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Companions' dilemma of intervention when they mediate between patients with intellectual disabilities and health staff

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Companions' dilemma of intervention when they mediate between patients with intellectual disabilities and health staff

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1. Introduction

1.1. Background.

When a person with intellectual disabilities (ID) accesses a health service, they often require the aid of a companion to help communicate with the service provider. But as Mastebroek et al observe, "[i]n the ID health literature, relatively little attention is paid to exchange of information in the context of medical care" (2014, p 1979). Since then there has been a small-scale study by Mander (2016) of how health-related information is made accessible to adults with ID. It is useful and fine-grained, but is limited to the rather unusual case of an unmediated encounter between health-care professional and the person with ID. What is still missing is an examination of the (much more common) mediated consultation, with the mediator being a companion (a family member, friend, or a paid carer). That is the focus of this article. We shall be researching, for the first time, the actual words exchanged between adults with intellectual disabilities, medical practitioners and the companions who mediate between them in primary care settings, and we shall be using a methodology that avoids casting what they do into pre-given categories; we shall use Conversation Analysis to see exactly how they bring off their interaction in fine detail.

In the case we consider here, the service is an annual health-check, provided by local primary care practitioners (physicians or nurses), a service reported to be "effective in identifying previously unrecognised health needs, including life-threatening conditions" (Robertson et al, 2011, p 1009). For full effectiveness, however, the medical practitioner must solicit information from the patient about their symptoms and lifestyle. But the patient is not always able to understand the question, or give a full answer, and the companion mediates. We want to know how.

1.2 Answering questions directed at the patient

We are focussing here on what happens when the medical practitioner asks the patient a question, and the companion intervenes in the provision of the answer. This is different from the kind of "brokering" that has attracted much interest in the literature on third parties in medical consultation, which have generally focussed on linguistic interpreters (be they professionals, or family members). In the case we consider here, the companion is not translating the doctor's questions (or advice and so on), as a matter of linguistic (see Krystallidou and Pype, 2018, for a recent example) or broader "cultural" translation or brokering (e.g. C. Raymond, 2014). Brisset et al 2013 give a useful a systematic review of such translation, but the point to note is that it deals with the explanation of the medical practitioner or the patient's words and their meaning. What we are interested in here, rather, is the companion; and specifically the companion as intervener: how they manage the task of taking a forward step when the medical practitioner has asked the patient a question, but has not received (or in some cases *before* they have received) an adequate answer.

1.3 Epistemic entitlements

The asymmetry between companion and patient with ID is perhaps not quite the same as between a parent and a child. Certainly there the parent is very largely in command: as Strong in his classic *Ceremony of the Clinic* (1979, reissued 2018), observes: "It was the parents who owned, managed and worried about their children's future; and it was to them that talk was normally addressed" (2018, p 9). The situation seems to have been much unchanged when Bates et al surveyed the scene some 20 years later: "[p]arents obviously regard matters of the child's health as their own responsibility and, therefore, they usually treat their children in medical interviews as if they were absent" (Bates et al, 2002, p 115), an observation given yet more interactional evidence in Stivers (2012). Their authority consists in a complex combination of socially-sanctioned rights and entitlements as parents over young children; not all those rights and entitlements will transfer to adult children, and will be most lacking, of course, when the patient is no relation at all. But perhaps more fundamentally, what makes the relation of companion to adult patient with ID different from parent to child (or indeed linguistic interpreter to client) has to do with the policy and organisational context –factors 'outside' the actual interaction that help us understand and make sense of what is going on, and which are as it were structurally distinct. The difference is the pervasiveness of a service ideology requiring people with intellectual disabilities to be autonomous and to speak up on their own behalf, and for services to facilitate that - a structural weight of expectation that doesn't obtain for parents *qua* parents, or most formal interpreters, or not in the same way (for example, police and courtroom interpreters are working to what is, at least nominally, a policy of strict neutrality).

What does survive as a difference between the two parties facing the practitioner is the asymmetry, by definition, in cognitive capacity. Whatever the companion may know about the patient (by dint of their better ability to process and remember the details of their lives) the patient must know it more personally, by definition. In speaking for the patient, the companion is treading on sensitive ground. The patient has rights - epistemic rights - over their personal, private life, including much that might be relevant to a medical consultation. According to Heritage's analysis (Heritage, 2012a) a speaker's epistemic status is granted them by a range of factors which can be called on to invoke authority vis-a-vis a given listener: their expertise, experience, position in a hierarchy, institutional privileges, and so on. If the patient is a child, their parent, for example, in principle has epistemic entitlement to describe their child's symptoms, by dint of the parent's greater capacity of understanding, as well as any socially-approved authority.

On the other hand, a person may claim an epistemic *stance* on some information in the way they express themselves - "through the design of turns at talk" (Heritage, 2012, p.33) - whatever their actual expertise and cognitive advantages. So even a parent who knows the facts of the matter may, for example, downplay their expertise, take a not-knowing stance, and invite their child to "remember" how high their temperature had been the day before. That is to say that any companion can defer to the patient's greater entitlement, whether or not it is well-founded. The situation of a person with an intellectual disability is the same as the child, or any other person: whether or not they actually know the answer to the medical practitioner's question, they can be *treated* as having it, or not. How the companion brings this off - whether they manage what Nilsson et al (2018), in studying companions helping a person with dementia tell a story, call "joint speakership", or whether they merely take

over, as Bates et al (2002) suggest, is a matter of discovery, and the key to it is the degree of epistemic authority the companion is willing to display.

1.4 Aim

So in the cases we shall be considering here, we need to keep an eye out for how the companion designs their talk - how they manage their claim to know information over which the patient has prior rights of entitlement. Do they use their greater epistemic status to simply over-ride the patient, or do they adopt different epistemic stances to manage the matter with more delicacy?

2. Material and Methods

2.1 Data collection took place between July 2016 and June 2017 in GP practices across London. Practices were eligible if they were taking part in a national incentivized scheme to complete annual health checks with patients registered as having intellectual disabilities (Slowie & Martin, 2014), and had conducted at least 5 health checks during the last reporting period. An initial invitation to take part in the study was made by practice staff to patients with intellectual disabilities who were over 18 and did not need support from an interpreter. A researcher followed up with a home visit to complete consent procedures, including recruiting research 'consultees' for patients deemed unable to give informed consent regarding their participation (Department of Constitutional Affairs, 2007). Ethical approval was given by an NHS Research Ethics Committee (Ref:16/LO/0455).

Altogether 33 health checks were video-recorded, conducted by 14 practitioners from 10 GP practices. Four (29%) of the practitioners were practice nurses, the others were doctors and one physician associate. Two doctors conducted health checks in the patients' care home, others took place in the GP surgery. The video camera was set up by the researcher who left the room before the health check started. Most patients (n=29, 82%) attended accompanied by a family member (n=9) and/or at least one paid carer or supporter (n=23); of these, 4 had a non-speaking patient, leaving 25 that are useable for the purposes of the analysis.

2.2 We analysed the data with the apparatus of Conversation Analysis (CA), an approach which combines close inspection of video data with a body of established findings about the workings of conversation - how the detailed placement and design of turns at talk perform actions. For a wide-ranging collection of authoritative accounts of the scope of CA, see Sidnell and Stivers (2012), for its application to a range of medical and other institutional interactions, see Maynard and Heritage (2005) and Antaki (2011), and for its particular applicability to doctor-patient consultations, see Drew et al (2001). CA has been usefully applied to interactions involving people with ID since the pioneering work of Yearley and Brewer (1989), with an acceleration of interest in the last ten years: see, for example, the work on how people with ID are offered choices (Antaki et al, 2009), or how they engage others in conversation (Antaki et al, 2016); how staff pursue answers from them (Finlay and Antaki, 2012); and, in a sustained analysis of their interactions with service-providers, Williams (2011). Following the conventions of CA, we report the video data in the form of transcriptions; for a glossary of their notation, please see the Appendix.

2.3 Cases left out of analysis

We are leaving aside two broad classes of companion's participation in the consultation which imply knowledge of the patient, but are not answers to the medical practitioner's questions. One class is their replies to questions directed specifically at the companion themselves (and not at the patient), and the other is their replies to questions asked them by the patient. We also leave aside the occasions on which the companion initiates some business directly with the medical practitioner - for example, describing the patient's current medication, asking about appointments, and so on. In other words, we shall be examining only those cases where the patient has been asked a question about themselves, and the companion intervenes.

3. Results

3.1 Cases considered: companions' interventions when the question is directed to the patient

When the medical practitioner directed a question to the patient, we found four broad kinds of intervention by the companion which involved some kind of claim to know information which would be, in typical circumstances, in the domain of the patient. To use the terminology from Heritage and Raymond (2005), this is information to which the patient has greater *epistemic* entitlement: it is knowledge about the details of their lives, and indeed sometimes their feelings and beliefs.

We set these out as a gradient:

- a) hinting at relevant information which the patient knows, but has not yet revealed
- b) elaborating/clarifying the patient's answer to better fit the medical practitioner's requirements
- c) repairing/correcting the patient's answer to better fit the medical practitioner's requirements
- d) bypassing the patient, to self-select as the recipient of the medical practitioner's question to the patient, in exact overlap with, in advance of, or after lapsed, turn from the patient

The interventions we discovered seemed to form a gradient of claimed entitlement, from least to most - as we have set them out in the list above. At the end of least entitlement, the companion defers to the patient by only offering some hint or clue to allow them to generate the answer themselves. At the most entitled end of the spectrum, they step in to answer the question themselves. The gradient moves from the companion displaying the least to the most entitlement to show that they know better, or know more, than the patient does - as Brown and Levinson (1987) would describe it, a gradient of "impositive cost". Figure 1 shows the gradient graphically.

[Figure 1 about here]

Figure 1: Interventions showing companions' epistemic stance vis à vis the patient

In what follows we document these interventions, and show that they are, necessarily, always a matter of the companion making a judgement between encroaching on the patient's epistemic rights - their entitlement to report the details of their own lives - and progressing the medical objectives of the interaction.

3.1.1 Hinting and prompting: Minimal assertion of epistemic authority by deferral to the patient's priority.

We begin at the least presumptive end of the gradient of entitlement.

In these cases, the companion defers to the patient's epistemic priority by a variety of hints or prompts. Although these hints and prompts must imply that the companion themselves already has the information, soliciting it this way displays the companion's knowledge only minimally, and gives the patient the opportunity to provide the information as if at first hand.

These cases arise when patient has been asked a question by the medical practitioner and has either provided no answer, or has provided one that is deemed by the companion to be incomplete. The companion uses a variety of techniques to induce the patient to either volunteer an answer, or a fuller answer, or to assent to the information implied in the companion's turn.

In Example 1 below, the medical practitioner has asked the patient Cliff about his mobility, selecting him explicitly, by gaze direction and body orientation. He answers by giving a long exposition of the guidance he's received from the occupational therapist. We join as he reaches the end.

[Example 1 about here]

The patient's answer, especially "So far it's been going good", line 568, is receipted by the doctor as a self-assessment in third position (Schegloff, 2007) completing his report. But it seems to prompt his companion Louis to issue a hint that in fact the patient nevertheless does "find it hard sometimes" (line 571). Notice the careful work done by the companion to intervene only after the patient has fully completed his turn and the action for which it is the vehicle (that is, an assessment of his current position (*so far t'ch wood... 's bin going good.*). The companion is the careful to defer to the patient's own expressed report (cf. Holt, 2000) of difficulty ("you told me this morning"), and the further evidence of the patient wanting an "oh tee" (OT, occupational therapist) on the basis of that difficulty. The companion does protect his turn by rushing-through his account of what the patient said (see Schegloff, 1982 on speeding up talk in "rush-throughs"). Nevertheless, by alluding to the patient's own expressed views, the companion minimises their epistemic status and defers to the patient's prior claim to the information.

3.1.2 Expansion and clarification: greater encroachment, but maintaining deference to the patient

In these cases, unlike the hints above, the companion presumes more direct knowledge of the patient's circumstances, by giving, in their own voice, a clarification or expansion of the patient's answer. Although the source of the information is now clearly the companion, nevertheless the integrity of what the patient had said, and its relevance to the medical practitioner's question, is not directly challenged. In Example 2 below, the doctor asks the

patient Jeanie a polar about earwax; the patient's turn in response (line 285) is not formatted as a yes/ no, and is hard to see as an intelligible answer. Her companion volunteers a candidate answer, and at 289 and 291 casts that candidate as one requiring confirmation from the patient (addressed by name, a further form of explicit recipient design). What we focus on here is that subsequently happens whether doctor issues a follow-up question at line 294.

[Example 2 about here]

The companion's intervention at line 296 is prefaced by an on-the-record explicit agreement with the patient, establishing her at-least-equal rights in the matter¹; then offers a tentative ("I think...") version of the possible time period that was implied by the patient's answer (the summer); then offers an alternative period. One way or another, the companion's answers are more attuned to the kind of evidentially-supported estimation of time that is more likely to be appropriate to the medical agenda - and, in that sense, superior to the patient's estimate of "longer". The design of her turns are what Heritage and Raymond (2005) would term epistemically inferior or at least as no more than equally knowing. She maintain the integrity of the patient's answer, while offering expansions from a position of low, or lesser, entitlement.

In Example 3 below, the medical practitioner has asked patient Phil about his leisure, and he has answered in terms of supporting a football team.

[Example 3 about here]

In this zone of the spectrum, where the companion expands and clarifies the patient's answer, there is a variant: the companion may add the information beyond the apparent needs of the required information, and is an initiation inserted into the interaction after the question-answer sequence has been apparently satisfactorily completed. Still, as in the other case here, the patient's answer is not gainsaid; it retains its integrity, but now the companion takes a further initiative in providing deeper background, distant from the required information. At line 113 the companion expands her own version of his habits with an increment (Schegloff 2007) ending with a tag question plus laughter particles. As Heritage and Raymond argue, the force of a tag question is its apparent concession to the other party: the questioner "formulates [their] turn as... a question to be answered rather than as an assertion to be agreed with; thus [they] cede epistemic authority in the matter to [their] coparticipant" (Heritage and Raymond, 2005 p 20). So the companion's tag implies that the source of the information about the cake and tea is the patient himself. Perhaps this comparatively respectful formulation (pace Hepburn and Potter, 2011, who have a darker analysis of tag questions) helps palliate the presumptuousness of the companion's intervention

¹ But not her *prior* right, which would have been signalled by a news receipt like "oh" and so on - see Heritage (1984), and the further treatment in Heritage and Raymond, (2008)

The two cases below show this move toward the more intrusive end of the gradient. In Example 4, at line 39 the nurse has resolved the reason for Barbara's visit to the surgery ("cos you needed the certificate"). Barbara gives minimal acknowledgement of this at line 41, and at this point the companion Ilaria self-selects to announce further - apparently irrelevant - information, unbidden (*she was happy it was a man*). It has an overtone of implying that the patient was sexually interested in the doctor, but note that the nurse after an initial arch "ooh", markedly offers a different candidate explanation - he was a *new face*, relieving the patient of reacting to what may have been an over-intimate revelation. In the subsequent example (5), patient Christina has answered in the affirmative about her general well-being (after questions about her sleeping, not shown); at that point the companion Sophia self-selects to offer a report about Christina's inner life, again, apparently without apparent warrant from the current conversational trajectory (line 202).

[Examples 4 and 5 about here]

The companions' contributions don't offer strictly relevant information unless they are meant to evidence the companion's intimate knowledge of the patient (and thus bolster their epistemic status more generally). What differentiates them in structural terms from the previous ones in this section is that the companions self-select to issue their turn, when the action underway is, ostensibly, over and done with. That signals a move towards the still more entitled zone of the spectrum, where the companion becomes more assertive in their offering of information.

3.1.3 Beyond expansion or qualification, and into correction

Now the companion encroaches farther into the patient's epistemic territory by not merely adding to, or clarifying, what was said, but qualifying it to the point of outright contradiction. In Example 6 below, the companion's new information casts doubt on what is familiar from Grice (1989) as the maxim of quantity - that the patient has said all that needs to be said.

[Example 6 about here]

The patient David has been asked about his fitness on a treadmill, and in lines 394-395 gives a comparatively positive account; when the medical practitioner checks (line 396-7), he confirms that he has not had to stop to draw breath. At this point the companion self-selects to issue a disjunctive (and, therefore, disaffiliative - see Steensig, 2012) qualification. That corrects the patient not by outright rebuttal, but by revealing an aspect which, when known, puts the information about his fitness in a less positive different light.

In the next example there is a still more direct correction of the adequacy of the patient's account:

[Example 7 about here]

Patient Cliff is describing positively his visit to the opticians. This is received with positive acknowledgements by the medical practitioner (line 1239 and 1242). At this point the

companion self-selects (line 1243) to issue a bald contradiction of Cliff's account of the visit, pointing to a mistake on the optician's part.

3.1.4 Bypassing the patient: taking unilateral epistemic control by directly answering the medical practitioner's question

We have now reached the point at which the companion displays the greatest entitlement to display their epistemic authority over the patient's circumstances. Here the companion answers the medical practitioner's question themselves, either in perfect overlap with the onset of the patient's turn or, in the clear. We give two short examples together to illustrate the practice.

[Examples 8 and 9 about here]

In each case, the medical practitioner has directed their question (and their gaze, as the video shows) at the patient, yet it is the companion who offers an answer; and in each case, the answer is about something about which the patient would typically be thought to have the greater entitlement to know - because it is a matter of preference or internal effort. In both cases, the patient exhibits no reaction to the intrusion by the companion - there is no change in their gaze, facial expression or body orientation.

Resistance

We should note that on a very few occasions, patients did register their resistance to their companion's intervention. These tended to be mute, and therefore ambiguous. One example is a case where the companion issues what might be seen as overly intimate, and unnecessary, information.

[Example 10 about here]

At the start, all seems to flow smoothly, though even here the nurse invites some sort of contribution from the companion. Although nurse certainly orients to the patient at the start of her question line 451, but right at the end does a brief eye-flick to the companion; nevertheless the patient selects herself to answer. The same happens again at turn-initial and turn-terminal position in line 457, and this perhaps licences the companion to respond; (but she does show sensitivity to the patient by waiting for 0.5 of a second before self-selecting, in overlap with the patient). At 462 the nurse directs her question unambiguously to the companion, who after a 0.6 second delay answers. Her oh-yes prefaced response on the patient's behalf at line 464 is a quite strong claim to epistemic priority (see Heritage, 1984 on "oh" as responses to news announcements). Notice also the companion's use of the terminal tag-question *don't you*; it looks like an orientation to the patient's contribution to the production of the information, but, like the tag question in Example 2, if we follow the analysis of Heritage and Raymond (2005), it constructs that contribution as a matter of agreement with the companion rather than as an independent source of the information.

[Figure for Example 10 about here]

So by line 467 both the companion and the patient have answered the question adequately, and the patient has confirmed it (if minimally). What then, do we make of the increment *sometimes twice* offered by the companion in line 469? Possibly it is an intrusion too far into the details of the patient's bowel movements; perhaps that is what the patient's arm-raise signifies, blocking the companion out at the moment when her response has been heard to start (the patient does raise her hands at other points in the interaction, but usually only to adjust her glasses, and not to occlude her face). And perhaps that is what motivates the companion to extend her turn with laughter particles, to signal her acknowledgement that she may have gone too far.

Those must remain speculations. In the example below, the patient's resistance is clearer. We join as companion Vicky offers a direct answer (line 718) to the doctor in the absence of a reply from her son, patient Sam. She then moves to the most impositive end of the spectrum by scolding him for not speaking (lines 722-725).

[Example 11 about here]

This consultation was one in which the patient and companion chose to be audio-recorded only, so we only see the doctor; she is in full view, looking towards the patient and companion, to one side of, and behind, the camera. Her expression throughout the exchange is smiling and could be glossed as 'encouragingly amused'; it may be that this optimistic visible reception of the patient's first answer is enough to licence what the mother says (although not delivered in "smile voice") as somehow affectionate, perhaps 'teasing'. One way or another, though, the companion has penetrated deep into her son's epistemic territory, claiming to know not only that he can speak very well, but that he does so only when he chooses. Sam's "oh be quiet Mummy" at line 729 is the most direct form of resistance in our data. But it is rare.

4. Discussion and Conclusion

4.1. Discussion

We set out in this article to identify how companions mediated between a medical practitioner and a patient who had an intellectual disability. We found that, in our sample, companions of intellectually impaired patients generally did not act as parents are reported, by Bates et al, to act *vis-à-vis* their children: "[p]arents obviously regard matters of the child's health as their own responsibility and, therefore, they usually treat their children in medical interviews as if they were absent" (Bates et al, 2002, p 115). Far from it; most answers directed at the patient were answered by the patient. On occasion, though, the companion did intervene; but when they did, perhaps mindful of the dangers of what has been called "epistemic injustice" (Carel and Kidd, 2014), they did so in a carefully calibrated manner, on a gradient of lesser or greater epistemic authority, from hinting to outright pre-emptive intercession.

One way of interpreting the findings is as a matter of the companion choosing how to solve the dilemma of encroaching on the patient's prior entitlement to know their own circumstances, versus hindering the objectives of the medical encounter. On the one hand,

to provide an explicit answer to the medical practitioner's question, when it has been asked of the patient, is to presume the patient's fundamental incompetence to know their own lives; but to leave the information unspoken, or the faulty answer uncorrected, fails to satisfy the medical practitioner's question and so vitiates the point of the health check.

4.2 Conclusion

The gradient of intervention we discovered describes the various levels of presumption the companion is willing to make. By choosing an intervention at the lower, less entitled end of the spectrum, the companion offers the patient the chance to give the required information as if at first hand. The other end is nakedly imposing.

As mentioned in the Introduction, this falls along the gradient of what Brown and Levinson (1987) classically called the gradient of "impositive cost". In Heritage's (2016) reading of Brown and Levinson (reading from most imposing to least) "across this cline... Self is less and and less obliged to risk positive face by going on record , constraints on Other are progressively reduced, and co-operation is progressively distilled into an ever more purified ... form of co-ordination" (2016 p 28). At that end, the recruiter's (or in our case, the companion's) merest hint works to produce the desired outcome. In our data, the pivot around which all this swings, of course, is the patient's standing status as intellectually disabled. If the companion wants to preserve the patient's fundamental epistemic rights as a person, they still have to *act as if* the patient has the answer to the doctor's question - whether they do or not. There are many factors which will be at play to move the companion up and down the gradient; one which promises useful new research is the nature of the relationship between patient and companion - do parents, for example, have greater right to transgress at the more impositive end of the scale than do paid carers? Does the degree of intellectual impairment make a difference (as of course, in the case of the profoundly impaired, it must)? These are questions for the future.

4.3 Practice Implications

Unlike previous studies, which have suggested a dichotomous classification of companions' interventions into, for instance 'autonomy enhancing' and 'autonomy detracting' (Wolff et al., 2017), this study provides practitioners with more granular and detailed examples of how companions themselves carefully manage issues of epistemic rights and responsibilities within triadic consultations. This contributes to ongoing refinement of what 'autonomy' might mean for people with significant support needs, as our findings reinforce contemporary conceptualisations of autonomy as relational and enacted through unfolding interactions (Williams et al 2019). However, negotiation of speaking rights and roles for patients with ID and their companions (talk about talk) is seldom introduced by practitioners as a topic meriting discussion within the health consultation and our CA analysis illustrates the risks to patient self-determination when consideration of these power dynamics is overlooked. We would therefore encourage practitioners to initiate a respectful conversation regarding their expectations of companions' role in interaction as a preliminary to effective communication when people with ID attend health appointments with a companion (Lidsaar-Powell, Butow, Boyle, & Juraskova, 2018).

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Appendix: Transcription Symbols

(.)	Just noticeable pause
(.3), (2.6)	Examples of timed pauses, in seconds
word [word] [word]	Square brackets aligned across adjacent lines denote the start and end of overlapping talk.
.hh, hh	In-breath (note the preceding full stop) and out-breath respectively.
wor-	A dash shows a sharp cut-off
wo:rd	Colons show that the speaker has stretched the preceding sound.
(words)	A guess at what might have been said
()	Talk too unclear to merit even a guess.
word= =word	The equals sign shows that there is no discernible pause between two speakers' turns or, if put between two sounds within a single speaker's turn, shows that they run together
<u>word</u> , WORD	Underlined sounds are louder, capitals louder still
£word£	Delivered in a 'smile' voice
word	"Creaky" voice
°word°	Material between "degree signs" is quiet
>word word< <word word>	Inwards arrows show faster speech, outward slower
↑word	Upward arrow shows upward intonation
↓word	Downward arrows shows downward intonation
wo(h)rd	(h) shows that the word has "laughter" bubbling within it
((gruff voice))	Attempt at representing something hard, or impossible, to write phonetically
→	Analyst's signal of a significant line

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Figures and Examples

(see also .png files sent separately)

Figure 1: Interventions showing companions' epistemic stance vis à vis the patient

Examples

Example 1: shopping. Pat = patient ("Cliff", Comp = paid carer.

At line 547, the Nurse orients her gaze and body to Pat.

HC7 15.06

547 Nurse: ((to Pat) Are you doing stuff like walking up the stairs.
[...]
563 Pat: When you carry your shopping, .hh an'- have i- your lef-
564 your left arm your left a:rm, (.5) .h so it balances
565 as you wal- as you're go- grabbin' on (.) t' the rai:ls.
566 (.3)
567 Pat: and that's what I've been been doing.
568 Nurse: Okay (.0) [perfect
569 Pat: [So far >t'ch wood< ((taps table)) 's bin
570 going good.
571 (.5)
572 Nurse: And .h
573 Comp: Wu- one thing with the stairs >th' you told me this morning
574 Cliff< is that (0.7) you find it hard sometimes >with those
575 stairs at your house< don't you=and that's why you wanted
576 the oh tee ("OT" = occupational therapist)).
577 Pat: My stairs?
578 Comp: Yeah

Example 2: summer. Pat = patient "Jeanie"; Comp = her mother.

Note that the configuration of the seating, with the doctor sitting side-on to the patient and companion, does not allow us to be completely sure of the target of the doctor's gaze; note, however, that when the doctor delivers the questions in lines 284 and 294, the companion is looking towards the patient, and it is the patient who takes it that she has been selected for the next turn)

HC4 08.20

283 Dr: ((to patient) so- is there any earwax in there, d'y think,

284 (1.0)
 285 Pat: Ah she just got a m- (.) (move) m-
 286 (.5)
 287 Comp: It w's- >they removed it<=But they had a look first
 288 Pat: Mmm
 289 Comp: Didn't they Jeanie.
 290 Pat: Yeah
 291 Comp: They had a look first din't they.
 292 Pat: yeah, they did have (t- a) look.
 293 Com:p: yeah [°(they had a look at that)°
 294 Dr: [Was that recently, or a long (.) er while ago.
 295 Pat: Er (.) longer
 296 **Comp: Yeah you're right °Jeanie yeah° I think it was over**
 297 **summer [or**
 298 Dr: [Yeah okay,
 299 **Comp: Or it could've been the beginning of the year, °I**
 300 **don't remember°**

Example 3: soaps . Pat = patient ("Phil"); Comp = his mother. Pat has been talking about football.

HC11 2.45

103 Nurse I can't ask you any questions ((*shaking head*))
 104 because I (0.9) I don't know about [that
 105 Comp [((laughs))
 106 (.8)
 106 Nurse But- (.) ((to patient)) an' that's your routine is it,
 107 Pat Yeah, (0.3)
 108 **Comp He likes a soap opera**
 109 Nurse Oh you like y' soa:ps
 110 **Comp Mm ((nodding)) heh**
 111 Nurse Ah::aw.
 112 (0.8)
 113 **Comp With his cake and tea isn't it Phil heh heh**
 114 Pat Oh mm yeah yeah

Example 4: a man. Pat = patient; Comp = her mother

HC15 1.55

35 Nurse: He's a nice doctor isn't [he
 36 Pat: [Yeah I know yes
 37 Nurse: Yes
 38 (.5)
 39 Pat: This reason now because I came to- (.4) see him.
 40 Nurse: Yeah 'cos you needed a (.3) <certificate>.
 41 Pat: [Hm
 42 **Comp: [She was happy it was a ma:n**
 43 (.5)
 44 Nurse: O:::h ((*"appreciative" voicing*))
 45 Comp: Yeah
 46 (.5)
 47 Nurse: New face.
 48 Pat: ((*nods*))
 49 Nurse: Had you met him befo:re,
 50 Pat: ((*nods*)) this's m'first time.

Example 5: Father Christmas. Pat = patient; Comp = her mother

HC13A 12.00

192 Nurse: O::h. But otherwi::se,
 193 (1.4)
 194 Comp: Otherwise (it's) alright innit? ((to Pat))
 195 (1.1)
 196 Comp: Oi ((to Pat)), what's (), do you ()
 197 alright
 198 Pat: [Oh yeah
 199 Nurse: [You're being all right (.) good. ((turns to computer))
 200 **Comp: An' she drea:m every night (1.0) of Father Christmas**

Example 6: treadmill. Pat = patient; Comp = paid carer

HC10 12.25

394 Pat I get out o' breath: (.) when I'm on the treadmill, but
 395 it wears off after a little while [yeah?
 396 Nurse ((to Pat)) [OK but you haven't got
 397 to s:top ((mimes inhaler))
 398 (0.5)
 399 Pat No hh °([] °
 400 **Comp [But then again he doesn't go that fast on**
 401 **the treadmill either,(3) [(he- he just wa:lks,**
 402 Nurse [Yeah
 403 **Comp [(**
 404 Nurse [That's just fine at least he's on the on the treadmill
 405 (1.4)
 406 Nurse and your asthma, (0.5) how often are you using the blue one

Example 7: optician. Pat = patient; Comp = paid carer

HC7 33.25

1238 Pat: When I left, everyfing was all good [(plan).
 1239 Nurse [(Yuh,)
 1240 Pat: An' nuffing-, .hh they looks after me good, .hh
 1241 [Eye drop- eye drops in yer eye,
 1242 Nurse: [Yes.
 1243 **Comp: But the optician missed [it didn'- didn't they=**
 1244 Pat [y'know,
 1245 **=the opticians missed it.**
 1246 Pat: Yeah, and then the opticians missed that
 1247 Nurse: [Oh really
 1248 Pat: [Yeah that's right yeah

Example 8: kilograms. Comp = patient's mother

Mother is doing up patient's cuff; both are looking down

HC5 20.40

736 Dr: ((looking at screen)) Do you want to know your weight.
 737 (.8)
 738 Dr: In er (.5) [stones, or are you okay with the kilograms.
 739 [((looks to patient very briefly))
 740 (.5)
 741 **Comp: [°Eh° he's okay**
 742 [((Comp looks up to Dr))

743 [*((patient continues to look down at cuff throughout))*
 744 Dr: yuh?
 745 Comp: °() °

Example 9: heart. Pat = patient; Comp = her mother

HC15 5.20 (*Nurse's gaze and body orientation shows that all her questions in this extract are directed to the patient*)

144 Nurse: That's very good for you, gets your heart (*(mimes heart*
 145 *pumping)*)
 146 (0.7)
 147 Nurse: Do you get all sweaty,
 148 Pat: No: [*((shakes head emphatically))*
 149 Nurse: [No?
 148 Nurse: But you get your heart (*(mimes heart pumping)*) (.5) going.
149 Comp: Yes
 150 Nurse: Wo:::w

Example 10: bowels. Pat = patient; Comp:= her mother

HC25 13.35

451 Nurse: (*((turning to Pat from the screen))*) and any problems
 452 going [to the toi:let?
 453 [*((eye-flick to Pat))*
 454 Pat: no, hh (.) [no
 455 Nurse: [*((to Pat))*] passin' urine okay,
 456 Pat: mm. (*(nods)*)
 457 Nurse: [yeah? And how are the bowels.
 458 [*((eye-flick to Comp))*
 459 (0.5)
 460 Pat: [M'yeah
 461 Comp: [Yep (*(nods)*)
 462 [*((Comp turns briefly to Pat as she nods))*
 462 Nurse: °yes?° (*((to Comp))*) Regular?
 463 (0.6)
 464 Comp: Oh yes [ev'ry, every (.6) day, don't you.
 465 Pat: [*((nods shallowly))*
 466 Nurse: [Yeah?
 467 Pat: Hm
 468 (0.2)
 469 Comp: Sometimes [twice. (*((turns to Pat))*) huh huh huh.
470 Pat: [*((raises the arm on Comp's side,*
471 *scratches her head))*

Example 11: be quiet. Pat = patient; Comp = his mother

HC33 15.50

[Note that throughout the exchange, the patient and companion are to one side of, and slightly behind, the camera; the doctor is clearly visible]

715 Dr: (*((to Pat))*) How about (0.2) fruit, d'you like fruit?
 716 Pat: ° Mm °
 717 (1.5)
 718 Comp: Bananas, (0.7) apples
 719 (1.8)
 720 Pat: Pear.
 721 (0.2)
 722 Comp: Are you going to spea:k?

723 (0.4)
724 Pat: No.
725 Comp: Cause you can speak very well (0.2) when you feel
726 like it.
727 Pat: Hmm
728 (0.6)
729 Pat: Oh be quiet Mummy.