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Treatment recommendations as complex activities: A sequential unfolding of acceptance

Zalecenia dotyczące leczenia jako złożony proces: sekwencyjny rozwój akceptacji

Abstract
This paper offers empirically grounded observations on the interactional organization of treatment recommendations in secondary care in the context of Polish healthcare. Drawing on conversation analysis as a method of analysis, the paper highlights practices involved in the design of the activity of recommending treatment. It begins with a background sketch of the available interactional research on the organization of treatment recommendations in Polish doctor-patient communication, followed by a case study that focuses on the format in which invasive treatment recommendation is presented and the sequential unfolding of patient's acceptance thereof. The paper concludes that patients and doctors use joint interactional strategies to manage the progressivity of the treatment recommendation activity towards a mutually agreeable and acceptable outcome.

Keywords: Polish, conversation analysis, doctor-patient interaction, sequential analysis, treatment recommendations

Abstrakt
Publikacja przedstawia empirycznie ugruntowane obserwacje dotyczące interakcyjnej organizacji zaleceń lekarskich w kontekście polskiej opieki zdrowotnej. Opierając się na metodzie analizy konwersacyjnej, tekst przybliża praktyki dyskursywne wykorzystywane przy konstruowaniu zaleceń leczenia. Artykuł rozpoczyna się od zarysowania tła dostępnych badań interakcyjnych nad organizacją zaleceń w polskiej komunikacji lekarz-pacjent, po czym następuje analiza sekwencyjna przebiegu rozmów dotyczących leczenia inwazyjnego i rozwoju tychże do momentu akceptacji przez pacjenta. Stwierdzono, że pacjenci i lekarze wspólnie zarządzają progresywnością działań związanych z zaleceniami dotyczącymi leczenia w celu osiągnięcia wzajemnie akceptowalnego scenariusza.

Słowa kluczowe: język polski, analiza konwersacyjna, komunikacja lekarz-pacjent, analiza sekwencyjna, zalecenia lekarskie

1. Introduction

Even though interactionally-oriented empirical research on the interactional organization of doctor-patient communication in Poland is still scarce, there has been some increasing interest in the topic within other fields, mainly within sociology, psychology and market research projects. Studies on the development of family medicine in Poland point to the fact that changes in habits and attitudes take place slowly; in effect the Polish healthcare system is still largely paternalistic and in transition (Coulter and Jenkinson 2005; Czachowski and Pawlikowska 2011; Marcinowicz et al. 2009; Oleszczyk et al. 2012; Ostrowska 2003; Piasecka-Robak 2020; Stangierska and Sikorska-Horst 2007). When it comes to treatment recommendations specifically, in Ostrowska's (2011: 15) study, patients report that most doctors do not give patients alternative therapy options, do not offer patients choice of medication, rarely inform patients about the aim of additional tests, and do not explain the working of drugs to patients. Other studies (e.g., Marcinowicz et al. 2009; Ratajska et al. 2023), highlight a significant gap in clinical communication skills among patients and doctors (and medical students). The authors note that among medical professionals, the highest need for developing communication skills is related to recommendations for surgical treatment. Ostrowska's (2011) study reveals that Polish patients are not offered enough opportunities to ask questions and to discuss treatment decisions with their doctor during the medical visit. Instead, they question the treatment by non-adherence, when outside the doctor's office, changing their treatment regimens without their doctors' knowledge, altering the dosage of the medication or abandoning treatment altogether. This resonates with observations from international research; patients resist doctor's treatment recommendations to solicit more information on their condition, side-effects of treatment or the impact of treatment on their everyday life (Stivers 2005; Toerien 2021; Wang 2023). However, as empirical studies show, treatment recommendations are not unilateral decisions, but rather, they are bilaterally negotiated by patients and doctors and accomplished over the course of the interaction (for the most current reviews of state-of-the art see Barnes and Woods 2024; Ekberg et al. 2024; Stivers and Tate 2023). This paper builds on that research and contributes to it by offering the first conversation analytic observations on the dynamics of the interactional organization of an invasive treatment recommendation in Polish secondary care.

2. Data and method

Conversation analysis (CA) is a qualitative research method, which pioneered empirical collections-based analyses of the design of turn-constructional units (TCUs) and turns-at-talk, examining actual, sequentially organized interactions (see Heritage 2008; Sidnell and Stivers 2012 for detailed descriptions)[1]. CA studies offer systematic observations on how social actions are designed, they identify sequential, deontic and epistemic patterns of these actions, and document sequential environments of practices for accomplishing actions. CA analyses draw on recordings and transcripts of naturally-occurring data. Accordingly, the corpus for this study comprises twenty audiotaped doctor-patient consultations from secondary healthcare settings in public medical institutions, which were transcribed and translated into English[2]. Transcription conventions can be found at the end of this paper. All participants were volunteers who agreed to participate in a study on the quality of patient-doctor communication; they gave written consent to the recording of their interactions. All names and details that could provide identifying information are changed.

The analysis starts with a brief illustration of a non-invasive treatment recommendation and then turns to a single case analysis (cf. Schegloff 1987), which demonstrates that patients and doctors orient to the overall progressivity of the activity of recommending treatment towards agreeable and acceptable outcome. The single case analysis draws attention to the phenomena and interactional practices that doctors and patients use to manage the co-construction of an invasive treatment recommendation.

3. Formulating treatment recommendations

The issuing of a recommendation defines the situation here-and-now as a goal-oriented course of action, creating an expectation that the patient will display an understanding of it and take up a stance toward what has been put forward by the doctor. The preferred response to a recommendation in the context of a medical interaction seems to be its acceptance in a next-positioned turn (e.g., Koenig 2008; Stivers 2007). However, research has demonstrated that patients can use different forms of receipt in these next-positioned turns (e.g., silences or on-record challenges) to negotiate or resist treatment (e.g., Toerien 2021). A careful analysis of the entire corpus used for this study suggests that the activity of recommending treatment

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1 For a brief description of CA in Polish see Dorota Rancew-Sikora (2007: 151).

2 The transcripts are rendered in a simplified form and the English translations offer a pragmatically-grounded approximation of the Polish original lines.

is accomplished differently when it involves a change in diet or medication as treatment (non-invasive) and some form of a physical intrusion into the body as treatment (invasive) (but see De Marco et al. 2024). Accordingly, cases involving surgery as a treatment option may be fraught with incipient resistance. As my analysis shows, however, interactants exploit interactional practices for the maximization of agreement in the anticipation of this resistance.

3.1. Non-invasive treatment recommendations

Examples (1a) and (2a) illustrate the delivery and the receipt of non-invasive treatment recommendations. The recommendation in Example (1a) concerns the patient's lifestyle. The patient was diagnosed with multifocal cerebral ischemia (insufficient blood supply due to blocked arteries) and here, in lines 137–138 the doctor inquires about the patient's smoking habits. Having stated that he used to smoke (line 139), the patient then confesses that he hasn't smoked in the hospital yet. The doctor picks up on the patient's last TCU (line 140) and uses it as a move towards formulating a recommendation.

(1a) Multifocal ischemias/Neurology_Treatment recommedation

137	D:	.hhh (.) Y::: dobrze. A prosze mi powiedzieć tak. Papierosy= .hhh (.) *Y:::* alright. And please tell me this. Do you=
138		=Pan pali? =smoke?
139	P:	Paliłem. (0.2) Chociaż tu jeszcze nie pali:łem. I used to. (.) Though I haven't smoked here yet.
140	D:	=Tu jeszcze nie paliłem? (.) No to: (.) y=myślę że już:, =I haven't smoked here yet? (.) *No* so (.) *y*=I think that now,
141	P:	Chcia:łbym. I would like to.
142		(.)
143	D:	[Ta::k,] [Yes,]
144	P:	[Ju:sz] tak na za:wsze no:. [From now on] never again *no*.

Even though the doctor's turn is designed as grammatically and prosodically incomplete, the patient recognizes it as (pragmatically) informative enough for him to respond to it. In line 141 the patient first states his willingness to quit smoking and after a brief silence, in overlap with the doctor, expresses

his commitment to quit smoking forever (line 144), thus fully accepting the recommendation[3].

The fragment in Example (2a) illustrates the first mention of a recommendation for medication. The doctor informs the patient (diagnosed with encephalitis) of his discharge from the hospital and presents a treatment recommendation that the patient is expected to follow at home (lines 296).

(2a) Encephalitis/Neruology_Treatment recommendation

```
296          puszczę Pana do domu. W domu Pan będzie brał le:ki.
             I'll let you go home. At home you'll be taking medications.

297          (0.8)

298   D:     Nadal.
             Still.

299          (0.7)

300   D:     Te które Pan dostaje w tej chw[ili, ] dobrze[:?  J]e=
             The ones you're getting right n[ow,] alri:gh[t? Y]ou=

301   P:                                    [Mm::,]       [Ta:k.]
                                             [Mm,]        [Yes.]

302   D:     =będzie Pan bra:ł sobie: do:ustnie, y::: hh z: tym że ta:k.=
             =will be taking them orally, y::: hh but the thing is that.=

303          =y:: dietka, (.) racze:j, (.) nie jakieś [(kotlety) smażo:ne i  ta]k=
             =y:: diet, (.) rather, (.) not some [fried  (pork chops) and ] so=

304   P:                                         [Tak=tak=tak=tak=tak=tak.]
                                                [Yes=yes=yes=yes=yes=yes.]
```

Since the initial recommendation lacks specificity and is insufficient (cf. Stivers 2007), the subsequent silence (line 297 and 299) orients to the fact that it would be too early to accept the treatment at this point. The doctor's next TCU *Te które Pan dostaje w tej chwili, dobrze:?* (line 300) re-specifies the recommendation, drawing on the patient's familiarity with the medication. The patient's initial response (line 301) consists of a minimal acknowledgment token *mh*, followed by a stronger confirmation token *Tak*. When the doctor adds to the recommendation (line 302–303), the patient comes in with a yet stronger confirmation, producing multiple interjections (line 304), thus unequivocally accepting the recommendation (see Stivers 2004). As these two examples suggest, non-invasive treatment recommendations seem to progress rather unproblematically towards acceptance. As will become apparent, the sequential progression towards acceptance is more elaborate in the case of an invasive treatment recommendation.

[3] No in Polish is not a disagreement token, but a stance-conveying particle, and it has been left intentionally untranslated in all examples presented in this paper.

3.2. A sequential analysis of an invasive treatment recommendation

Examples (1)–(7) come from one neurological consultation and they illustrate the unfolding of an invasive treatment recommendation towards its acceptance[4]. To aid in a smoother consideration of the relevant issues, the data fragments and the discussion are divided into segments. The patient in this consultation is a man in his early forties, he used to do a physically demanding work at the time of his first admission to the hospital some years ago and still complains about recurrent lumbar pains. A week prior to the current consultation the pain got severe and the patient ended up in the emergency unit and was subsequently referred to the hospital, to the neurological ward. Excerpt (1) opens with the doctor presenting the decision concerning treatment to the patient (lines 246–247).

(1) Hernia/Neurology_Treatment recommendation

```
247        Zadecydowaliśmy wspólnie, po tej konsulta:cji z panem profesorem,=
           We decided together, after consultation with mister professor,=

248        =że: y::: ponieważ na jednym poziomie, (.) .hh w tym=
           =that y::: because on this one level, (.) .hh in the=

           ((24 lines omitted))

274        .h Także, (.) pan profesor twierdzi że po opera:cji:,=
           .h So, (.) mister professor believes that after the surgery,=

275        =(.) y:: tego oddcinka, (.) powinny te dolegliwości=
           =(.) y:: of this segment, (.) these ailments should=

276        =(.) ustąpić.>Oczywiście nie może:my dać gwara:ncji:=
           =(.) stop. Obviously we cannot guarantee=

277        =.h że nie pogłę:bi się przepuklina
           =.h that the hernia
```

The first turn-constructional unit (TCU) in the doctor's turn *Zadecydowaliśmy wspólnie*, uses the institutional We-format (e.g., Drew and Heritage 1992) to present the treatment as a joint decision of two doctors and a logical consequence of the patient's test results – objective medical facts (line 248). The progression of the treatment recommendation delivery is suspended mid-turn (signaled by *y:::* at line 248) and, beginning with a conjunction *ponieważ*, the doctor now turns to presenting diagnosis to the patient (the presentation of diagnosis is omitted from the transcript). The design of the treatment recommendation changes, with respect to responsibility and accountability, as the We-format is abandoned and the responsibility for the

[4] Line numbers were preserved in the successive Excerpts, but some lines have been omitted for reasons of space limitations.

recommendation is shed solely on the third party (line 274), *pan profesor*. In the context of presenting a treatment recommendation for surgery (i.e., invasive option) the reference to the person with greater authority than the attending doctor may have the function of coercing the patient's acceptance. As the doctor rounds up the activity of informing the patient about treatment, she once again draws on objective medical facts.

In Excerpt (2), at line 420, the doctor refers to the result of the patient's lumbar puncture and the increased protein value in the cerebrospinal fluid (lines 420–423). This objective medical evidence is used to account for surgery as the preferable treatment option (increased protein value proves that the disk slipped into the vertebral canal, which in turn implies that surgery is the only way to get it out of there). The doctor's TCU is brought to completion with a turn-final upward intoned *Prawda:?* (line 425), which is an element that "presents the speaker's point of view not as a point of view but as an objective truth; and it doesn't seek agreement but an acknowledgement of this truth" (Wierzbicka 2003: 40).

(2) Hernia/Neurology_Treatment recommendation

```
420   D:    =no i ten płyn mózgowo-rdzeniowy który Pan był=by:ł=
            =no and this cerebrospinal fluid that you^V had you^V had=

421         =Pan nakłuty, i tam to białko jest podwyższone, bo tam=
            =the puncture, and this protein is elevated, because there=

422         =jest zero dziewięćdziesiąt dwa bia:łka, to te:ż świadczy=
            =is zero comma ninety two of the protein, this also proves,=

424         =o tym, że ten dysk wypadł do kanału kręgowe:go. Prawda:?
            =that this disc slipped into thet vertebral canal. Right?

425   P:    [°Tak.°]
            [°Yes.°]

426   D:    [Także] (.) to też potwierdza jak gdyby że ta operacja=
            [So   ] (.) this also seems to be confirming that this surgery=

427         =jest jedy:nym skuteczną w tej chwili metodą leczenia. Prawda?
            =is the only effective method of treatment right now. Right?

428         Żeby to nie wracało.
            So that it doesn't revert.

429         (0.6)

430   D:    I zobaczy:my. Myślę że powin[no być  dobrze.]=
            And we'll see. I think it shou[ld   be   alright.]=

431   P:                                [Znaczy jak prze]bie:ga=
                                          [I mean what does s]uch=

432   P:    =taka operacja?
            =a surgery look like?
```

Starting simultaneously with the patient's affirmative interjection (line 426) that acknowledges the doctor's prior turn in a confirmatory way, the doctor's next turn uses the patient's confirmation of the objective medical facts to leverage this confirmation in a pro-surgery direction. In what follows (lines 426–428) the doctor emphasizes that surgery is the only effective method of treatment and seeks acknowledgement of this proposition with the-truth-seeking token *Prawda:?* (428). The preferable response is not forthcoming (line 431). After a considerable silence (line 429) the doctor (line 430) adds a "post-completion musing" (Schegloff 2007: 143) that offers an evaluative afterthought to the otherwise complete sequence. Such utterances often offer some analysis or assessment of the prior sequence, but do not establish an unequivocal relevance of a response. Here, the doctor's assessment (line 430) offers an optimistic analysis of the surgical treatment and its outcomes, which may be pre-closing implicative. Pre-closings are interactional strategies that are used "not only possibly to initiate a closing section, but also, by inviting the insertion of unmentioned mentionables, to provide for the reopening of topic talk" (Schegloff and Sacks 1973: 247). Indeed, as the continuation of Excerpt (2) shows, the patient, coming in interjacently (Jefferson 1986) with the doctor's ongoing turn (line 431–432), initiates a question and thus reopens the conversation on surgery as treatment.

```
433    D:     .hh To znaczy proszę Pa:na, y: to tak jak ja że tak powiem=
              .hh I mean sir, y: like I so to speak have=

434           =ju:[ż-
              =alrea[dy-

435    P:         [ogólnie wspomin[a:łam.
                    [been saying gene[rally.

436    D:                            [Więc właśnie.
                                        [Well exactly.

              ((30 lines omitted))

466    D:     Mam pacjentów którzy napra:wdę w dru:giej dobie=
              I have patients who honestly on the second day=

467           =trzeciej, (.) wstają, (.) chodzą, (.) rehabilitują=
              =the third day, (.) get up, (.) walk, (.) rehabilitate=

468           =się, (.) i naprawdę jest dobrze.
              =(.) and it is really alright.
```

Apart from reopening of topic talk, the "ancillary question" (lines 433 and 435) shifts the action agenda, from accepting the treatment, to now making an answer from the doctor a relevant next turn (Heritage and Clayman 2010; Jefferson 1984; Maynard 1980). The question inquires specifically about the steps involved in the surgical procedure. The doctor addresses the patient's question (lines 433–434) pointing to some previously occurring interaction in which the doctor has already given the patient some

information about the surgery. The patient's collaborative completion of the doctor's turn-in-progress at line 435 (Lerner 1991, 1996) cooperates in the co-construction of this response as a repetition of something that has been previously touched upon, but qualifies the doctor's prior description of the surgery as a general one. Having confirmed the patient's collaboratively positioned unit (line 436), the doctor launches a more detailed description of the surgical procedure (data not shown), highlighting the optimistic outcomes of the treatment (lines 466–468). The last item in the doctor's three-part list (Jefferson 1990) at line 467, is the verb *rehabilitują się*. The patient selects this last item as the focus of his next turn and initiates another question, about the duration of the rehabilitation process (line 469), which is where Excerpt (3) begins.

The patient's *A*-prefaced question initiates a new sequence (Weidner 2012), which attends to a different topic agenda than the one before (details of the surgical procedure). The patient's question is referentially linked to the treatment recommendation, but does not orient to it in terms of acceptance or rejection (none of which have been produced yet).

(3) Hernia/Neurology_Treatment recommendation

```
469   P:     A jak długo trzeba z rehabilitacją,
             And how long does one have to rehabilitate,

470   D:     =To znaczy z tą rehabilitacją to zależy od pacjenta.=
             =I mean with rehabilitation it depends on the patient=

471          =[Ja my- ] y=zależy.
             =[I thi-    ] y=depends.

472   P:      [Zależy.]
              [It depends.]
```

The doctor responds to the patient's question, by transforming its agenda (Stivers and Hayashi 2010). The first TCU in the doctor's turn (lines 470–471) does not supply the *datum quaestionis* (Ajdukiewicz 1975) of the question, which should properly be some specific timeline, requested by the wh-word *jak długo*, but broadens its focus to put a conditional and a subjective qualification on this timeline (conveyed by *to zależy od pacjenta*). In what follows, the doctor shifts the topic agenda and shifts the focus of her elaboration toward the bright side, moving away from the post-operative downside (that is a rather long period of rehabilitation) to the upside, as the doctor's successive TCUs in Excerpt (4) "display an orientation and sensitivity to the particular other(s) who are the co-participants" (Sacks et al. 1974: 727). They offer an optimistic evaluation of the patient's body-build (slender physique) and use this evaluation to convince the patient that both the surgery and the post-

operative rehabilitation are a lot easier then. The grammatical design of the doctor's turn reflects the principle of "recipient design" (Sacks 1995) and attends to both issues that have been visibly sensitive so far – the surgical procedure itself and the inevitable rehabilitation process.

(4) Hernia/Neurology_Treatment recommendation

```
490   D:    .hh A Pan jest szczupły, więc i sam zabieg operacyjny=
            .hh And you are slender, so both the surgery=

491         =powinnien przebiec bez powikłań, bardzo (.) jest=
            =should go without any complications, there is (.) then=

492         =wtenczas ła:twe do:jście do tego [kręgosłupa oni od razu=
            =easy access to the [sp  ]ine they can immediately=

493   P:                                  [Ta:k.]
                                [Yes.]

494   D:    =wi:dzą (0.2) y: ten dysk, w którym miejscu tam uciska=
            =see (0.2) y: the disc, the place where it constricts=

495         =na te korzenie, nie to:pi to się (0.2) w żadnym=
            =the nerve radicles, it's not drowned (0.2) in any=

496         =tłuszczu. Także:. I rehabilitacja też jest łatwiejsza.=
            =fat. So. And also rehabilitation is easier.=

497         =Także wszystko (0.2) y: świadczy na korzyść Pana.
            =So everything (0.2) y: speaks to your advantage.

498         (0.2)
```

Following the turn-initial evaluation, the next unit, *więc i* (line 490), projects multiple components to come. Accordingly, the doctor tells the patient that in his case the surgery will be a lot easier, because he does not have a lot of fat tissue, which could obstruct the surgical vision (lines 490–496). The patient's affirmative interjection (line 493) mid-turn signals agreement with this line of argument. The doctor also emphasizes the patient's advantage as far as post-operative rehabilitation is concerned. This second argument is delivered in a TCU that begins with *I* (line 496) and that is designedly and recognizably the subsequent component of the compound grammatical structure initiated by *więc i* (line 490). Both arguments are summarized in the doctor's final TCU (line 497), where she makes a connection between the patient's physique and surgery-as-treatment, and evaluates this connection as felicitous for the patient.

In Excerpt (5) below the doctor acknowledges the fact that the patient's health has improved now (lines 499–500), and follows this acknowledgement with a conditional pre-emptive candidate option (Gill et al. 2009) *czy: by nie poczę:kać.* (line 500) and a post-completion recompleter *Prawda:¿*. After a minimal acknowledgment from the patient (line 502), the doctor extends the candidate scenario by presenting it as a viable possibility (line 503).

(5) Hernia/Neurology_Treatment recommendation

```
499    D:    =Poza tym (.) y:: jeszcze rozmawiam z profesorem, no=
             =Besides (.) y:: I'm still talking professor as well, no=

500          =bo (.) te:raz się Pan poprawił, czy: by nie pocze:kać.=
             =cause (.) now you have improved, if we should not wait.=

501          =Prawda:,
             =Right,

502    P:    °°Uhm,°°
             °°Mhm,°°

503    D:    No bo te:ż taką ewentualność można by wziąć pod uwagę.
             No cause we could also consider such a possibility.

505    P:    =°°No właśnie.°°
             =°°No exactly.°°
```

The patient responds with °*No właśnie.*°° (line 504), latched onto the doctor's prior turn. The placement of the patient's response is crucial here, because the patient confirms immediately after the doctor's prior turn, whose design did not seek confirmation. Being *no*-prefaced, this response contributes a "knowing" confirmation (Heritage 2012, 2013; Weidner 2018), which underlines the patient's position regarding the necessity of the surgery as already held (it conveys the patient's evaluation of surgery as *not* necessary). In the context of the larger ongoing activity, this confirmation is the first explicit indication of the patient's resistant stance concerning the recommendation. Yet, as the continuation of Excerpt (5) illustrates, in her successive turn the doctor negatively assesses the alternative to wait with the surgery and pursues her efforts to convince the patient of the benefits of an early surgery.

```
506    D:    =Natomiast prA:wda jest taka. (.) że w tej chwi:li (.) jest =
             =But the truth is. (.) that right now (.) you=

507          =Pan (0.2) mło:dy. Ma Pan czterdzieści cztery lata. Nie ma=
             =are (0.2) young. You are forty four years old. You don't have=

508          =Pan cukrzycy. Nie ma nadciśnienia. Ma: Pan zdrowe serce.
             =diabetes. You don't have hypertension. Your heart is healthy.

509          (0.2)

510    D:    .hh Prawda? Czyli (0.2) opera:cja, (.) prawda?
             .hh Right? So (0.2) surgery, (.) right?

511    P:    °Tak,°
             °Yes,°

512    D:    Y:=ry:zyko operacji jest dużo mniejsze, jakiekolwiek=
             Y:=the risk of surgery is a lot smaller, any sort of=

513          =powikłania.
             =complications.
```

She draws on objective medical facts (i.e. the patient's age and by implication relatively good health, lines 506–508) and seeks acknowledgement of these facts with *Prawda?* (line 510). The patient's *°Tak,°* , at line 511, provides such an acknowledgement.

In Excerpt (6) the doctor continues enumerating the factors in favor of surgical treatment, thus making it clear to the patient that it's better to have the surgery now. A general category *różne rzeczy* "different things" (line 514) is narrowed down to three more specific health-factors (hypertension, diabetes and heart attack), as the design of the doctor's turn (lines 514–517), again, uses the three-part list format. The second TCU (line 515) begins with *A: to*, which is a commonly used preface for listing in Polish and as such projects more than one item to come. The doctor's arguments in favor of surgery contain some self-evident observations (e.g., the older the patient gets the greater the risk of hypertension).

(6) Hernia/Neurology_Treatment recommendation

```
514    D:      =I:m człowiek sta:rszy, tym różne rzeczy mogą się=
               =The o:lder you are, the more different things can happen=

515            =przyplątać. A: to nadciśnie:nie, a: to jaka[ś cukrzyca, ]=
               =to you. Be it hypertension, o:r som[e diabetes,  ]=

516    P:                                              [No: wiadomo.]
                                                   [No of course.]

517    D:      =a: to jakiś za:wał nie daj bóg odpu:kać, .hh prawdha:?=
               =or some heart attack god forbid touch woo:d, .hh rihght?=

518            =Ale różne rzeczy mogą si[ę zda:rzyć.
               =But different things can [happen.

519    P:                                [Te rzeczy są wszystkie=
                                          [These things are all=

520            =przerażające że:,
               =so scary that,

521    D:      No::, ale wie: Pan. Po prostu wtenczas operować. Prawda:?
               No::, but you know. Simply to do the surgery then. Right?

522            (0.3)

523    D:      To: to ryzyko się zwiększa.
               Then the risk increases.

524    P:      =Oczywiście.
               =Of course.
```

Therefore, when the patient's overlapping *No: wiadomo.* (line 516) evaluates the doctor's list as truisms, it can be in fact hearable as setting these arguments aside (Weidner 2012, 2018). Moreover, this evaluation may in fact be using the obviousness of the doctor's arguments as a preliminary to rejecting the treatment recommendation altogether. The doctor's last

TCU recapitulates her prior arguments and is designed in a recognizably similar way to the first TCU in this turn (compare lines 514/515 and 518). The patient comes in in overlap and offers an assessment of the health-risks presented by the doctor (lines 519–520), but the doctor's next turn (line 521), beginning with *No::, ale wie: Pan* (line 541) creates "an interactive focus on speaker-provided information" (Schiffrin 1987) and coerces the patient's agreement (note, again, the use of *prawdha:?*). Eventually the patient agrees (line 524), but his agreement is again directed at the local arguments of the doctor's prior turns (i.e., that the surgery is riskier as people get older), and not at the overall recommendation for surgery as treatment. Nevertheless, the doctor takes advantage of this local agreement and uses it as a starting point for her subsequent turn, which is where Excerpt (7) begins.

(7) Hernia/Neurology_Treatment recommendation

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526   D:    =Więc jeżeli je:st możliwość, (0.3) Ma:my: y: wyniki badań,=
            =So if there is a possibility, (0.3) We have y: the test results,=

527         =(.) To my:ślę że należy się poddać tej operacji tE:raz,
            =(.) I) think that one needs to undergo this surgery now,

528   P:    =Ta[k.
            =Ye[s.

529   D:       [Bo nie mamy. Prawda:? [A nie czekać.
               [Cause we don't have. Right? [And not wait.

530   P:                              [Wy:jścia nie mam innego=
                                            [I don't have a choice=

531         =[(żadnego wy:jścia,)]
            =[(no other choice,)]

532   D:     [PIĘ:Ć     LA:T     ] Pan czekał, (.) y:: dużo cza:su, prawda,
             [five     years    ] you waited, (.) y:: a lot of time, right,

533         (.)

534         I wysiłku Pan wło:żył na tą rehabilitację, tak dalej, (.) No i=
            And effort went into this rehabilitation, and so on (.) No and=

535         =skończyło się że dwa tygodnie temu unieruchomiło Pana=
            =it ended up that two weeks ago you got completely=

536         =w łóżku zupełnie. Prawda:, .hh Także:: no z te:go wynika=
            =immobilized in bed. Right, .hh So no it all speaks to the=

537         =że: jednak myślę że ten zabieg operacyjny (.) ymy:=
            =fact that I think that this surgical treatment (.) ymy:=

538         =tut[aj      jest] (.) jedynym wyjściem.
            =her[e that  it's] (.) the only solution.

539   P:        [Konieczność.]
                [A necessity.]
```

The doctor's turn at line 526 is *so*-prefaced, bringing into relevance "something that was already on the conversational agenda" (Bolden 2008: 306) and indexing "the upcoming matter's emergence from incipiency" (Bolden 2008: 331). The beginning of the third TCU has the verb *my:ślę* as its focal component, produced at a boundary signaled by a brief pause (line 527). Also, the verb *my:ślę* comes before the gist of the doctor's turn, and as such "displays a certain orientation towards a proposition or parts thereof" (Kärkkäinen 2003: 115). Following this explicit marker, each successive element in the doctor's turn emphasizes and re-constitutes the importance of the recommendation for surgery as treatment. The verb *należy*, which belongs to the same class of modal verbs as *trzeba*, portrays surgery, and simultaneously the patient's acceptance of it, as an objective necessity (Zinken and Ogiermann 2011; Zinken 2016). The turn is brought to a possible completion with an adverb of time *tE:raz*, which reinforces the pending character of the surgery.

The patient responds with an agreement-conveying *Tak.* (line 528), but, as data show, this seems to be too weak in this context. The doctor continues and builds her turn in a way that is hearable to be conveying to the patient the imminence of his decision concerning the surgery. The patient's next turn offers a concessive response to the coercive trajectory proposed by the propositional content and the design of the doctor's turn, where the patient overtly admits that there is no other choice but to have the surgery (lines 530–531). Notwithstanding this acceptance-implicative response, the doctor layers more arguments on top of the patient's tacit acceptance. Beginning with a prosodically marked *PIĘ:Ć LA:T* in overlap with the patient (line 532), the doctor's multi-unit turn summarizes the patient's history so far (data not shown). Again, the doctor presents three pieces of evidence from the patient's past that illustrate the ineffectiveness of the treatment-so-far, and then follows them up with a logical syllogism that surgery is the only reasonable solution to the patient's problems. The patient comes in overlap and corroborates the doctor's conclusive statement. The lexical TCU produced by the patient (line 539) qualifies the surgery as *Konieczność*, where this word choice may signal the patient's orientation to the doctor's prior turn as an imperative that mandates acceptance rather than an option that may be rejected. The patient's antecedent qualification of the nature of the treatment has the same conclusive value as the doctor's subsequent *jedynym wyjściem* (line 565), but because it comes first, it is hearable as conveying the patient's independent conclusion, rather than just agreement with the doctor's conclusive statement. Additionally, this position of the patient's turn signals the patient's commitment to treatment that he himself now recognizes as necessary. It is only at that point that the treatment recommendation, which has so far been the doctor's (and the professor's) preferred treatment option, is turned into a mutually acceptable treatment plan.

4. Discussion

In sum, the analysis illustrated a potential pattern whereby the syllogism of individual arguments coerces the overall acceptance of the treatment recommendation by the patient. Drew (1992) discusses this sort of syllogistic reasoning through next-positioned sequences that organize the activity of questioning during cross-examination in a rape trial. His analysis reveals a pattern whereby confirming the proposition of a question makes it hard to back down from it, which in turn can contribute to creating damaging inferences (see also Heritage and Clayman 2010). Looking back at the fragments analyzed here, a logical conclusion is being drawn from the individual contributions of the patient and the doctor. In the case of treatment recommendation sequences presented in this paper, the doctor's arguments in favor of an invasive treatment and the patient's agreement with these arguments creates a logical conclusion that corners the patient into a position where they themself recognize the necessity of this treatment option. Consequently, the bit-by-bit agreement, accomplished in and through the individual component sequences is being used to co-construct agreement with the invasive (and potentially rejection-implicative) treatment recommendation.

The fragments discussed in this paper demonstrate an emerging pattern for organizing the activity of recommending invasive treatment. The doctor's turns are built for securing confirmation or agreement from the patient on a particular aspect relevant for the recommendation. This way of progressing with the treatment recommendation creates a unidirectional local context; once the patient agrees to one (and every single next) pro-surgery-as-treatment-constituting argument, it may be very difficult for them to back down. The doctor's subsequent turns use the patient's local agreement to forward the general course of action towards an acceptance of the entire recommendation.

Finally, the single case presented in this paper (as well as other cases in my corpus) suggests that the doctors may tailor the format of their treatment delivery to the sort of recommendation that they issue. First, when the doctor presented an invasive treatment option (surgery), the recommendation was formulated as a logical consequence of medical tests (that is objective medical facts). Second, the process of presenting the recommendation to the patient did not rely on a single turn or single sequence format, but rather, it was stretched over several turns and sequences that embraced the immediate necessity of an account for why this form of treatment was being recommended. These strategies may embody the doctor's efforts toward mitigating the patient's potential resistance in that they prepare the grounds in advance of the actual treatment announcement and work toward increasing the acceptability of the recommendation.

To conclude, this paper contributes insights addressing the view of the doctor-patient relationship in Poland as paternalistic. Building on several excellent CA studies of medical interactions, this paper demonstrated that as far the interactional dynamics of treatment recommendations in secondary care is concerned patients and doctors orient to the overall progressivity of the activity toward agreeable and acceptable outcome. The data fragments illustrated, for instance, that turns are designed in a way that make it possible for patients to confirm a given proposition. Overall, the structure of an invasive treatment recommendation seems to favor negotiations and accounts over immediate acceptance, as a way of working toward the acceptability of the recommendation as an ultimate treatment plan. The analysis revealed how the activity of recommending invasive treatment unfolds in and through intricate component sequences, where both the patient and the doctor work on the contingencies that shape the feasibility of the treatment. The restricted number of fragments analyzed here mandates some degree of caution regarding the generalizability and the representativeness of the findings reported in this paper. The overall objective was to identify certain patters and practices that organize talk-in-interaction in the context of doctor-patient communication in Poland. It was beyond the scope of this contribution to offer generalized observations on the nature of the entire Polish public healthcare sector. However, it would certainly be a welcome endeavor if the macro-scale presence and the implications of these patterns and practices were taken up more broadly by future empirical investigations.

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A glossary of transcription symbols adapted from transcription conventions developed by Gail Jefferson (Jefferson 2004)

underline	-	emphasis
[ ]	-	overlap, left bracket for overlap beginning, right bracket for overlap end
=	-	latching of turns
(0.2)	-	pauses measured in tenths of a second
(.)	-	micropause
---	-	cut of speecj
.hhh	-	inbreath
hhh	-	outbreath
.	-	final intonation contour
,	-	continuous intonation contour
?	-	pitch rise at the end of a unit
_	-	level intonation contour
↑	-	sharp rise in tone
a::::	-	lengthening of a sound
stRONg	-	louder than surrounding talk
°yes°	-	sotto voce
>yes<	-	faster than surrounding talk
no	-	lexical item not translated into English
(yes)	-	transcriber's uncertainty