**When do patients exercise their right to refuse treatment?   
A conversation analytic study of decision-making trajectories in UK neurology outpatient consultations**

ABSTRACT

Using conversation analysis, this paper investigates when patients exercise their right to refuse treatment in neurology outpatient consultations recorded in the UK’s National Health Service in 2012 (n=224). NHS patients have a *right* to refuse treatment. However, there are good reasons to suppose that this may be difficult to exercise in practice. We know that clinicians tend to pursue acceptance if it’s not forthcoming and those studies that have tracked decision-making trajectories through to their outcomes have shown that clinicians typically convert resistance to acceptance. By contrast, I show that, in 35/40 (87.5%) cases in which patients sought to refuse treatments made available by a neurologist, they left without a prescription or referral. This paper seeks to explain this apparently anomalous finding. Starting with an example of what I expected to find – a ‘duel’ that ends with the neurologist persuading the patient to accept treatment – I show that this is, in fact, the exception. By contrast, most of the (attempted) refusals are collaborative, occurring after the neurologist has initiated decision-making in a way that designedly foregrounds the patients’ views as the basis for deciding. I show also that, having done so, the neurologists typically continue to treat the decision as subject to the patient’s preferences. Thus, the trajectories in my collection – despite including attempts to refuse treatment – do not typically become duels. Rather, patients are refusing treatment in a sequential context that *facilitates* making their own decision.

KEYWORDS: active resistance; conversation analysis; neurology; offers; treatment recommendations; treatment refusal

Highlights

* Enacting the right to refuse treatment can be difficult
* Surprisingly, most attempted treatment refusals were successful
* Refusals were mostly made when clinicians explicitly invited patients’ views
* Clinicians usually did not try to persuade patients if they’d sought their views
* Clinicians appear to be balancing patient choice with their duty of care

*“You have the right to accept or refuse treatment that is offered to you”*   
(the NHS Constitution for England, 2021)

INTRODUCTION

Patients have *the right* to refuse treatment – even when it is deemed to be in their best interests *–* in most healthcare settings across the globe. However, there is good reason to suppose that it may not be easy to exercise this right in practice. Patient refusals are not done from a level playing field. Despite widespread emphasis on the value of ‘shared decision-making’ and ‘patient-centered care’, clinicians remain in a position of authority, founded on their medical expertise and right to prescribe (Pilnick and Dingwall, 2011). To resist a treatment recommendation is to go against an expert’s view of what is best, medically. This is particularly challenging given that clinicians’ expertise is precisely what patients are seeking when they attend the clinic; to refuse a proffered treatment is thus to risk violating a basic responsibility of the sick role: to try to get better (Parsons, 1951). Moreover, we know that patient resistance typically engenders sequence expansion. As Stivers and Timmermans (2020) note: “clinicians do not simply cave in response to patients’ preferences” (p. 61) – they pursue acceptance (and see Kushida, Kawashima and Abe, this issue). Thus, exercising the right to refuse treatment may take sustained effort. Given these potential challenges, this paper asks: *when do patients exercise their right to refuse treatment, within the consultation?* Of course, patients have the final say beyond the consulting room. But despite long-standing interest in how clinicians and patients may ‘duel’ in the clinic, we know almost nothing about when patients leave without a prescription or referral that was made available by the clinician. My focus is thus on the *interactional accomplishment* of refusal within the medical encounter.

BACKGROUND

Prior conversation analytic literature on treatment decision-making has shown how patients influence the outcome. This is often accomplished through subtle practices. Minimal responses can accomplish resistance because clinicians treat acceptance as necessary for closure of decision-making; in pursuing acceptance, the clinician may make concessions or change the recommendation (Kushida, Kawashima and Abe, this issue), sometimes prescribing inappropriately (Koenig, 2011; Stivers, 2005a; Wang and Liu, this issue). Patients (or their caregivers) may also resist recommendations actively (e.g. Lindström and Weatherall, 2015; Stivers, 2005b) or pressure clinicians for a preferred treatment (Stivers, 2002). Reciprocally, clinicians seek to influence patients’ decisions. They too may engage in subtle practices, seeking to ward off resistance before it materialises. The *design* of treatment recommendations is particularly important. For instance, Stivers (2005) showed that recommendations *for* a non-antibiotic treatment are less likely to be resisted than recommendations *against* antibiotics; and Clark and Hudak (2011) showed how surgeons design recommendations against surgery in ways that seek to counter likely expectations for surgery. Clinicians have been found also to apply overt pressure for their preferred treatment option (e.g. Quirk et al*.*,2012; Tate, 2020).

Despite the intense interest in treatment negotiations, we know little about the outcome by the end of interactions in which resistance occurs. Three studies, in paediatrics, provide valuable insights, pointing to the importance of *clinician pursuit* of acceptance. In paediatric neurology in the US, Stivers and Timmermans (2020) found that clinicians’ persuasive practices were typically successful, converting resistance to acceptance in 37/39 cases. This sometimes involved ‘accommodating’ the parent’s concerns by modifying the recommendation, but this only occurred if the resistance was based on parents’ prior experience with the drug. Preference- or fear-based resistance was typically met with (successful) efforts to persuade. Similarly, Wang and Liu (this issue) found that clinicians successfully stood their ground in over 80% of 174 cases of active resistance to paediatric treatment recommendations in China. Again, clinician pursuit was essential in derailing the resistance. In the context of childhood vaccination decisions in the US, Opel et al*.* (2015) found a lower level of acceptance: overall, 64% of parents agreed that all vaccines be given there and then. However, they were significantly more likely to do so if the clinician initiated with a ‘presumptive’ format (“Well, we have to do some shots”) than a ‘participatory’ one (e.g. “What do you want to do about shots?”) (p. e1). Again, clinician pursuit made a difference, mediating the effects of the participatory formats.

These studies show that parents *can* win when dueling with clinicians, but that they typically do not. In this study, I address an important gap in the literature, asking: when do adult patients exercise their right to refuse treatment on their own behalf? Based on the findings outlined above, together with the fact that there is good reason to assume that refusing treatment may be interactionally challenging (see Introduction), I began from the assumption that successful refusals would be uncommon – with success defined by the patient leaving without a prescription or referral proffered by the neurologist. In this paper, I show the opposite. Nearly 90% of my 40 cases of attempted refusal ended in the patient leaving without treatment. This paper seeks to explain this apparently anomalous finding.

DATA

The analysis reported here is based on data from a wider project on patient choice, funded by the UK’s National Institute for Health Research. We recorded 224 adult outpatient consultations, with 14 neurologists, in two major clinical neuroscience centers in the UK, between February and September 2012. Participants consented to audio or video-recording. Approvals were obtained from the appropriate NHS Research Ethics Committee and the participating hospitals’ Research and Development departments. More on our methods can be found in the project reports (Anonymous).

ANALYTIC METHODS

I used the qualitative methodology known as conversation analysis (CA), now widely advocated for investigating how medical interactions function in real time. CA understands talk as a means to perform social actions, focusing on actions in their sequential context. Thus, patient refusal may be understood as it is accomplished within the moment-by-moment decision-making trajectory – from initiation to closure.

The original project identified all neurologist-initiated decisions for a treatment, referral or investigation. In this paper, I narrowed my collection to treatment decisions requiring a prescription or referral by the neurologist. This gave a clear outcome measure for attempts to refuse (a prescription or referral was/was not provided) and maintained a focus on treatments about which the clinician might be presumed to know best. Note: UK Neurologists can prescribe directly but usually do so by writing to the patient’s General Practitioner (GP). This allows the GP to make adjustments to the dosage over time if needed, within limits set by the neurologist. Thus, decisions to ask the GP to prescribe are understood, within this study, as prescriptions by the neurologist.

I identified all cases in which patients responded – at some point across a trajectory initiated by the neurologist – with a turn that indicated a refusal (or attempted refusal) of a treatment that the neurologist had made available. Because my goal was to focus on how patients exercise their right to refuse treatment entirely, I excluded negotiations about *which* treatment might be prescribed, how a dose might be changed or whether to stop a treatment.

**FINDINGS**

**What I expected to find: a duel won by the neurologist**

Extracts 1a-c show the kind of trajectory I assumed would unfold if a patient sought to refuse treatment recommended by the neurologist. In this case, the patient’s sleep is severely affected by periodic limb movements, leaving her exhausted and with headaches. Previous treatments have failed and/or caused side effects. We join the consultation as the neurologist returns to a previous recommendation for an iron supplement (*l*.1-3, 6). His turn conveys a strong deontic force in that he treats the supplement as necessary based on his diagnostic findings. Positioned immediately after reports of ongoing and new/worsened symptoms (data not shown), the turn is hearable not only as seeking confirmation of whether the patient has started treatment, but as projecting a *redoing* of that recommendation if she has not (marked as RR, for ‘revisited recommendation’). From the start, it’s clear that the neurologist deems treatment to be medically advisable. The patient grants knowledge of the prior recommendation (“yeah”, line 4). However, it quickly becomes apparent that she has exercised her ultimate right to refuse treatment by not acquiring the prescription.

Extract 1a (S04803)

01 Neu: RR→ I wrote to the GP: in A:pril ((recorded in June))   
02 RR→ about your i:ron levels and said that you were   
03 RR→ sho:rt and needed some: (0.3) s[ome:

04 Pat: [**Yeah=he an’t**   
05 **been in touch** **#wi’ [me.#**

06 Neu: RR→ [i:ron.

07 (0.4)

08 Neu: Pur→ .tchh (0.5) Ri:ght, that was A:pril.

09 Pat: Mm:.

10 (0.2)

11 Neu: Pur→ I wrote to you: too.

12 (0.1)

13 Pat: **Yeah=but I- I- .hh >we haven’t-=I haven’t been**    
14 **able to** **leave the house ‘cos we’ve had<**

15 **cou:ncil in wo:rking. fo::r >for the last<**

16 **(0.2) well since A:pril,=haven’t we,**

17 (0.1)

18 Pat: **N[o: Ma::rch,**

19 Neu: [°Okay°

20 (0.3)

21 Oth: °March they started (working.)°

22 (0.8)

23 Neu: Okay.

24 (0.7)

25 Neu: Pur→ But you’re telling me that- (0.1) y:ou’re

26 no better,

27 (0.1)

28 Pat: **Mhm,**

29 (0.2)

30 Neu: Pur→ The other tablet hasn’t wo:rked,

31 Pat: **Ye[ah,**

32 Neu: Pur→ [There’s an option: of: (0.2) i:mproving

33 Pur→ things by giving you some i{:ron, (1.7)

{((looks up from notes and holds patient’s gaze))

34 Neu: Pur→ but nothing’s happened.

35 {(0.5)

36 Pat: {((shakes head)) **°Mm°**

37 {(0.5)

38 Pat: {((Shakes head))

39 Neu: ((shrugs)) Okay,

40 (1.2)

41 Neu: Al:right,

42 (0.2)

In the above extract, the patient does not challenge the neurologist’s view that she needs iron. Instead, she positions the problem as one of access. First, she deflects responsibility, blaming her GP’s inaction (*l*.4-5). When the neurologist pursues by calling her to *personal* account (*l.*11), she claims inability to leave the house, rather than unwillingness to take the supplement (*l*.13-18). The neurologist does not buy this. He pursues (marked as Pur on the transcript) by setting up a rhetorical puzzle: despite the potential to improve her condition, there’s been no action (*l*.35-34). The patient concedes these points, minimally (*l*.28, 31, 36), but gives no ground with respect to accepting the treatment. The neurologist’s shrug (*l*.39) conveys something like: *so what can I do?* Thus, before we get to a recommendation produced for the here and now, the neurologist and patient are dueling, with neither backing down from their opposing positions.

Extract 1b, below, shows how the neurologist pursues by changing tack, producing two pre-recommendation questions (Barnes, 2017). These reveal previous side effects (*l*.53). The neurologist exposes this as the real reason for the patient’s resistance, refuting her earlier inability account (*l*.59, 63), which the patient concedes (*l*.65). Thus, while the patient’s views on treatment do seem to be revealed, she never articulates these herself; the neurologist deduces them. He continues to build a case in favour of iron. While recognising that treatment can be difficult to get right, he projects recommending an alternative that the patient may tolerate (*l*.80). Here, we see his efforts to accommodate the basis for her resistance (Stivers and Timmermans, 2020); he remains committed to prescribing iron, but open with respect to what form it will take.

Extract 1b (S04803)

43 Neu: Pre→ Um:, (5.5) ((looking through notes)) Have we ever   
44 Pre→ given you:: (0.2) iron befo:re.

45 (0.4)

46 Pat: Yeah h.

47 (0.2)

48 Pat: Me doctor’s give it (me) ((syll))/(mind you) (0.2)

49 (it-/if-) I’ve tri:ed three: different ki::nds:.

50 (1.2)

51 Neu: Pre→ And did you tolerate it #last time#.

52 (0.4)

53 Pat: >They were< making me si:ck,

54 (0.8)

55 Neu: Three: different k[i:nds

56 Pat: [Yeah, three different ki::nds:,   
57 my GP give ‘em me,

58 (1.7)

59 Neu: **So you’re obviously not happy to go back on (it).**

60 (0.6)

61 Pat: No:.

62 (0.2)

63 Neu: **Which is why you’ve >not gone,<**

64 (0.1)

65 Pat: Yea[h.

66 Neu: [#(M)Yeah.#

67 (0.5)

68 Neu: .HHHH ALright. (0.1) One thing that- (0.5)

69 #m- #um-# >I struggle with here is you can’t<

70 underestima:te the effects of low iron in this

71 conditio:n. [You have got particularly bad

72 Pat: [Mm.

73 Neu: movements at ni:ght, and- .hhh (0.4) I: suspect

74 if we can get your iron up one way or another,   
75 that- y- you may well start to feel better ↑fo:r

76 it, .HHHH u:m:: (1.5) .tch but: doing that in some

77 people can be really difficult=‘cos they- they don’t

78 tolerate the [iron. .hh

79 Pat: [Mm:

80 Neu: Pre→ So which ones have you ha:d…

We rejoin the consultation – in Extract 1c – after almost three minutes, during which there is further history-taking. Returning to the question of treatment, the neurologist seeks a mutual commitment to “keep trying” (*l*.141-144). This receives agreement. Having positioned treatment as the only way forward, the neurologist then produces a new recommendation for iron in the here and now. This explicitly foregrounds the *neurologist’s preference*: “I would really like to get your iron up” (*l*.156). Still failing to get more than a nod in response, he provides extensive information about the options for receiving iron (not shown). Orienting to the unresolved battle, he then explicitly seeks *the patient’s* *permission* to prescribe. Even now, there is no uptake. The neurologist continues to press, minimising what he’s asking (just “have a go”, *l*.344). Acceptance is secured around twelve minutes after the decision was initiated.

Extract 1c (S04803)

141 Neu: Pur→ .thhh I’ll kee:p trying as long as you’re-

142 Pur→ you’re- (0.2) [are still prepa[::red to:

143 Pat: {[Mm::, [YEA:H,

{((patient nods repeatedly))

144 Neu: Pur→ (0.9) exPEriment.=which is essen[tially

145 Pat: [Yeah.

146 what we’re doing here?

147 (0.1)

148 Pat: Yeah,

149 Neu: Pur→ [Um : : : our backs are pretty much against

150 Oth: [Mm: (hhh.)

151 Neu: Pur→ the wall=aren’t (we) so we can only go one way.

152 Pat: Mm[:.

153 Neu: [.HH[HH

154 Oth: [Yea:h.

155 {(0.7)

Neu: {((facial expression suggests that he’s projecting   
 something less than optimal from the patient’s point of view))

156 Neu: Rec→ I- I would rea:lly like to get your iron up.

157 (0{.4)

158 Pat: {((nods))

159 Neu: Um:: (0.3) and: (1.0) there is: (0.7) there=is

160 two options…

((lines omitted))

341 Neu: Rec→ >What are we gonna< do:.=I’m:, (0.5) CAn: I

342 give you some more iron.

343 (0.5)

344 Neu: Will you have a go[:

345 Pat: [I’ll try ow:t ((i.e. anything)).

346 (0.8)

347 Pat: I’ll try owt.

Here, then, we see a trajectory that may be described as a duel. The patient’s attempt to refuse treatment entails sustained interactional effort and the maintenance of a stance that is at odds with an expert’s view. Just as Stivers and Timmermans (2020) noted, the neurologist does not back down and the patient leaves with a prescription for iron. Most of the cases in my (attempted) refusals collection, however, look nothing like this.

**What I actually found: agreement not to treat**

There were three outcomes in my collection. The neurologists: i) Prescribed or referred the patient for treatment, thereby overcoming their reluctance; ii) Deferred the decision, thereby allowing the patient to leave without a prescription/referral, for now; iii) Accepted the patient’s refusal, with or without attempting to persuade. Table 1 shows the relative frequencies. It was remarkably rare for neurologists to end up prescribing/referring following patients’ attempts to refuse treatment. Most commonly, the neurologist accepted the patient’s refusal*.* Including the deferrals, patients left without a prescription/referral in almost 90% of cases.

Table 1. Outcomes of neurologist-initiated decision trajectories containing   
patient attempts to refuse treatment

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Neurologist prescribes/refers** | **Neurologist defers decision** | **Neurologist accepts patient’s refusal** |
| Total n=42 | 5  (11.9%) | 10  (23.8%) | 27  (64.3%) |

Extracts 1a-c, then, show the exception, not the rule. With respect to outcome, my expectation was wrong: the neurologists do not tend to ‘win’. However, I have used scare quotes because my expectation was also wrong with respect to the nature of the decision-making trajectories. In contrast to Extracts 1a-c, I will show how the neurologists tended to facilitate patient refusal in my collection. Evidence for this lies in: i) how they initiated the decision-making; ii) how patients responded to those initiations; and iii) how the neurologists handled patients’ attempts to refuse.

**i) Initiating decision-making: foregrounding the patient’s vs. the doctor’s views as the basis for deciding**

Unlike in Extracts 1a-c, most of the (attempted) refusals began with the neurologist foregrounding the patient’s views – rather than their own – as the basis for decision-making (see Table 2). This was often accomplished through offer formats that make the decision contingent on the patients’ preferences (Boldface text in Extracts 2a-4; and see Curl, 2006).

Extract 2a (S07002)

01 Neu: We’ve got: I can >give you   
02 something to< help (0.3) dr- dr- dry:

03 the mouth out a b↑it, **↑if you wa:nt:,**

04 [o::r

Extract 3 (S08004)

01 Neu: D’you- **d’you want** to ↑try some steroids?

Extract 4 (G08704)

01 Neu: E::r right >what do we do about this.<

02 (0.7)

03 Neu: **D’you want** this ↑treated,

As Stivers et al. (2017) have shown, “the language of offers (e.g., *do you want*; *would you like*) highlights the role of patient preferences, rather than medical necessity, in the final treatment decision” (ibid., p. 1340). Offers thus contrast markedly with those recommendations that foreground what the neurologist thinks is best. To appreciate this, compare “I would really like to get your iron up”, from Extract 1c, with the focus on what the patient wants in Extracts 2a-4. Unlike in 1c, these patients have a slot in which they can refuse treatment – based on their personal preference – without directly challenging an expert’s preference.

In my (attempted) refusals collection, this foregrounding of the patient’s views was achieved in a variety of ways. One neurologist recurrently used an offer format that made the decision contingent on the patient’s self-assessment, thereby folding together two questions: how significant the symptom was for the patient and whether they wanted treatment (as in Extracts 5a-7a, below).

Extract 5a (S05304)

01 Neu: Is that enough of a problem that tha:t

02 needs: [referring.

Extract 6a (S05204)

01 Neu: Is this bad enough to want some steroids::.

Extract 7a (S08104)

01 Neu: Are you trippin’ o:ver your left foot

02 at a:[l*l.*=do you think you need a] foot-up:?

The neurologists also sometimes invited the patient’s thoughts, feelings or preferences about treatment after introducing one or more options (e.g. Extract 8) (see anonymous). Extract 8 shows the end of an extensive informing about migraine treatments. We join the discussion as he seeks the patient’s preference (*l.*10). Again, treatment refusal can be done without challenge to an expert opinion. Indeed, the patient later seeks a recommendation (data not shown), displaying that she has not heard the neurologist as conveying his view of what’s best (anonymous).

Extract 8: (S01606)

01 Neu: So::: (0.4) that’s how they work.

02 (2.8)

03 Neu: [And that’s rea:lly my job done.

04 Pat: [((visibly gearing up to speak))

05 (0.1)

06 Neu: At [that point.

07 Pat: [Okay

08 (0.2)

09 Neu: **I have to >sort=of pass it back to you**

10 **and say what do you< want?**

As Table 2 shows, these *patient’s*-view initiations were over-represented in my (attempted) refusals collection compared with the dataset as a whole. Within the collection, neurologists typically initiated the decision by foregrounding the patient’s view rather than their own (a roughly 80/20 split). Across the dataset, it was much less common for them to do so (roughly a 30/70 split).

Table 2. Foregrounding the doctor’s vs. the patient’s views in the full dataset vs. (attempted) refusals collection

|  |  |  |
| --- | --- | --- |
|  | **Trajectories containing (attempted) refusals of treatment prescription or referral** | **All decision-making trajectories** |
| **Doctor’s view foregrounded as basis for decision-making** | 8/40  (20.0%) | 173/246  (70.3%) |
| **Patient’s view foregrounded as basis for decision-making** | 32/40  (80.0%) | 73/246  (29.6%) |

Table 2 thus gives us a starting point for understanding my apparently anomalous findings. The patients in my neurology dataset are (mostly) exercising their right to refuse treatment when the neurologists have already foregrounded patient preferences as the basis for deciding. These are not duels lost by the neurologists.

i**i) How patients respond**

Thus far, my argument rests on the design of the neurologists’ initiating turns and the numerical preponderance of (attempted) refusals following those that foreground the patient’s, as opposed to the doctor’s, views. In this section, I show how patients typically respond, demonstrating that they understand these turns as giving them license to refuse treatment based on their personal views alone. This was most starkly apparent in response to those offer formats that made the decision subject to the patient’s self-assessment of their symptoms. Extracts 5b-7b show patients’ responses to the neurologists’ initiating turns seen already in 5a-7a. Each patient answers with an unmitigated *no*. In 5b, this comes in early (*l.*3); the delay in 6b (*l.*2) is minimal and, once the lack of understanding is resolved in 7b (*l.*6-8), the patient responds immediately (*l.*10).

Extract 5b (S05304)

01 Neu: PVE→ Is that enough of a problem that tha:t

02 → needs: [referring.

03 Pat: [**No:.**

04 (0.2)

05 Pat: [**No.** I can- I- it’s: you know (1.2) ve[ry=

06 Neu: [(Mm) [Yeah

07 Pat: (in) infrequently,

08 Neu: Y-yea:h,

Extract 6b (S05204)

01 Neu: PVE→ Is this bad enough to want some steroids::.

02 (0.2)

03 Pat: **N:o::.** **No** I fee:l (0.5) because I rested I’ve:

04 Neu: Right.

05 Pat: sort o:[f

06 Neu: [(So) you think you’re on the t- (0.2)

07 on th[e turn.

08 Pat: [Ho::pefully.

Extract 7b (S08104)

01 Neu: PVE→ Are you trippin’ o:ver your left foot

02 at a:[l*l.*=do you think you need a] foot-up:?

03 Pat: [ I h h. s : : t i : l l ]

04 (0.5)

05 Pat: A what?

06 (0.2)

07 Neu: PVE→ A foot-up,=something to lift your foot

08 [up=>do you trip over your< toe:s.]

09 Pat: [**N o : : n o :** I(‘ve-) I: ] it’s:

10 it’s:: (0.7) I- I- I’m fine with it=It’s

11 just- .hhh >if I get a little bit< ti:red

12 then I’ve- (0.2) that leg doesn’t go up,

13 (0.2) as much and I- (0.2) catch me

14 [shoe:=I: ‘oop[s:’

15 Neu: [Yea:h [Yeah

An unmitigated, upfront *no* is highly atypical when blocking a course of action like a doctor’s recommendation; such declinations are usually delayed and softened, often to the point that *no* is never uttered (Pomerantz and Heritage, 2013; and see Koenig, 2011, on passive resistance). We have seen examples of this in Extract 1c. By contrast, the recurrent use of an upfront *no* suggests that the patients in Extracts 5b-7b are not treating themselves as resisting the neurologist’s view of what is best. Rather, they are providing the requested *self*-assessment of their need for treatment. This accords with Robinson’s (2020) finding that, when responding to information-seeking questions, either confirmation or disconfirmation is interactionally acceptable. Moreover, in each of these three cases, the requested information lies in the patient’s epistemic domain (their lived experience of a symptom). The patients fit their accounts for refusal to the contingencies in the neurologist’s turns; their symptoms aren’t ‘enough of a problem’ (Extract 5b), ‘bad enough’ (Extract 6b), or substantial enough to count as real ‘tripping’ (Extract 7b). They are, then, displaying their understanding that the neurologist’s initiating turn has legitimised decision-making based on their own views.

Patients were more cautious in their attempted refusals when there was an indication that the neurologist thought treatment was advisable. Extract 9a shows a complex case in that the neurologist looks set to produce a recommendation that foregrounds his view. He builds a case for treatment across lines 1-14 and – somewhat akin to Extract 1a – he orients to this as something he has raised previously (*l*.1, 10-11). Unlike in 1a, however, he stops short of recommending that the patient start treatment; he recommends only *revisiting* the previous decision (*l.*14). Thus, while he appears to favour treatment, he has not voiced this view *per se*. Instead, he seeks the patient’s “own thoughts” (*l.*16), thereby opting to foreground her views instead.

Extract 9a: G02401

01 Neu: No::w (0.9) we’ve spoken before about

02 the nature of this illness [and the::

03 Pat: [Mm

04 Neu: (.) kind=of (right) you’ve got relapsing

05 MS=you’ve had a further relapse [and that

06 Pat: [Mhm

07 Neu: was three relapses between July and

08 Dece[mber (of) last year. .hhh U:m (0.2)

09 Pat: [Mhm

10 Neu: an:d (0.3) you kno:w (0.4) we spoke about

11 disease modifying therapy:.

12 (0.2)

13 Neu: And (.) clearly (s:) as you’ve had a further

14 relapse I think we need to revisit that a[gain.

15 Pat: [Mhm

16 Neu: → **.hhhh What are your own thoughts about that.**

17 **(0.3)**

18 Pat: **.tch.hh (0.2) I have thought (0.8) quite**

19 **deeply about [this.**

20 Neu: [Mhm.

21 (0.1)

22 Pat: **And I think at this stage (0.7) I’m still**

23 **not rea:dy to (0.2)**

24 Neu: Right.

25 (0.2)

26 Pat: **to start treatment::.**

Given that the neurologist has begun to build a case for treatment, it is not surprising that we see some markers of interactional dispreference in the patient’s response: the turn is delayed by the gap (*l.*17), and by the tongue click, breathiness and further silence at the start of line 18. Moreover, at first, she does not provide an answer to the question (*l.*18-19). This produces further delay and subtly wards off any suggestion that her response may be ill-considered. Her refusal is mitigated by ‘at this stage’ (*l.*22); she is claiming only to be “**not ready** to start treatment” (*l.*23, 26). Compared to Extracts 5b-7b, then, this is less upfront. Nevertheless, it’s an active attempt to refuse (compared with the passive resistance seen in Extract 1c), which overtly asserts her preference not to treat (compared with the neurologist having to deduce this in Extracts 1a-b). And, just like in Extracts 5b-7b, it is closely fitted to the neurologist’s turn design: “What are **your own** **thoughts**” … “**I have thought quite deeply about this… I think**… **I’m** still not ready”). Again, we see how the patient herself understands the neurologist to be giving her the right to voice her personal opposition to treatment.

Similar responses were produced following typical offer formats like that shown in Extract 2b (a longer version of 2a). Like in 9a, we see markers of interactional dispreference: the turn-initial ‘well’ and orientation to the previous discussion of treatment (*l.*5-6) delay the response proper. There is, then, some orientation to the fact that the patient is blocking a course of action initiated by the neurologist – and one that has been positioned as being for the patient’s own benefit (*l*.2-3). As in Extract 9a, the refusal is mitigated (“I don’t **really** want to be taking things… **at the moment**” (*l.*12-13; 18). But, again, the patient asserts his opposition to treatment, rather than merely implying it. Moreover, he provides no account beyond his own preference, keeping the decision entirely in his own domain. Again, the response maps closely onto the design of the initiating turn ( “if you **want**”… “I don’t **want**”). In both cases, then, the patients are orienting to the neurologists’ turns as making their preferences relevant as the basis for decision-making.

Extract 2b: S07002

01 Neu: → … we’ve got: I can >give you   
02 → something to< help (0.3) dr- dr- dry:

03 → the mouth out a b↑it, ↑if you wa:nt:,

04 → [o::r

05 Pat: [**W:::ell you did discuss this with me**

06 **last** [**ti::me but I thought, (0.7)**

07 Neu: [((nods))  
08 Pat:  **.thhh I don’t- #Ihh.# I don’t want to**

09 **be taking <I know this is one with a**   
10 **patch [on your throat=’n that, but**

11 Neu: [That’s right.

12Pat: **(0.2) .hthh (0.3) I don’t really want to**

13 **be taking thi[ngs:.**

14 Neu: {[°Okay.°

15 {((raises hands above lap, palms down))

16 Neu: [((Nods))

17 [(0.8)

18 Pat: **At the momen’, <I KNOW the:se (a:ll/:are)**

19 **things to he:lp, but obviously: (0.7) if=I**

20 **can do: with{ou:t ‘em: (0.4)**

21 Neu: {((raises hands above lap, palms down))  
22 Pat: **[#I::# I- I’d rather do: [without ‘em.**

Thus far, I’ve focused on how the (attempted) refusal trajectories are initiated. I have argued that refusals are typically produced when they have been *facilitated* by the neurologist through the design of the initiating turn, which patients themselves understand as making the decision a personal-preference-based one. Next, I show a second way in which the neurologists facilitate refusals: how they respond to the patients’ attempts to say no to treatment.

**iii) How do neurologists respond to patients’ (attempts to) refuse?**

Table 3 combines the outcome figures in Table 1 with the distinction between patient’s- vs. doctor’s-view initiations shown in Table 2. This indicates that the vast majority of the neurologists’ acceptances of patients’ refusals (25/27) occurred when they had initiated decision-making by foregrounding the patient’s views.

Table 3. Relationship between initiation and outcome

|  |  |  |  |
| --- | --- | --- | --- |
|  | Neurologist prescribes/refers | Neurologist defers decision | Neurologist accepts the patient’s refusal |
| Doctor’s-view foregrounded as basis for decision-making (n=8) | 3/40  (7.5%) | 3/40  (7.5%) | 2/40  (5.0%) |
| Patient’s-view foregrounded as basis for decision-making (n=32) | 2/40  (5.0%) | 5/40  (12.5%) | 25/40  (62.5%) |
|  | 5/40 (12.5%) | 8/40  (20.0%) | 27/40  (67.5%) |

This pattern is unsurprising in cases where the neurologist appears to have little preference for treatment. Returning to the case shown in Extract 6b, we can see that acceptance by the neurologist is reached readily, with no attempt at persuasion (shown in Extract 6c, below). Having heard the patient’s self-assessment that her condition is not bad enough to warrant steroids, the neurologist overlaps the patient’s account (*l*.3, 5) with a candidate positive upshot: she seeks confirmation that the patient thinks she’s improving. This briefly holds open the decision, but in a way that is tilted towards a no-treatment outcome. Indeed, even when the patient only partially aligns with this optimism (“hopefully”, *l*.8) the neurologist accepts (*l*.10). The patient leaves without a prescription.

Extract 6c (S05204)

01 Neu: → Is this bad enough to want some steroids::.

02 (0.2)

03 Pat: **N:o::.** **No** I fee:l (0.5) because I rested I’ve:

04 Neu: Right.

05 Pat: sort o:[f

06 Neu: [(So) you think you’re on the t- (0.2)

07 on th[e turn.

08 Pat: [Ho::pefully.

09 (0.1)

10 Neu: [O:kay

11 Pat: [Hopefully yeah.

What is striking, is that the relationship between patient’s-view initiating turns and neurologists’ acceptance of patient’s no-treatment preferences held even when the neurologist appeared to favour treatment. Recall that in Extract 9a, the neurologist seemed to be building a case for disease-modifying therapy, but then pulled back from recommending treatment. Extract 9c shows how they reach agreement not to treat (yet).

Extract 9c: G02401

22 Pat: And I think at this stage (0.7) I’m still

23 not rea:dy to (0.2)

24 Neu: Right.

25 (0.2)

26 Pat: to start treatment::.

27 Neu: **↑Okay**

28 (0.7)

29 Neu: Ri:ght (0.2) I think- (.) you know the

30 na:ture of the atta:cks have been largely

31 sensory.

32 Pat: Mmhm,

33 (0.6)

34 Neu: From which generally people make a good

35 (0.3) (mm-) respo:nse:.

36 Pat: Mmhm[:,

37 Neu: [U::m .hhh and o:ften when people

38 >get this condition initially they can get

39 a< cluster of episodes?

40 Pat: Mmhm,

41 (0.2)

42 Neu: And then it can settle do::wn.

43 Pat: Yeh.

44 (0.2)

45 Neu: So:: you know, (can) ma:y go a long time

46 before (you h-) anything else ha:ppens.=

47 **=SO:.HHH I don’t think it’s unrea:sonable**

48 **to wait and see::.**

49 Pat: Mmhm,

50 Neu: Be different if you were having significant

51 motor attacks and being left with ongoing

52 disability=[then .hhh I’d probably be:

53 Pat: [Mhm:

54 Neu: suggesting to you more stro:ngly that you

55 consider (0.2) treatment at this sta:ge.

56 .hhh **But given the na:ture of these episodes=**

57 **=I think you ca:n afford to wait and [see:.**

58 Pat: [Yeah.

59 (0.2)

60 Neu: .hhh And if it continues (like this) I think

61 we will need to re:consider a[gain.

62 Pat: [Mmhm,

63 (0.2)

64 Neu: **U::m (1.3) but- .HHHH >you know I think we’ll**

65 **just keep a-< (a) WAtching brief on things** and

66 if something further does happen the::n (0.4)

67 you know (0.3) e::r I would- .hhh you know-

68 (0.3) CONtact the nurses and I’ll see you again,

69 if necessary[:.

70 Pat: [Mhm

In Extract 9c, the neurologist accepts the patient’s stated preference with “okay” (*l.*27). He then expands (boldface above), providing a justification for *not* treating, based on her symptoms (*l.*29-57). He orients to this decision as potentially provisional: they will “wait and see” (*l*.48, 57), with the possibility of (again) revisiting the decision if she has further attacks (*l*.60-61, 66-69). For now, however, the neurologist does not attempt to persuade her to start treatment. The patient’s view that she is “still not ready to start treatment” has been accepted.

The same pattern occurred even when the neurologist was sufficiently in favour of treatment to pursue acceptance in the here and now. Like the patient in Extract 6c, the patient in Extracts 10a-b is offered steroids to help her recover from a possible relapse (of multiple sclerosis).

Extract 10a: S08004

01 Neu: → (º#Er#º) (0.2) d’you- d’you want

02 → to ↑try some steroids?

03 (2.5) ((pat shifts gaze downward))

04 Neu: **if we rule out (>an<) infection?**

05 (0.3) ((Pat’s gaze towards floor))

06 Neu: **D’you think i:t’s:: would that be worth a go,**

07 (0.7) ((No eye contact from pat))

08 Neu: **We can either do: tablets or get you come in**

09 **as a da:y** **patient.=I know you’re: you’re not**

10 Neu: **keen on in-hospital** **stays are you,**

11 (2{.6)

12 Pat: {((Slight shake of head which appears to be responsive))

13 Pat: Mind you I: do like coming in(‘t) ºhospitalº

14 (0.6)

15 Pat: I must be honest because it’s (the) only time

16 I see people.

The offer in Extract 10a makes treatment contingent on the patient’s preference (*l.*1). Unusually (following offers), there is no response (*l.*3). This may reflect that they have not yet established whether the patient is eligible for steroids, which the neurologist addresses through her increment at line 4. In the absence of a response, the neurologist pursues further (*l.*6). Notably, however, she continues to seek the patient’s view, rather than trying to build a persuasive case (*l*.6). Further pursuit also foregrounds the patient’s preferences with an option list for how treatment might be administered (*l.*8-9). The patient then appears to be paving the way for acceptance when she asserts a liking for hospital visits (*l.*13-16). However, the decision gets derailed as the patient indicates another symptom (not shown).

We rejoin the consultation, in Extract 10b, as the neurologist offers hospital-based treatment (*l.*47-48), further pursued with an inducement to accept (*l.*52). After another long gap, the patient overtly declines (*l.*54). The neurologist still holds open the decision (*l*.58). Following confirmation, she accepts with “okay” (*l.*62) but provides a contingency plan if symptoms worsen (*l.*65-68).

Extract 10b: S08004

46 Neu: So u::m (1.6) ((visible inbreath during

47 this silence)) **d’you want me to try and**

48  **get you in?**

49 (1.0) ((Pat looking away))

50 (Neu): (Mm-)

51 (0.2)

52 Neu: **>Get< some ↑steroids=a bit of physio?**

53 (2.0) ((Pat still looking away))

54 Pat: (.hh) ºI don’t want to (go-)º <uh no::

55 (1.4)

56 Pat: I’m gonna: I’m gonna try:: me hardes:t and ri:de,

57 (0.1) ºitº ou:t.=

58 Neu: **=Are you sure?**

59 (0.2)

60 Pat: Yea:h.

61 (.)

62 Neu: Oka:y,

63 Pat: Yeah.

64 (0.3)

65 Neu: U::m well obviously if (th-)/(it-) if things are getting

66 worse then ring the nurses and we can always: you know

67 (0.2) fetch you in <you know beds permitting

68 .hhh [uh as it- as it we:re.=U:m .hh >and the NES

69 Pat: [Yeah

70 Neu: team are coming tomorrow< are they?

71 (0.9)

72 Pat: Yeah.

In stark contrast with Extract 6b, then, the neurologist in 10a-b *does* try to persuade the patient to accept, revealing her own view of what’s best. Her check on whether the patient will receive at-home support (*l.*68 & 70) also implies concern that she isn’t well-placed to “ride it out”. Nevertheless, the neurologist never shifts into announcing her own views. All her pursuits (boldface, above) maintain the focus on what the patient wants. Thus, the patient remains able to provide a preference-based declination that is fitted to the format of the neurologist’s offer (“d’you want”/ “I don’t want”). She leaves without a prescription.

The analysis in this section helps make better sense of the figures in Table 1. It’s not only that the decision-making trajectories in my (attempted) refusals collection were typically initiated in a way that facilitates patients’ expression of a preference. Once a decision was set up in that way, the neurologists almost always accepted patients’ anti-treatment stance. Thus, most of these trajectories look more like collaborative agreements not to treat than like duels.

**Deviant cases**

As we’ve just seen, even when neurologists thought treatment was advisable, they usually only pushed so far once they’d set in motion a patient’s-view based trajectory. What, then, are we to make of the two cases in which they ended up prescribing (see Table 3)? These differ from the usual pattern in one key respect: the neurologists shifted from seeking the patient’s views to announcing their own. Extracts 11a-b show a deviant case that contrasts starkly with Extracts 10a-b. Both neurologists are offering steroids to try to improve possible MS symptoms. Each make the offer contingent on the patient’s view (personal preference in 10a; self-assessment in 11a). Unlike in 10a, however, when the patient fails to accept in 11a (*l.*7), the neurologist does not continue to foreground the patient’s views. Instead, he makes a doctor’s-view recommendation (*l.*21-24). When the patient resists that (passively, *l*.25), he continues to build a case for treatment.

Extract 11a (G01805)

01 Neu: And there’s two: ways of dealing with this,

02 (0.2) If you: don’t feel that things are (1.2)

03 absolutely back to normal,=**if you still feel**

04 that you’re inhibited a wee bit (0.2) in this:.

05 .hh **then I can (0.3) give you** some (0.3)

06 steroid treatment for a short while,

07 Pat: Mhm,

08 (0.9)

09 Neu: .tchhh and we could see how you (1.0) do after tha:t,

10 Pat: Yeah.

((lists option for a specialist referral))

21 Neu: .Hhhh Now no matter what happens (0.3) **I think** a

22 short course of steroids may well be helpful=

23 >If you’re having difficulty with the<

24 stai::rs, .hh that would make sense to me.

25 (0.5)

26 Neu: Is that absolutely essential, no it’s not.

27 (0.5)

28 But I think if you’re tellin’ me that you

29 h’ve problems on the stai::rs,=

30 Pat: =It’s j’s:t (.) you fee:l the tingles more

31 (0.1) [doctor.

32 Neu: [(Mm)

33 Neu: °Oka[y,°

34 Pat: [Um: (0.5) and obviously if I’m carrying=

35 which I always am carrying heavy bags ‘cos

36 (of-) (.) I work security so .hh I’ve also

37 got the horses .hh so I’ve always got a big

38 bag with me with either my uniform in it,

39 (0.2) or my,

40 Neu: Mhm,

41 Pat: horsey clothes in it, .hhh so if I’m carrying

42 bags of shoppin’ I just (0.2) by the time I get

43 up (0.2) to (the top) flight of stairs I’m startin’

44 to (0.4) feel the pre:ssure a wee bit, (0.2) but

45 I mean it’s no: (1.0) cripplin’ or sto:ppin’ me or

46 anything but-

47 Neu: °Right.°

48 Pat: I’m awa:re of it, put it that way.

49 Neu: °Okay.° .h[hh

50 Pat: [I’m aware of it.

As the neurologist advances his argument for treatment and the patient counters, Extract 11a starts to look more like the duel in Extracts 1a-c than the more typical cooperative agreements shown across this paper. At lines 30-31 and 34-48, the patient builds her case, minimising the severity of her symptoms (“It’s **just** you feel the tingles more”; “I’m startin’ to feel the pressure **a wee bit** but … **it’s no cripplin’ or stoppin’ me**”) and normalising her difficulty with the stairs. Extract 11b shows how the neurologist responds to this resistance by redoing his recommendation, reiterating his own view (*l*.51-58).

Extract 11b (G01805)

51 Neu: How about (0.9) (uh-)/(I-) >I mean I< (m-)

52 think that whether or not you’re seen by the

53 MS specialist,=I think if that, (.) if the- if

54 these are affecting you, if these are affecting

55 what you’re doing:. my take on this would be:

56 (0.2) could we leave it alone, yeah we could.

57 .hh But **I think a wee trial of a >short course**

58 **of steroids< would >make a bit of< sense to me:.**

59 (0.4)

60 Pat: Mhm,

61 (0.4)

62 Neu: How d’you feel about that,

63 (1.0)

64 Pat: Yeah,

65 (0.2)

66 Pat: (mhh.)

67 (0.3)

68 Neu: °Okay.°

69 Pat: I think,

As we see in lines 59-60, the patient still fails to accept. Now the neurologist overtly seeks her view, but, against the backdrop of his repeated recommendations, this functions as a pursuit of acceptance. This is evident in how the patient responds, not by announcing her views, but with an acceptance token, thereby orienting to the recommendation. This is recast as uncertain acceptance, with the increment at line 69. Nevertheless, the neurologist goes on to prescribe (data not shown). To sum up: while it was rare for neurologists to switch from foregrounding the patient’s view to pushing hard for their own, when they did so, the outcome was treatment acceptance.

**A note about the deferred decisions**

Table 3 shows that a fifth of the decisions in my collection were deferred. By this, I mean that no agreement was reached – in the consultation – about what to do next. In terms of the immediate outcome, these are equivalent to the acceptance cases, because the patient leaves without a prescription or referral*.* However, deferrals were handled in different ways. If the neurologist began by making the decision subject to the patient’s views, but no decision could be reached, the neurologist typically left the patient to decide on their own (e.g. “I’ll leave you to think about that then, whether you need help”, S06304). By contrast, if the neurologist began by voicing their own view, but failed to secure acceptance, deferral was used as a way out of the stalemate, but with steps in place to try to secure acceptance in the near future (e.g. “I think that we should certainly consider treatment… generally what happens is that one of the nurses go through the treatments sort of in more detail… so I’ll arrange that”, G08202). The two sets of deferrals in Table 3, then, are not (interactionally) equivalent. There are not enough cases to draw firm conclusions, but the patterns are in line with what we have already seen across this paper.

DISCUSSION

This paper has examined how patients exercised their right to refuse treatment in UK neurology outpatient consultations. That patients who attempted to refuse typically left without a prescription or referral appears anomalous given previous findings that clinicians usually convert resistance to acceptance. The answer to this puzzle lies, I have argued, both in how neurologists initiated the decision-making and in how they responded when patients attempted to refuse. Most of the (attempted) refusals occurred when neurologists foregrounded patients’ views as a basis for decision-making. I have shown how these turns designedly allow patients to voice an anti-treatment stance without having to contradict an expert opinion. Crucially, I have provided evidence that patients understand these turns in this way. This makes refusal easier. Neurologists were also typically less willing to press for acceptance when they began by foregrounding the patient’s views rather than their own. Thus, the trajectories in my collection do not generally look like the duels I was expecting. Rather, patients are refusing treatment in a context that *facilitates* their own decision-making.

This accords with Opel et al.’s (2015) finding that ‘participatory’ initiating formats were associated with fewer parental vaccine acceptances than ‘presumptive’ formats. Moreover, Tate (2019) showed that US oncologists used the most presumptive form of recommendation – a pronouncement, which treats the decision as if it doesn’t require acceptance (Stivers et al., 2017) – when mid-way through a treatment course. By contrast, they used formats that seek patients’ buy-in – mainly suggestions and proposals – when recommending new or ancillary treatments (e.g. for side effects). Again, this accords with my findings. I limited my collection to new treatments due to my interest in overall refusal (rather than negotiations about treatment dose or type). And there is a parallel with the ancillary treatments: in my collection, patients’ views were more commonly foregrounded for symptomatic treatments, like alleviating dribbling (Extract 2a), or reducing the day-to-day impact of MS (Extracts 5a-7a, 10a) or migraines (Extract 8). Less than 20% (6/32) of the decisions initiated by foregrounding the patient’s view were for some disease-modifying treatment, while 75% (6/8) of those initiated with a doctor’s-view-focused recommendation were. Thus, like in Tate’s cases, the neurologists appear to be prioritizing patients’ agency when starting a new treatment or when treatments are less risky with respect to health outcomes.

This helps explain the apparent anomaly between my adult neurology findings and those from paediatric neurology (Stivers and Timmermans, 2020). Not only were the latter decisions initiated with turns that foregrounded the neurologist’s view, but most were for changes to a current regimen. They were, then, like Tate’s ‘mid-course’ treatments; those in which oncologists were *least* likely to prioritise the patient’s agency, acting as though the original ‘buy-in’ gave them “carte blanche for subsequent medical decisions” (p. 1606). They were also directed towards controlling childhood epilepsy – a condition that the neurologists oriented to as highly risky (Stivers and Timmermans, 2020, p. 69). The greater orientation to patients’ preferences in my dataset, then, at least partly seems to reflect the different nature of the decisions. My study thus addresses Tate’s (2019) call to show how apparently contradictory findings may be reconcilable if we take “treatment context” into account (p. 1606).

As Tate (2019) notes also in US oncology, there is a long-standing drive within the UK’s NHS to get clinicians to offer patients choice more routinely, particularly for chronic conditions (anonymous). This helps explain the fairly extensive soliciting of patients’ views as a basis for decision-making in my dataset. However, as Table 1 shows, efforts to foreground the patient’s view were considerably over-represented in my (attempted) refusals collection relative to the whole dataset. I would argue that this most likely reflects patients’ reluctance to refuse treatment when explicitly endorsed by the neurologist. Likewise, I think that the patterns described in the paper reflect neurologists’ decisions regarding which treatments are worth ‘fighting’ for. When they deem it safe to do so, they typically prioritise patients’ agency – from beginning to end of the decision-making trajectory. When they consider the decision too risky, they prioritise their medical expertise.

My collection includes eleven neurologists but is skewed by the tendency for one to favour using offer formats (Anonymous). She often initiated decisions around symptomatic treatments, which accords with my argument. However, further research is needed to tease out individual differences from those based on the nature of the decision. I found no evidence that the neurologists were selecting their approach based on prior signs that the patient would resist. But more statistical research is needed to model the elements that have been identified as consequential for decision-making – including what comes *before* the recommendation.

We know that, when clinicians stand their ground, they generally convert resistance to acceptance. This is evident also in the exceptional cases I have shown (Extracts 1a-c and 11a-b) – at least *within* the consultation. In Opel et al.’s study (2013), the vaccines could be delivered immediately. They could thus conclude that – if seeking to balance parental satisfaction with vaccine uptake – best practice entails a participatory approach (associated with increased satisfaction) coupled with pursuit if the parent resists. Best practice conclusions for neurology are less clear, partly because the balancing act between patient choice and duty of care is so complex. Tate (2019) worries about the implications of leaving little “interactional room for patients to put their own treatment preferences on the table” (p. 1606). Similarly, I worry that the greater use of recommendations that foreground the neurologist’s preference (across the full dataset), coupled with the tendency for patients to refuse treatment only when their views are foregrounded, means that they are regularly acquiescing to treatments they don’t want. As we saw in Extracts 1a-c, one consequence may be that they enact their resistance outside the clinic. At the same time, patient-preference-based decisions carry their own risk – not only because patients are more likely to refuse, but because neurologists are less likely to press for acceptance. This can mean (as in Extract 10a-b), that patients leave without a prescription that could have helped (either immediately or in the longer term).

Like most CA researchers, I don’t know what happened after the consultation. Further research, to understand whether the persuasive practices that work in the consulting room hold sway beyond, is crucial. This could radically adjust the calculus that neurologists appear to be performing when deciding whether to give patients choice. If it turns out that – despite the lower levels of acceptance when doctor’s foreground patients’ preferences – more patients end up *enacting* a chosen treatment plan than when doctors press for their preferred option, giving choice might be less risky than it appears.

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