting their wrists on the pulse-pillow as they are sitting down in the patient’s chair, or immediately after they are seated. The beginning of pulse-taking also marks the successful transition from the opening sequence to activities that are medically relevant.

The fourth component discussed in Chapter 4 is launching medical talk. Although medical talk can be initiated by both parties, TCM patients treat the first opportunity to initiate a medical topic as belonging to doctors. There are different types of medical topics that may be invoked at the beginning of a TCM visit. Doctors may solicit patients’ new medical problems, ask patients a routine evaluative question or request that patients provide an update on their past/chronic conditions. Similarly, when patients launch medical talk, they may present a newly emerged medical concern, or report on a problem they presented in their prior visits.
In the second analytic chapter (Chapter 5), I examined the *sui generis* phenomenon of bystander participation in TCM encounters. Findings from this chapter reveal that a bystander (Goffman, 1981) may get involved in another patient’s medical consultation after being enlisted by the doctor, or in a spontaneous fashion, without being prompted in any way. Frequently this occurs in the environment of patient resistance to doctors’ diagnosis or treatment recommendations. When a bystander is involved in another patient’s visit, they may enact different roles and help accomplish different interactional tasks. Some of these roles are passive, such as serving as a contrastive, healthy candidate to demonstrate what is visibly wrong with the patient, or as a recovered fellow patient whose condition testifies to the effectiveness of the doctor’s treatment regimen. Other roles require active participation from bystanders. For instance, a bystander may be enlisted by the doctor as a lay witness to the patient’s clinical manifestations. In that case, the bystander may cooperate with the doctor and acknowledge the existence of the patient’s clinical signs. Bystander participation primarily occurs in response to patient resistance. When the bystanders are involved in patients’ visit, they act predominantly in support of doctors’ courses of action, such as diagnosis delivery, lifestyle advice and treatment recommendations. However, there are rare cases where the bystanders participate to challenge and counter the doctors’ medical opinions, in the service of expressing their own concerns.

In the last analytic chapter (Chapter 6), I explored communication situations in which patients’ companions get involved in patients’ medical consultations. Cases of companion participation and cases of bystander participation (Chapter 5) share some common features. For example, in terms of the interactional environment, both
companion and bystander participation are likely to be occasioned by patient resistance. Also, similar to bystander participation, companion participation may be solicited or voluntary. However, companion participation also has a relational dimension to it, which does not apply to bystander participation. That is, patients’ companions’ membership in certain relationship categories becomes relevant and consequential for the interactants as companion participation unfolds. For example, a companion may be recruited by the doctor to help facilitate a dietary change by cooking a specific food item regularly. In doing so, the doctor treats the companion as the food preparer of the family, and thus, invokes the companion’s membership in the spouse category by requesting that the companion fulfill their category-bound obligations. In cases where companions voluntarily participate in the patients’ consultation, companions may offer medically relevant information in the service of helping doctors diagnose and treat patients’ problems, or they may use these reports as Trojan horses – vehicles to implement other social actions, such as complaining about their spouses’ unhealthy lifestyle choices. I also showed a case in which the companion enacts being the patient’s parent by invoking their category-bound right to make decisions on the patient’s behalf.

Implications

The findings of this dissertation have implications for our understanding of how medical interactions are organized in the context of TCM. Since TCM encounters are predominantly chronic in nature, this dissertation provides insight into how opening sequences in chronic care visits are interactionally organized. Next, I discuss the implications of my findings for patient-provider communication, membership categories
and category-bound activities, communication in TCM encounters, and practical implications for TCM practitioners and patients.

**Patient-provider Interaction**

First, this dissertation has implications for patient-provider interaction and therefore for medical communication. The three analytical chapters (Chapter 4, Chapter 5 & Chapter 6) focus on different aspects of patient-provider interaction, offering an emic, interactionally sensitive analysis. These aspects include a) the structural organization of the medical encounter; b) patient participation and patient resistance and c) triadic medical interaction. Next, I discuss each of these aspects.

**The Structural Organization of Medical Encounters**

In Chapter 4, I examined the opening sequences of TCM visits. Prior research on openings has demonstrated that during conversational openings, interactants establish co-presence (Robinson, 1998; Pillet-Shore, 2018), determine the goal of the encounter (Schegloff, 1986) and navigate through social relationships (Pillet-Shore, 2008). Findings of Chapter 4 reveal the orderliness of opening sequences in TCM consultations by outlining the core activities in the opening phase. In line with Robinson’s (1998) findings, I show that in the opening sequences of TCM visits, doctors and patients collaboratively achieve interactional tasks that are preparatory to dealing with the official medical business of maintaining the patients’ health. Each activity in the opening sequence is implemented to accomplish a specific task. Some of the tasks are seen across different medical contexts, such as securing patient identity; while others are specific to the TCM context, such as the initiation of pulse-taking, which doctors and patients treat as the official beginning of the
data-gathering activity. Despite these differences, findings from this dissertation demonstrate that opening sequences are not socioemotional moments of interaction, but rather, are predominantly task-oriented (Robinson, 1999).

Also, as argued by Robinson (2003), medical visits are organized into a set of activities that revolves around the therapeutic goal of the visit. In the case of acute care visit, the goal is to solve the patients’ presenting concern. All the phases and activities (data gathering, diagnosis delivery, treatment recommendation etc.) are implemented to accomplish this interactional project. TCM visits, on the other hand, are predominantly chronic in nature. Patients visit the doctors’ offices routinely for health maintenance purposes, meaning that they do not have to account for their visits by presenting a doctorable problem (Heritage & Robinson, 2006). Hence, some of the activities that take place in TCM visits are organized and carried out differently. For example, while in acute care visits, doctors normally initiate the consultation by soliciting the patients’ presenting concerns (Robinson, 2006), the health-related business of TCM encounters, on the other hand, may be initiated by either the doctor or the patient. Instead of focusing on patients’ presenting problem, TCM doctors may ask routine medical questions or solicit updates on patients’ past conditions. These discoveries shed light on the important, underexplored question of how chronic care visits are interactionally organized.

**Patient Participation and Resistance.** Findings from this dissertation also have implications for two important topics in the realm of patient-provider interaction: patient participation and patient resistance. How patients can be engaged to participate in the medical consultation has received meaningful scholarly attention from researchers in different fields of study (Beisecker & Beisecker, 1990; Bennett, Smith, & Irwin, 1999;
Findings from Chapters 5 & 6 of this dissertation show that patients in TCM encounters frequently voice their concerns, solicit information, or challenge doctors’ medical opinions. There are different interactional features of TCM consultations that may enable this. First, the epistemic gradient (Heritage, 2012) between doctors and patients is relatively flat in TCM, which is closely related to how accessible TCM theories are. Many patients challenge doctors’ medical opinions based on their own knowledge of the basic principles of TCM. Second, TCM diagnoses are based on opaque diagnostic methods. TCM is experience-based, rather than evidence-based (Li & Zhang, 2013). While physicians in Western Medicine can present scientific evidence such as medical images or test results to their patients, it is more difficult for TCM doctors to explain how they gather information about patients’ health status from taking the patients’ pulse, looking at the patients’ tongues and observing their appearance. As a result, TCM patients frequently participate in the consultation to express their skepticism about doctors’ diagnostic claims or to solicit more information from doctors regarding their medical evaluations. Third, TCM doctors frequently engage in extensive case-building to convince patients to accept their diagnoses and/or treatment recommendations. This is not commonly observed in acute care visits, as previous studies report (Ijäs-Kallio, Ruusuvuori & Peräkylä, 2011; Peräkylä, 1998; 2001). Also shown in the analysis in Chapter 4, 5 and 6, these case-buildings generate more opportunities for the patients to participate in the consultations to present concerns, ask questions and display resistance.
This dissertation also explores in detail one form of patient participation: patient resistance. The concept of patient resistance used in this dissertation is from Stivers’ (2005, 2007) studies of treatment negotiation between patients and doctors in pediatric visits. In Chapter 5 and Chapter 6, I identified practices of patient resistance that are consistent with Stivers’ findings, such as minimal responses, newsmarks and explicit challenges (Stivers, 2007). I also observed some differences. Patient resistance in TCM encounters is likely to be more persistent, generating long sequences of talk. As pointed out by Koenig (2011), patient resistance is not necessarily obstructive, but rather, may be a way for patients to exert agency by participating in the treatment decision-making process. My findings show that this is indeed the case – patients use their resistance to solicit more medically relevant information from the doctors and to negotiate treatment options, and in that way, exert some control over the outcomes of their consultations. Additionally, since current studies on patient resistance focus predominantly on the shared decision-making process in treatment recommendations (Mikesell et al., 2016; Stivers, 2005; 2007; Koenig, 2011), this dissertation extends this line of research by expanding the scope of the medical activities currently under examination to include diagnosis deliveries in the TCM setting.

**Triadic Medical Interaction**

Findings from this study also have implications for our understanding of triadic medical interaction. There has been an extensive body of research on triadic medical interaction, but this work focuses mainly on patients’ companions’ involvement in medical consultations (Cahill & Papageorgiou, 2007; Greene & Adelman, 2013; Laidsaar-Powell et al., 2013). Findings from Chapter 6 explore companion participation in a different medical culture and reveal that companions may be recruited by the doctors to participate
in patients’ medical consultations as a way of addressing and offsetting patient resistance. This discovery connects two different concepts (companion participation and patient resistance) in patient-provider interaction and sheds light on the interactional environments in which companion participation occurs in TCM encounters. Past research on companion participation sees patients’ companions as “helpers” who provide assistance and support to patients. However, findings from this dissertation show that this is not always the case. Companions may contest patients’ courses of action and pursue their own interactional projects. Additionally, findings from Chapter 6 offer insight into our understanding of the relational dimension of companion participation. By looking at cases of companion participation in TCM, I show how relationship categories, such as the spousal and parental categories are made relevant and consequential for interactants during companion participation. TCM doctors frequently involve the patients’ companions in the ongoing consultation by invoking their category-bound rights and obligations. For example, as shown in Chapter 6, TCM doctors may recruit patients’ spouses to help implement a recommended lifestyle change, and thus make relevant the companions’ category-bound obligation to take care of the patients’ health.

In addition to examining companion participation in a different medical context, this dissertation adds to the current body of literature on triadic medical interaction by examining a *sui generis* form of triadic medical interaction – medical consultations that involve a bystander who is unacquainted with the patient. This interactional phenomenon may be unique to TCM encounters because of the physical environment in which they take place. Findings from Chapter 5 show that in many ways, bystander participation is similar to companion participation. However, there are also differences between these two forms.
of third-party participation since bystanders are not categorically obligated to assist patients. Cases of bystander participation offer us an opportunity to look at situations that are contrastive to companion participation by showing how third-party-involvement may unfold differently when the participating third parties are not related to the patients.

Past research studies on companion participation predominantly hold a positive view of companion participation. As findings from Chapter 6 indicate, in addition to offering support to patients, patients’ companions may pursue their own interactional projects. For example, companions may produce reports of information that purport to be relevant to the current health-related discussion but are actually complaints about unrelated conduct. In this way, some of their contributions may function as Trojan horses: although they are formulated as relevant to the ongoing consultation, they may in fact be vehicles deployed to pursue their own interactional agendas. This finding reveals that companion participation may not always be in the service of the patients’ consultations, and that more research is needed to further explore the interactional outcomes of companion participation.

**Membership Categories and Category-Bound Activities**

My findings have implications for exploring membership categories and category-bound activities (Schegloff, 2007) and how they are deployed in the TCM context. Both Chapters 5 and 6 examine how a third party gets involved in patients’ ongoing consultation. In Chapter 5, third parties were bystanders unrelated to the patients, so in the face of patient resistance, doctors deployed them (or they deployed themselves) to achieve different tasks in order to build a stronger case for their diagnostic claims and/or treatment recommendations. Bystanders’ participation was deployed mostly in support of the doctors’ courses of actions. Cases from Chapter 6, on the other hand, showed that companion
participation may unfold in a different way because of companions’ membership in particular relational categories. This is manifested in the following aspects: first, instead of enlisting companions as “tools” to offset or address patient resistance, doctors displayed a clear orientation to companions’ membership in certain relationship categories when they tried to get them involved in patients’ visits. Second, when patients’ companions inserted themselves into the consultations, they also treated their relationships to the patients as relevant and consequential. As shown in Chapter 6, patients’ companions volunteered information about patients’ lifestyle habits and in so doing in some cases fulfilled their category-bound obligations of attending to patients’ health. In some cases, companions faced conflicting sets of rights and obligations, and needed to pick sides or navigate the tension between assisting doctors or supporting patients. Butler and Wilkinson (2013) showed that two different types of membership categories, social structural categories (such as spouse) and contextually bound categories (such as patient-provider) may be intertwined in some interactional settings. In this dissertation, I have shown how interactants orient to both types of membership categories when they are organizing social actions.

In summary, in the cases of companion participation, category memberships and relationships were not only invoked but also generated in the sequential production of social actions. Membership categories became operative as companion participation unfolded.

**Communication in TCM**
My findings also have implications for patient-provider interaction in TCM. As discussed in Chapter 1 (Introduction) and Chapter 2 (Literature Review), although there have been studies of doctors’ and patients’ interactions in TCM consultations and other forms of CAM, these studies were overwhelmingly conducted in the Western biomedical setting. They have explored situations in which biomedical doctors discuss TCM as an alternative treatment option with their patients. Very few research studies were situated in the TCM context and examined the interactional dynamics between TCM doctors and patients in actual TCM encounters. Findings of this dissertation fill this gap by revealing how TCM encounters are organized on a turn-by-turn, moment-by-moment basis. Specifically, this dissertation contributes to our understanding of TCM encounters by showing how TCM doctors and patients produce and understand actions within the context of TCM by examining the following aspects of TCM consultations: how TCM consultations are interactionally organized (Chapter 4); how TCM doctors and patients negotiate diagnosis and treatment options (Chapters 5 & 6); and finally, how interactants in TCM encounters orient to relationship categories and category-bound activities in this medical setting (Chapter 6). All of these topics are uncharted territories that have yet to be fully examined and understood by researchers. Discoveries made in this dissertation shed some light on how the context of TCM is talked into being.

**Practical Implications for TCM Patients and Doctors**

This dissertation has many practical implications for people who routinely practice and use TCM. First, findings from the first analytical chapter (Chapter 4) reveal the seen but unnoticed orderliness of openings in TCM consultations. Identifying the core medical activities of openings may help TCM doctors and patients get into positions faster and
collaboratively achieve the bureaucratic tasks in a more efficient fashion. Findings from Chapter 5 and Chapter 6 have useful implications for doctors in terms of how to address patient resistance, and how and when to get patients involved in the diagnostic reasoning decision making process. As the data extracts show, doctors’ extensive case-building and efforts to explain their diagnoses to the patient generate opportunities for the patients to participate in the consultation, to express concerns, present problems, ask questions and to challenge the doctors’ medical evaluations. This finding is in line with Peräkylä’s (2001) argument that expanded diagnosis delivery sequences elicit more patient responses than diagnosis that is formulated as a plain assertion. This is a potentially useful implication not only for communication in TCM, but also for other types of medical interactions since it offers the doctors a way to increase patient involvement.

Findings from Chapters 5 and 6 also have practical implications for our understanding of patient resistance. As shown by the data extracts in these two chapters, the doctor seems to treat patient resistance as obstructive, but it can be seen instead as an opportunity for patients to engage more actively in the consultation. How to address patient resistance in a productive way then becomes an important question for medical practitioners. Chapters 5 and 6 shed some light on this matter, by showing how a third party may be utilized by the doctor to facilitate the medical agenda and address patient resistance.

Limitations

This dissertation has three limitations. First, there are limitations to the quality of data collected for this dissertation project; second, there are limitations to the translation
and transcription of data extracts. Third, there are limitations to the quantity of data collected for this dissertation. I discuss each of these limitations.

First, the data corpus that this dissertation draws upon is not of optimal quality. There are two parts to the data collection: ethnographic notes and video recordings. Although I tried to gather demographic information from all participants while taking the ethnographic notes, some of participants were reluctant to share information such as their age, occupation, or primary medical concerns. The note-taking was sporadic at times, given that the data collecting activity was sometimes disrupted by the busy physical environment of Chinese hospitals.

In terms of video recordings, there are some obvious flaws as well. First, per the participants’ request, there was only one small camera placed in the doctor’s office (usually on the doctor’s desk). My request to install multiple cameras was rejected by the doctors and the hospital officials on the basis of not wanting to make the patients feel uneasy. Hence, many videos in my data collection have a limited view of the doctor’s desk. This makes analyzing the openings sequences (Chapter 1) challenging since many of the patients’ embodied actions occurred outside of the camera view. Also, although the patients agreed to be video-recorded, some did not want to show their whole face. Hence, some of the videos only have the bottom half of the patients’ faces, which made analyzing the patients’ eye gaze difficult. Additionally, since the video camera was placed on the doctor’s desk, the patients’ belongings also occasionally blocked the view of the camera. In that case, I was unable to analyze the embodied actions in those recordings.

Second, the data transcription process could be improved to include more interactional details. Although the three-line transcription system discussed in Chapter 3
allowed me to capture most linguistic features, some important elements of Mandarin Chinese were not comprehensively documented. For example, a lot of actions in Mandarin Chinese are implemented by particles, rather than intonation contours (Kendrick, 2010; 2018; Wu, 2004). The notations that I used to represent Chinese particles (e.g., P (particles); FP (final particles); Q (question particles) do not fully capture the linguistic functions of these particles, which may have made the analytical evidence less transparent. Additionally, when translating the actual utterances into English, the grammatical structures of some of the utterances were slightly modified. These issues with translation and transcription raise interesting questions about the “Unique Adequacy Requirement” proposed by Garfinkel, given that by translating and transcribing the data segments, I have used standards, concepts or theories that are not already a part of that setting (Garfinkel & Weider, 1992). Therefore, I was not completely “ethnomethodologically indifferent” in the analytical process (Garfinkel & Sacks, 1970, p 345).

Third, the data corpus could be further expanded to include more participants and other institutional settings. Two TCM practitioners participated in this research project. Future research could include more TCM doctors to corroborate the pervasiveness of the phenomena that I have discussed. Also, both research sites are hospitals in which both TCM and Western medicine are practiced (hence we saw the doctors and patients refer to medical procedures that are specific to Western medicine, such as medical images and medical tests). It would be useful to also examine TCM consultations that occur in small, privately owned clinics where only TCM is practiced. Also, since TCM patients visit the doctors routinely, obtaining longitudinal data would provide more insight into the management of chronic care visits.
Future Directions

Although this dissertation has offered some insight into the interactional organization of TCM encounters, there are many aspects of communication in TCM that need further investigation.

First, future research could examine what happens after the opening sequence. For example, how do doctors collect medically relevant data by utilizing the four diagnostic methods? How do doctors recommend treatment options to the patients? How do doctors and patients collaboratively close medical encounters? Although there were some discussions of these topics in the analytical chapters, more thorough and systematic analysis is needed to understand how these activities are interactionally organized, and how doctors and patients achieve a smooth transition from one activity to the next.

Second, this dissertation has reported some discernible patterns in the ways that patients display their resistance towards the doctors’ medical opinions. Patient resistance in the TCM context needs to be explored further. A collection of cases of patient resistance needs to be established to answer the important question of “why that now?” (Schegloff & Sacks, 1973). Also, findings from this dissertation showed only one way for doctors to respond to patient resistance, getting a third party involved in the consultation. Future research should identify other practices that doctors deploy to address patient resistance and move the consultation forward.

Third, this dissertation examined cases of multi-party interactions, but did not focus specifically on such interactional technicalities as the practices that doctors deploy to recruit third parties into the interactions, or the practices that third parties use to insert themselves into the consultations. Future work could examine the issues of turn-taking and
turn-allocation in triadic (or larger) TCM visits. Prior research has outlined some of the practices that interactants use to negotiate turn-taking in a multi-party environment (Bolden, 2009; Lerner, 2019). It might be useful to see whether or not the same practices are used by doctors and patients in TCM consultations. The data segments in my collection provide a productive site to further explore multi-party interactions since most TCM consultations involve at least three parties.

This dissertation has explored TCM consultations through the lens of conversation analysis. Findings have revealed three different aspects of provider-patient interactions in TCM encounters: the opening sequence, bystander participation and companion involvement. Overall, this dissertation has furthered our understanding of communication in TCM. Since TCM encounters are chronic in nature, my findings may offer some unique perspective on the interactional construction of chronic care visits, where the main therapeutic goal for the doctors and patients is to manage the patients’ chronic conditions or maintain the patients’ health statuses. For example, the first medically relevant topics introduced at the beginning of TCM visits are not limited to questions about the patient’s presenting problem.

Findings from this dissertation further our understanding of TCM interactions and enable an exploration of the distinctive interactional practices that TCM doctors and patients use to collaboratively achieve their therapeutic goal. As the predominant branch of CAM, TCM has evolved over thousands of years and attracted followers all over the world. Understanding the communicative processes within TCM encounters may help us obtain a better understanding of the culture of TCM, and the unique social and medical concerns that TCM doctors and patients may have.
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Appendix A: Transcription Conventions

**Jefferson Transcription System**

[ ]  simultaneous or overlapping speech or nonvocal conduct

=  no interval between utterances

(0.2)  timed silences in seconds

(.)  micropause

word  stressed sound

word  prolonged sound

wo-  cut-off sound

word.  falling intonation

word,  continuing intonation

word?  rising intonation
word: somewhat rising intonation
°word° quieter than surrounding talk
↑↓ markedly higher/lower pitch
>word< quicker speech
<word> slowed speech
.hh hearable inhalation
hh hearable exhalation
wo(h)rd interspersed laugh tokens
(word) uncertain hearing
( ) undistinguishable hearting
((looks)) transcriber’s comments and descriptions of nonvocal conduct
| 28 continuous embodied conduct over several turns
{looks} 29 interaction details based on ethnographic notes
Word 30 doctor lays finger on the patient’s wrist
Word 31 doctor/patient delivers medical talk

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28 Note: this is not a Jeffersonian transcript symbol, but has been adopted by the researcher
29 Note: this is not a Jeffersonian transcript symbol, but has been adopted by the researcher
30 Note: this is not a Jeffersonian transcript symbol, but has been adopted by the researcher
31 Note: this is not a Jeffersonian transcript symbol, but has been adopted by the researcher