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Patient participation in action: patients' interactional initiatives during interdisciplinary goal-setting meetings in a rehabilitation clinic

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Abstract: Clinical guidelines require the patient's participation in the entire rehabilitation process, including discharge planning. However, very little is known about how this institutional requirement is actually dealt with in everyday clinical practice. Adopting a conversation analytic approach, our paper tackles the matter, looking at situations in which patients achieve interactional initiatives within interdisciplinary entry meetings (IEMs) at a rehabilitation clinic in German-speaking Switzerland. Based on audio-visual recordings of 11 IEMs, whose central aim is to formulate patients' rehabilitation goals and to plan their discharge, the paper offers a detailed analysis of two conversational environments in which patients accomplish initiatives: incipient disagreement among the interdisciplinary team and difficulties faced by the professionals in moving towards the formulation of a goal. In both situations, the progress of the activity is at stake. Moreover, the analysis reveals the interactive and stepwise accomplishment of patients' initiatives. Our paper argues that shedding light on how patients' initiatives are interactively implemented makes it possible to discuss how issues of epistemic rights and entitlement to participate are locally negotiated. In the final discussion, the paper raises the question of how patients' competence in intervening in the goal-formulation activity can be taken into account in clinical guidelines on patient participation.

Keywords: rehabilitation, discharge planning, patient participation, interdisciplinary meetings, conversation analysis

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1 Introduction

1.1 Background of the study

Discharge planning (DP) refers to a complex process that involves the development of an individualized plan aimed at facilitating a patient's transition from hospital to home and preventing problems following discharge (Mistiaen et al. 2007). Lately, clinical guidelines (SIGN 2010) on rehabilitation have stressed the importance of patient participation throughout the rehabilitation processes, including discharge planning. At the same time, studies on DP have highlighted the fact that most patients have a desire for information and want to be involved in DP (Anthony and Hudson-Barr 2004; Roberts 2002; Thompson 2007), and that greater patient participation has led not only to an increase in patient satisfaction but also to a decrease in complications and readmissions after discharge (Anthony and Hudson-Barr 2004: 133; Popejoy et al. 2009: 940).

Yet there seems to be a mismatch between requirements for patient participation in clinical guidelines, its desirability for patients and its positive impact on patient satisfaction on the one hand, and patients' real opportunities for actually participating in DP on the other hand (Foss and Hofoss 2011; Levack et al. 2011). Even when DP meetings involve patients, they seem ultimately to have little impact on the official goal of the meeting, which is shown to be controlled by healthcare professionals (Barnard et al. 2010; Levack et al. 2011). When *asked* about her participation in DP conferences, one patient said that she felt powerless and treated like an object (Efraimsson et al. 2003), while others mentioned that they did not dare to voice their anxieties concerning discharge or felt unsupported (Kydd 2008), alienated from the events, unprepared for participation (Efraimsson et al. 2006), or excluded from active decision making (Huby et al. 2004, 2007). Moreover, patients' needs regarding participation have not yet been ascertained, nor have the factors favoring increased participation been identified. Studies on elderly patients' participation (Foss and Hofoss 2011: 68) stress, for example, that "factors like gender and education have little influence on participation" (see also Anthony and Hudson-Barr 2004).

Finally, *how patients actually interact with professionals* in interdisciplinary DP processes (Barnard et al. 2010: 240) has not yet been sufficiently analyzed. Questions such as "how do they participate?" and "how do they manifest their point of view on specific issues?" remain unexamined.

1.2 Patient participation from a conversation analytic point of view

Examining empirical studies on the interactional organization of dyadic doctor–patient encounters, conversation analysis (CA) researchers have critically discussed clinical guidelines’ insistence on increased patient participation (Ijäs-Kallio 2011; Peräkylä and Ruusuvuori 2007; Pilnick and Dingwall 2011; Robinson 2003). A central argument holds that before clinical prescriptions (or interventions aimed at their implementation) can be disseminated, detailed analyses on the interactive organization of healthcare encounters are required (Gill and Roberts 2012).

Studies focusing on practices through which patients manifest their position, or exert pressure for specific medical interventions during primary care consultations (Drew 2001; Gill 1998, 2005; Stivers 2002; Stivers and Heritage 2001), have stressed that for a better understanding of how patient participation is implemented, the ways in which practitioners and patients orient towards a larger activity structure need to be taken into account (Ijäs-Kallio 2011; Gill 1998, 2005; Robinson 2003). In her paper “Patient ‘demand’ for medical interventions” (Gill 2005), Gill describes how a practitioner might withhold a type-fitted response (a granting or refusing) to a patient’s demand for a medical intervention until the activity of history-taking and medical examination has been properly completed. In her conclusion, Gill (2005: 470–471) argues that participants’ orientation towards a sequential order in a consultation implies that patients’ demands might be treated as inappropriate and even sanctioned at one point in a consultation, whereas this same action might be considered unproblematic at another point in the same interaction.

Furthermore, it has been stressed that practitioners’ different communication styles must also be considered when we investigate patient participation (Collins et al. 2005; Stivers 2005). For example, it has been shown that when a practitioner asks a patient to share “unmet concerns” at the end of a consultation, when the patient’s initial concern has already been dealt with (Robinson 2003), and furthermore opts for the lexical “*some*” instead of “*any*” (Heritage et al. 2007), this has a significant impact on the patient’s readiness to actually voice his or her “unmet concerns.”

In a nutshell, patient participation needs to be considered as incorporating patients’ dynamic adjustments to the contingencies and sequential ordering of the different activities constituting a healthcare encounter. Arguing against the adoption of a unique model of patient participation, which could lead to ill-informed clinical guideline prescriptions, CA therefore aims primarily to identify the interactive organization and sequential structures of a healthcare encounter. Its goal is on the one hand to understand how each encounter presents opportunities

but also limitations for patient participation, and on the other hand how patient participation impacts the course of interaction (Gill and Roberts 2012: 581).

1.3 Our analytical focus: patients' initiatives in interdisciplinary entry meetings

Adopting a conversational analytic approach (Pilnick et al. 2009), our study is based on audio-visual recordings of interdisciplinary entry meetings (IEMs) at a rehabilitation clinic. At the examined clinic, these meetings are an integral part of DP, since they constitute the setting in which patients' short-term and rehabilitation goals are discussed, agreed upon and formulated for the record. Throughout the DP process, the patient's improvement is assessed in relation to these goals. They are key for developing the plan for continued therapy and ultimately for deciding upon the discharge date.

Drawing upon the notion of "interactional initiative" as introduced by Drew (2001: 263), our paper focuses on patients' accomplishment of initiatives during the goal-formulation activity as it takes place during IEMs. Drew's (2001: 263) discussion of initiatives occurring in dyadic doctor–patient encounters refers to patients' "requests for courses of action" (Gill et al. 2010) or to patients' talk extending beyond an answer to the doctor's initial question (Stivers and Heritage 2001). In the first case, the initiative accomplishes a first pair part (see also Gill and Maynard [2006] on patients' proposals, or Merlino [In press] on patients' topic initiations during speech therapy sessions). In the second case, it achieves something more than a type-fitted second pair part. In both cases, the patient's initiative not only conveys what is on his or her mind, but also makes a response from the doctor relevant in turn. It thus impacts the course of action usually controlled by the doctor's sequence-initiating actions, such as history-taking questions or delivery of a diagnosis and treatment recommendations.

In this paper, we examine patients' initiatives occurring in an interdisciplinary, multi-party, healthcare setting. This adds another layer. Although professionals are required to involve the patient in the goal-formulation activity, they might *orient towards each other* and talk *about* the patient instead of addressing him or her as an active participant. Beyond their impact on the further course of action, which is said usually to be controlled by the professionals (see Barnard et al. 2010; Levack et al. 2011), the initiatives discussed here thus transform the *participation framework* (Goffman 1981) from one in which the patient is not addressed as an active participant to one in which he or she contributes to the direction of action. As such, the initiatives are of particular interest for those investigating patient participation in action.

On the one hand, this paper offers a detailed analysis of the *conversational environments* in which patients produce their initiatives (the “a-part” of Extracts [1]–[4]), accounting for (i) the action-based context of its occurrence: participants’ engagement in actions such as disagreeing with a goal formulation; (ii) the participatory configuration: for example, two participants’ (out of six) involvement in the ongoing course of action; and (iii) the sequential position of the initiative, such as in overlap with another participant’s turn or after a long silence. On the other hand, it reveals the initiatives’ interactively fine-tuned turn-by-turn accomplishment (the “b-part” of Extracts [1]–[4]). Describing the initiatives’ context of emergence and local production sheds new light on participation as it is interactively implemented in interdisciplinary DP meetings, and moreover makes it possible to show how *issues of epistemic right and entitlement to participate* are locally negotiated (on business meetings, see Asmuss and Oshima 2012; Clifton 2009; Markaki and Mondada 2012).

In its conclusion, the paper discusses the extent to which examining patients’ interactional initiatives and focusing on their participative competences (instead of their low participation) might be relevant for interdisciplinary healthcare practices more generally and for this type of encounter particularly.

2 Data

Eleven patients were recruited at a 27-bed rehabilitation center for patients with neurological or muscular-skeletal disorders in German-speaking Switzerland. Ethical approval was granted by the local ethics committee and informed consent was obtained from all participants. The paper is based on audio-visual recordings (about four hours in total) of 11 interdisciplinary entry meetings (IEMs). Although the IEM takes place upon admission, it is, as explained above, an integral part of DP at the examined clinic. The aim of the IEM is to discuss, decide upon and formulate the patient’s rehabilitation goals (which should be achieved by the end of the patient’s stay at the clinic) and short-term goals (which are to be reached within a week’s time), integrating the patient as an active partner in this process.

In addition to the patient, the participants in the IEM are his/her primary nurse (NUR), a medical doctor (MDR), a physiotherapist (PTH), an occupational therapist (OTH) and, if necessary, a speech therapist (STH). The meeting is usually chaired by one of the professionals and organized in two parts; altogether, it lasts no more than 20 minutes. The first part is dedicated to clarification of the patient’s medical history and his/her current state of health. The second part concerns the goal-setting process and begins with a presentation of

the patient's overall goal, to which the participants orient as they discuss and agree upon two specific rehabilitation goals and two short-term goals.

The patients' interactional initiatives discussed in this paper (Extracts [1]–[4]) all occur while the healthcare professionals are discussing the content or exact wording of these goals. The conventions used for transcribing participants' talk-in-interaction are those developed by Jefferson (2004: 24–31), and their use of multimodal resources, such as gaze, gesture and posture, are those developed by Mondada (2007a; see the Appendix). In the original data, participants speak (Swiss) German. Talk is therefore translated into English using a three-line representation (Jenks 2011).

3 Patients' initiatives

The analysis focuses on initiatives that patients might produce in specific conversational environments: (i) when professionals disalign with each other regarding the formulation of a rehabilitation or short-term goal (Extracts [1a] and [2a]), or (ii) when professionals manifest difficulties in moving on to the formulation of a goal (Extracts [3a] and [4a]). Elsewhere, it has been argued that agreement among participants is closure-implicative, whereas disagreement tends to delay the closure of an action sequence (Pomerantz 1984; Stivers and Robinson 2006). In the aforementioned environments (i) and (ii), the progress of the activity at hand – formulating goals for the patient – is thus at stake. Patients seem to identify these moments of stagnation as opportunities to contribute to the activity at hand.

3.1 The professionals display disalignment regarding the formulation of the goal

According to the clinic's guidelines, the goals need to be formulated in accordance with the SMART guidelines (Specific, Measurable, Achievable, Relevant and Timely Goals; Bovend'Eerd et al. 2009) in general, and the patient's overall goal in particular (see Section 2). Meeting these requirements often proves difficult, and disalignment among the professionals regarding the exact wording is not infrequent in the goal-formulation activity. In both cases, the patient's initiative accomplishes an assertion that undercuts the adequacy of the professionals' disalignment.

In the a-part of Extract (1), the nurse (NUR) and the physiotherapist (PTH) manifest disalignment with the occupational therapist's (OTH) initial goal proposal. The other participants of Extract (1a) and (1b) are the medical doctor (MDR) and the patient 1 (PA1).

(1a) Part I (RRZ1_1_IA6)

Extract 1aI (RRZ1_1_IA6)

- 1 OTH Sache usem Schrank über Schulterfhöchi=
 Things out of the closet above shoulder height=
Taking things out of the closet safely above=
 pal <<lks OTH->
 pth <<lks OTH->
 nur <<lks doc, writing flks OTH->
 oth <<lks NUR->
- 2 =und °under Hüfthöchi°, (1.4) °med Entlaschtig,=
 =and °below hip height°, (1.4) °with partial weight-bearing,=
=shoulder height and °below hip height°, =
 3 =secher chöne usenäh.°°
 =safely to can taking out.°°
=°while complying with partial weight-bearing restrictions.°°
 4 (§1.6)
 pth flks NUR->
 5 NUR (([la[ughfi][ng)])
 nur flks OTH->
 6 MDR [((laughing))]
 7 OTH [°Jo oder firgendwie+] öpis [i dem+ Stil.°]
 [°Yes or somehow] something [in this style.°]
°Yes or something in this style.°
 nur flks doc->
 oth +lks down +lks PTH->
 8 PTH [fUNDER Hüf*t%höchi?]
 [BELOW hip height?]
BELOW hip height?
 nur flks OTH->
 pal *lks PTH->
 pth flks PAI->
- 9 (0.3)
 10 OTH °Ja.°
°Yes.°
 11 (0.6)
 12 OTH Aso +wäifsch% ([]) **Well you know ([])**
 oth +leans back in the chair, gaze direction not visible->>
 nur frh: against right cheek->
 pth flks OTH->
- 13 NUR [Wäi][mer-% wäi]mer ned äifacher* säge ↑
 [Shall][we- shall] we not more simply say ↑
Shall we not say it more simply ↑
 pth flks NUR->
 pal *lks NUR->
 14 PTH [>Jo, jo<]
[>Yes, yes<]
- 15 (0.5)
 16 NUR E::hm vo überau usem Schaft, (0.2) chönne.
 E::hm everywhere out of closet, (0.2) to can.
To be able (to take out things) from the closet in general.

At the beginning of the extract (lines 1–3), OTH proposes an initial rehabilitation goal for PA1 that targets the patient’s presumed difficulties in getting things out of the closet. During meetings, a proposal is usually treated as a first pair part (FPP) that makes the occurrence of a type-fitted second pair part (SPP) – an acceptance or rejection – from the other participants relevant, and acceptance is the preferred response (Asmuss 2012: 325). In this extract, OTH’s formulation is first followed by a silence of 1.6 seconds (line 4), during which PTH shifts her gaze to NUR, who produces a hearty outburst of laughter (line 5) and is joined in this by MDR (line 6). As mentioned above, disalignment among professionals regarding the formulation of a goal is frequent, and professionals’ laughing at each other’s proposals is not rare either.

However, it has been argued (see Sacks 1987; Levinson 1983) that delay in a response to an FPP might indicate that a dispreferred action will follow next. By backing down from her initial proposal and pointing to the possibility of other formulations (line 7), OTH retrospectively treats the other professionals’ silence and laughter (lines 4–6) as indicating their rejection of her initial proposal (lines 1–3) and prospectively, she manifests her willingness to collaborate in the search for an alternative formulation. In overlap with OTH’s turn, PTH then produces a partial repeat of OTH’s initial proposal, using interrogative intonation (line 8). As Robinson and Kevoe-Feldman (2010) argue, partial questioning repeats of an FPP can manifest skepticism about the adequacy of the previous action as a whole.

In our case, OTH seems to understand PTH’s questioning repeat in this way. She responds with an agreement token that is barely audible (line 10), and a “well you know” construction (line 12) that projects a justification to come. However, this justification is not fully audible, since NUR’s suggestion of rewording OTH’s initial proposal in simpler terms (line 13) comes in overlap. While NUR talks, PTH addresses a reduplicated response token, “yes, yes” to OTH (line 14), thus indicating that she does not need to elaborate further (Golato and Fagyal 2008), and then shifts her attention to NUR, who proposes an alternative formulation of the goal (line 16) as she herself had suggested in line 13.

(1a) Part II (RRZ1_1_IA6)

Extract 1aII (RRZ1_1_IA6)

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16  NUR  E::hm vo      überall      usem  Schaft, (0.2) chönne.
      E::hm from everywhere out of closet, (0.2) to can.
      To be able (to take out things) from the closet in general.
17      (%0.2)
      pth  %lks OTH->
18  OTH  °Jo de* esch es wirklich (    ).°
      °Yes then is it really (    ).°
      °Yes then it is really°
      pal  *lks OTH->

```

19 (0.7)
 20 NUR °Jo:..°
 °Ye:s.°

21 (#1%.6)
 im. #image 1
 pa1 *lks NUR->
 pth %lks NUR->
 22 NUR °A*hf°
 °Oh f°
 pa1 *lks MDR/OTH->
 23 (0.8)
 24 NUR °Okay.°
 °Okay.°
 25 (0.4)

Following this reformulation, PTH shifts her gaze back to OTH to monitor her reaction (see image 1), which is immediately forthcoming (line 18). Although OTH's turn is not fully audible, NUR's response to it – a stepwise (lines 20, 22, 24) but reluctant (lines 19, 21, 23) acknowledgment of OTH's turn – indicates that NUR does not align with OTH.

While the professionals attempt to come to an agreement regarding the formulation of a rehabilitation goal during this first part (a) of Extract (1), albeit with an obvious lack of success, PA1 follows the discussion silently (see multimodal transcription and image 1). Moreover, apart from PTH's short glance at the patient (line 8), the professionals are oriented towards each other throughout the entirety of Extract (1a). Nevertheless, PA1 uses this configuration to launch an interactional initiative:

(1b) Part I (RRZ1_1_IA6)

Extract 1bI (RRZ1_1_IA6)

26 PTH {Ex[klusi]fve% Boden.
 Ex[clusi]ve floor.
 Apart from the floor.
 nur %lks PA1--%lks PTH->
 pth %lks OTH->
 27 PA1 [*Aso]
 [Well]
 pa1 *lks PTH->
 28 (0.3)

29 NUR MH.
 MH.
 (0.3)
 31 PA1 <*Exklusiv%ive [Bo::d]en*£((laughing voice))=>
 Exclusive [flo::]or=
Apart from the floor=
 pal *lks MDR/OTH/PTH-----*
 nur £lks PA1 £lks OTH->
 pth %lks PA1->
 32 OTH [Zwü:sche:,]
[Be:tw:en:,]

33 NUR =[((la#ugh**ing))]
 34 PTH =[((la #ughing))]
 im. #image 2
 pal *lks NUR**lks PTH->
 35 OTH [Oberhalb fo ChnÜ- [ober]halb fo ChnÜ]h%öchi?
 [Above from knee- [abo]ve from knee]height?
Above knee- above knee height?
 pth %lks OTH->
 36 PA1 [*Aber, aber #sof*wei*t-]
[But, but as far-]
 im. #image 3
 pal *lh: directs forward, back chin*
 nur £lks PA1->
 pal *lks OTH->
 37 (0.6)
 38 PTH £%J[o.£] ((nodding))
Y[es.]
 nur £lks OTH£
 pth %lks OTH->
 39 NUR [Mm]£h.
[Mm]h.
 nur £lks PA1->>
 40 (0.2)
 41 PTH Also gue%t.= ((lifts left shoulder))
 Well good.=
Well then.=
 pth %lks PA1->>

At the beginning of Extract (1b), PTH's "Apart from the floor" (line 26) constitutes an alternative formulation of OTH's laughed-about initial specification (lines 1–3), and a specification to NUR's "simple" formulation (line 16). While PTH talks, PA1 shifts her gaze to her, produces the discourse marker "well" (line 27), but stopping there to let PTH finish her turn. As argued by Depperman (2012: 9), the discourse marker "well" in turn-beginning position

may indicate a dispreferred next to come.¹ Following two short silences (lines 28, 30) and NUR's response token, "MH." (line 29), PA1 produces the projected dispreferred next: a full repeat of PTH's turn (line 31), deploying a laughing voice. Like the professionals (lines 5, 6), instead of treating PTH's suggestion as a valid contribution, PA1 laughs about it, thus challenging PTH's authority as an expert.

At the same time, PA1 lets her gaze wander from MDR to OTH, PTH, and finally NUR, while smiling impishly, engendering embodied alignment by NUR and PTH, who both return her gaze and join in with her laughing, even though PTH herself is the one who produced the laughed-about turn (lines 33, 34; image 2). In overlap with their laughing, OTH proposes a reformulation of PTH's suggestion (lines 32, 35), thus treating it as a contribution that needs to be discussed seriously. However, in overlap with OTH's turn (line 35), PA1 begins a contrastive turn (line 36) that projects more to come, while looking at PTH and directing her left hand forward, *indicating imminent speakership* (see image 3; Mondada 2007b).

However, she then progressively drops out to let OTH complete her turn: she shifts her gaze to OTH who is still talking, discontinues her own talk and withdraws her left hand, touching her chin. After a silence of 0.6 seconds, PTH and NUR look at OTH again and align with her reformulations (lines 38, 39, 41), projecting an agreement between the professionals to come. After displaying alignment with OTH, they both shift their attention back to PA1 (NUR in line 39 and PTH in line 41), thus tacitly inviting PA1 to resume talking:

(1b) Part II (RRZ1_1_IA6)

Extract 1bII (RRZ1_1_IA6)

```

42 PA1 =A*(1)so *soweit es bei mir ist also *das ist das=
    =Well      sofar it at my is well that is that
    =Well at my place now the closets=
    pth <<1ks PA1->>
    nur <<1ks PA1->>
    pal *1ks PTH->>
    pal *lh: open palm, forward      *index/thumb pinch->

```

¹ As an anonymous reviewer commented, PA1's discourse marker "well" cannot be understood as indicating a dispreferred response to PTH's turn, since it occurs in overlap with this turn. However, with her continuation of the turn in line 31, PA1 is treating PTH's turn in line 26 as a laughable. This shows that although line 27 may initially have been meant to address the patient's dispreferred stance towards the professionals' previous turns in general (lines 1–25), it is then retrospectively transformed to respond to PTH's turn (line 26) in particular.

43 = sind m- #alle Schieben (.) öh Schrän#ke*.
 = are m- all sliding (.) ehm closets.
 = have all **sliding doors**.
 im. #image 3 #image 4
 pal *lh: moves from very left to right*
 44 PTH =[%Ja.%]
 =[**Yes.**]
 pth %nodding%
 45 NUR =[Mmh.]
 =[**Mhm.**]
 46 (0.2)
 47 PA1 *Und ich habe alles eso,
 And I have all alike,
 And I have everything like this,
 pal *lh/rh: palm open/down forward, "grasp" sth., back->>
 48 (0.7)
 49 PTH S[%o#:]
 L[i:ke]
 pth %rh: palm open/down moving from right to left, back->
 50 PA1 [Ich] kann schön %nehme#n.
 [I] can nicely take.
 I can easily take.
 pth %rh: moves up->>

Accepting their invitation to continue speaking, PA1 orients back to PTH and asserts that her current closet situation at home is utterly non-problematic with respect to her limited mobility (lines 42–43, 47, 50). She does this in an embodied way (images 3, 4), rendering the talked-about closet situation “intersubjectively available” for the others (Stukenbrock 2012). By using continuers, nods (lines 44, 45) and an elicitation token (line 49), PTH “conveys preliminary affiliation with the teller’s position” (Stivers 2008: 31) and supports the patient in her endeavor to build up her case.

The discussion of Extract (1a) highlights how the professionals’ orientation towards each other, disaligning on the formulation of a rehabilitation goal for the patient, while PA1 silently monitors their discussion, does not establish PA1 as an active participant. In contrast, the analysis of the b-part shows how PA1 uses gaze to monitor the different parties’ availability, makes several attempts to intervene in the ongoing talk (lines 27, 31, 36), deploys laughing to achieve supportive alliance(s) (Kangasharju 2002: 1457) and finally builds her case with respect to an issue that she has primary epistemic access to. PA1 thus not only transforms

the participation framework, producing herself as an active participant, but also undercuts the adequacy of OTH's initial proposal and the professionals' disalignment regarding the adequate formulation of its specifications.

As in the previous Extract (1a), in Extract (2a), PA2 launches her initiative in a context of disalignment between professionals – the physiotherapist (PTH) and the nurse (NUR) do not align on the specification of the goal that is to be set for PA2. Before Extract (2a) begins, the professionals have agreed to formulate a rehabilitation goal for patient 2 (PA2) that targets her mobility:

(2a) (RRZ2_1_IA15)

Extract 2a (RRZ2_1_IA15)

- 1 PTH fSe*[cheres Mobiliftät am+ Hilfsmittel+]
Se[ecure mobility on the walking device]
Secure mobility on the walking device
pth <<%lks NUR->
nur <<%lks doc flks PTH ->
pa2 *lks PTH->
oth +lks PTH ->+
- 2 NUR [Dä wäi mer (dert am Roll- met-)]
[Then want we (there on the wal- fra=)]
So we maintain (the following): on the walking frame=
- 3 (0.6)

- 4 NUR =+tel# im Inn und Usse+be%rich.
=me in the inside and outside realm.
=inside and outside realm.
im. #image 1
oth +lks NUR -> +lks PTH->
pth %lks PA2->
- 5 (0.3)
- 6 PTH [Im Innenbereich] dass sie draussen% würd=
[In the inside realm] that she outside would=
Inside realm, but outside I would say=
pth %lks NUR->
- 7 NUR [Wöu si het (0.3) a Rol-]
[Because she has (0.3) a wal-]
Since she has a wal-
- 8 PTH =ich sagen in Begleitung.
=I say in company.
=accompanied.
- 9 (+1.1)
oth +lks NUR ->

At the beginning of Extract (2), line 1, PTH formulates a rehabilitation goal for PA2 while looking at NUR: “secure mobility on the walking device”. In overlap with PTH’s turn, and looking at her, NUR also formulates a rehabilitation goal that concerns PA2’s mobility (line 2). However, in contrast to PTH, NUR adds a specification: the goal is to be applied to the “inside and outside realm” (line 4). At the end of NUR’s specification, PTH shifts her gaze to PA2, who looks at her, and after a brief silence (line 5) repeats the first part of NUR’s specification, “In the inside realm” (line 6). In overlap with PTH’s turn beginning in line 6, NUR produces the conjunction “because”, followed by “she has” (line 7), thus projecting an account to come. However, she then discontinues her talk, leaving the floor open to PTH. Shifting her gaze back to NUR, PTH disagrees with the second part of NUR’s specification, suggesting that for the outside realm, the patient should be accompanied (lines 6, 8). Following PTH’s disagreement with NUR (line 8), there is a silence that could indicate further disalignment between the professionals.

Throughout Extract (2a), the professionals are oriented towards each other, apart from PTH’s short gaze at the patient (line 6). Furthermore, both professionals use the third-person “she” (lines 6, 7) to refer to the present PA2, and thus produce her as a subject of discussion (Sacks 1992 I: 712) instead of treating her as a participant, thereby excluding her from the discussion at hand (see Heinemann 2009: 2438). In contrast to Extract (1a), there is no constant monitoring of the professionals by PA2; instead, she merely looks at PTH throughout the entire extract. This participative configuration is modified by PA2’s initiative:

(2b) (RRZ2_1_IA15)

Extract 2b (RRZ2_1_IA15)

10 PA2 #Ja% aber+ de-(der)+(0.3) i be dusse scho f[gäng] nümme=
 Yes but yo-(you)(0.3) I am outside already [always] anymore=
Yes but I've already been walking for a long time=
 im. #image 2
 pth %lks PA2->
 oth +lks PA2->
 nur flks PA2 ->

11 PTH [s-]

12 PA2 =*(o num-) *(0.4) nume **med dä[mf ume#(g)lou]ffe.*
 = (also onl-) (0.4) only with that walked around.
 = **only with that.**
 im. #image 3 #image 4
 pa2 *lks walking frame-----*lks PTH->
 pa2 *lh: directs tw walking frame*
 nur flks PTH ->
 13 PTH [Si sind]
 [You are]
You are
 14 *(.)*
 pa2 *lh: retracts back into home position*
 15 PTH +Ja?
Yes?
 oth +lks PTH->
 16 (0.6)
 17 NUR Ja +das* müesst'i fascht weder go wenn si alläi*ge esch.
Yes that must nearly again go when she alone is.
That should be possible again when she is alone.
 oth +lks NUR->>
 pa2 *lks OTH/NUR ----->*lks PTH->>
 pth %lks NUR->>

At the beginning of Extract (2b), PA2 addresses PTH (line 10), getting the professionals' (PTH, NUR, OTH) attention (image 3). The patient's turn is prefaced by an agreement token followed by a "but", and the personal address term "you", which highlights the addressee of the projected contrastive next (Lerner 2003). Following the preface, PA2 asserts that she has always walked outdoors independently with the walking frame (line 10). At the same time, the patient first looks at, and then uses her left arm to make a vague movement towards, the walking frame, which is positioned at her left side: she thus renders intersubjectively available the object that the indexical "that" (line 12; image 3 and 4) is referring to, and gains the professionals' attention (image 3). Her assertion stands in contradiction to PTH's proposal of limiting the patient's autonomous mobility to the indoors and she thus clearly disagrees with PTH. At the end of her turn, PA2 shifts her gaze back to PTH, the addressee of her initiative, manifesting her expectation for a response by PTH.

When confronted with the professionals' disagreement regarding the exact wording of the rehabilitation goal, PA2 produces her interactional initiative in a direct way – there is no hesitation or markers, it is produced in one go, and it is addressed to the PTH as a complaint regarding the adequacy of the latter's proposal. As such, it achieves NUR's support (line 17) without actively seeking it and stands in contrast to the stepwise-accomplished initiative discussed above ([1b]).

These distinctive ways of launching and producing the initiative are even more noteworthy if one considers the distinctive participative framework in which they occur. Whereas the professionals address their disaligning turns about the exact wording of the goal to each other in Extract (1a), the professionals in Extract (2a) additionally use the third-person pronoun "she" to talk about PA2 instead of addressing her directly, thus virtually excluding her from the discussion at hand.

PA2's determination to launch an initiative and the high entitlement she displays in doing so may be related to what is at stake. In Extract (1a), the professionals' disagreement is over the closet locations that PA1 needs access to in order to manage everyday business, despite her restrained mobility. By portraying her closet situation at home as utterly unproblematic, PA1 undercuts the relevance of the proposed goal as a whole. Since the professionals have no epistemic authority to counter PA1's assertion, this is quite a safe move. In Extract (2a), the professionals' disagreement is over PA2's ability to walk with a walking aid, versus with the aid of another person. As in Extract (1a), PA2's assertion concerns a matter to which she has primary epistemic access and authority. However, a claim of autonomous walking in the past can easily be undercut by the professionals' examination of the patient's present capacities. Launching an initiative in a straightforward way and displaying high entitlement to counter the professionals' proposal could prove effective at preventing their suspicion of a possible problem, at least for the time being.

We will now turn to another environment in which patients might launch an initiative.

3.2 The professionals display difficulty in moving on to the formulation of goals

In this section, we look at two extracts in which patients launch an initiative when the professionals are manifesting difficulty in moving on to the formulation of a rehabilitation goal for the patient (Extracts [3a] and [4a]). In both cases,

the patients' initiative accomplishes a goal-proposal that potentially helps overcome the professionals' difficulty in moving ahead (Extracts [3b] and [4b]).

Just before Extract (3a) starts, the professionals had agreed on an initial rehabilitation goal that targets patient 5's (PA5) difficulties in speaking intelligibly. At the beginning of Extract (3a), PA5 is gazing in front of him, and the professionals – including a speech therapist (STH) – are all oriented towards their documents, apart from NUR who looks towards PTH:

(3a) (RRZ5_1_IA38)

Extract 3a (RRZ5_1_IA38)

- 1 STH U::nd# as zwöits
A::nd as second
And as a second
im. #image 1
pa5 <<lks in front of him->
sth <<lks doc->
pth <<lks doc->
oth <<lks doc->
nur <<lks PTH->
mdr <<lks doc->
- 2 (3.*£2)
pa5 *lks at doc in front of STH->
nur flks STH->
- 3 STH Wör(d) %i sfäge:
Would I say:
Would I say
pth %lks STH->
nur flks tow MDR->
- 4 (*£4.2)
pa5 *lks in front of him->
nur flks STH->
- 5 STH Äh:m
Eh:m
- 6 (0.4%)
pth %lks doc->

While looking at her documents, STH produces a nominal turn that she begins with the connector “And” (line 1). Placed turn-initially, it refers to a previous sequence of interaction between the same interactants. In this case, they had agreed upon the formulation of an initial goal. By adding the nominal structure “as second” she projects the activity of formulating a second goal (line 1). However, she then stops talking, engendering a silence (line 2) during which NUR shifts her gaze towards STH, manifesting her expectation for more to come from her. After 3.2 seconds of silence, STH resumes talking: “Would I say” (line 3). By beginning her turn with the verb “will” in its subjunctive form, she produces it as a continuation of the previous one (line 1), announcing its formulation. However, instead of the projected talk there is another long silence (4.2 seconds) in line 4, which is followed by STH’s production of an “Eh:m” (line 5), indicating a word search, and another silence (line 6).

At no point in Extract (3a) do the professionals orient towards PA5 as a participant who might help overcome their difficulties in formulating a second goal. However, in this conversational environment of stagnation, PA5 self-selects to launch an initiative:

(3b) (RRZ5_1_IA38)

Extract 3b (RRZ5_1_IA38)

7 PA5 Nächst&sch Woche f&Konver\$ation
 Next week conversation
 sth &lks PA5---&leans tow PA5->
 nur flks PA5->
 mdr \$lks PA5->

8 (1.0)

9 PA5 (% ph.h.) Konversatio:n↑#
 (ph.h.) **conversation:n↑**
 im. #image 2
 pth %lks PA5->
 10 (0.8)
 11 PA5 Muesch (0.6) scho e e ihaute.
 Must (0.6) MOD I I comply with.
Must I comply with.
 12 (*+1.&2)
 pa5 *lks STH->
 oth +lks STH ((smiling))->
 sth &back into vertical position->>
 13 STH %GENAU.
EXACTLY.
 pth %lks STH ((smiling))->>

PA5 begins his turn with a temporal marker, “next week” (line 7), which is followed by the lexical “conversation”. With this nominal format and continuing intonation, PA5 projects more to come. While PA5 talks, all the professionals, apart from OTH and PTH, shift their orientation towards him (image 2). After a silence (line 8) followed by an inaudible segment, PA5 repeats the word “conversation”, deploying a “slightly rising pitch”, thus again indicating more to come (Betz 2011: 418). Indeed, the following pause (line 10) is not treated by the professionals as a *transition-relevance place* for speaker change to occur (Sacks et al. 1974: 704). Quite the contrary, in addition to her colleagues’ gaze orientation to PA5, STH leans with her upper body towards him, adapting her posture to his “low” sitting position, and thus adopts the posture of a very attentive listener, such that PA5 completes his initiative with the professionals’ full attention (line 11).

PA5 begins his turn with the auxiliary verb “must”, followed by a pause; this dislocates the repeated personal pronoun “I” to the right and emphasizes his own agency in “comply[ing] with.” (line 11). Deploying terminal intonation at the end of his turn, PA5 indicates that speaker change might occur. However, following it, there is a silence (line 12) during which both PA5 and OTH look at STH, who resumes an upright position before producing a confirmation of PA5’s proposal, deploying higher volume (line 13). Using the particle “GENAU (‘Exactly’)” (line 13) for her confirmation, STH indicates previous, independent knowledge (Oloff 2016 18), thus ratifying not only the adequacy of PA5’s contribution but also its status as a reminder (see PA5’s utilization of a temporal marker to begin his initiative in line 7).

In Extract (3b), PA5, whose official difficulty is in participating actively and intelligibly in conversations, launches an initiative in a context in which the professionals manifest difficulties in moving on to the goal-formulation activity

(Extract [3a]). Beginning his initiative with a temporal marker and a nominal structure (line 7), PA5 accomplishes his goal proposal as a reminder. As evidenced in the professionals' shift of orientation away from each other to the patient's talk (Extract [3b]), not only is PA5 treated as having entitlement to contribute to the course of action, but STH's confirmation (line 13) also ratifies his epistemic authority to remind the professionals of a previously made proposal.

In the final extract, patient 6 (PA6) launches his interactional initiative – an alternative goal formulation – in a context in which the professionals have displayed difficulty in finding an adequate formulation of the goal, both tacitly and overtly:

(4a) (RRZ6_1_IA46)

Extract 4a (RRZ6_1_IA46)

- 1 PTH Eifach adäquat ou %d'Pause: selberf gschta%lte, oder↑
 MOD adequate also the pauses self arrange, or↑
MOD arrange one-self adequately the pauses, or↑
pa6 <<1ks in front of him/down->
pth <<1ks doc ---%lks PA6 ---%lks doc->
nur <<1ks PTH ----%lks doc->
mdr <<1ks doc->
oth <<1ks PTH->
- 2 (1.*%5)
*pa6 *lks PTH->*
pth %kls MDR->

- 3 PTH °(Ech) be %schlächte %em Formulierte° #((lau+ghing)) =
 °(I) am bad in formulating° ((laughing))=
I'm bad in formulating=
im. #image 1
pth %lh: in front of mouth, on left cheek->
mdr %lks PTH->>
oth +lks doc->>

((lines 4–16 are omitted for reasons of space))

- 17 NUR =°Ihaute (fo:)%
 =°Maintaining (o:f)%
=To maintain
 18 (*0.8)
*pa6 *lks PTH->>*

In line 1 of Extract (4a), PTH orients to her documents, then glances briefly at PA6, and back to her documents, while proposing a goal for PA6 by adding a *tag question* with an interrogative intonation at the end of her turn (line 16), thus “morphologically mark[ing] the turn as seeking response” (Stivers and Rossano 2010: 11). However, although orienting either to her (NUR, OTH) or looking at their documents (MDR, PA6), the other participants keep silent, possibly indicating a dispreferred response: a rejection (see also Extract [1a]). At least it is in this sense that PTH interprets it, since the others’ non-response engenders PTH’s negative evaluation of her own competence in formulating a goal (line 3): she holds her left hand in front of her mouth, and laughs in an “embarrassed” way (image 1).

Following PTH’s self-criticism in line 3, the other professionals start to suggest alternative formulations in lines 4–16 (omitted for reasons of space). As one can see in line 17, the other professionals are not able to find a convincing wording either, since NUR discontinues her proposal after two words, and so engenders another silence (line 18).

In contrast to the previous extract, (3a), the difficulty in moving on to the formulation is not only manifest in discontinued turn beginnings, followed by long silences, but also in PTH’s overt acknowledgment of her difficulty (line 13). In this context of the professionals’ evident difficulties in moving ahead, PA6 takes the floor by self-selecting:

(4b) (RRZ6_1_IA46)

Extract 4b (RRZ6_1_IA46)

19 PA6 .H% jo£\$ tier mäinet () *Pöüse ma[che* (und) #ned]=
 .H yes you mean () pauses do[ing (and) not]=
 .H **you mean do pauses and do not**

im. #image 2
 pth %lks PA6->
 nur flks PA6->
 mdr \$lks PA6->
 pa6 *nod-----*

```

20 PTH                                     [Ja (      )]=
                                           [Yes (      )]=
21 PA6    =[a Schtung lang umesekle?]
           =[one hour long  around running?]
           =run around for an hour?
22 PTH    =[ (      f      ) %GENAU jo] ( ) das er we=
           =[ (      ) EXACTLY yes] ( ) that you like=
           = yes exactly, that you do enough=
           nur      flks PTH->>
           pth      %lh/rh: gesticulate, play with pen->>
23 PTH    =[+gnüged Pause mached.]
           =[enough pauses do.]
           =pauses.
           oth      +lks PA6->>

```

In line 19, PA6 first takes an audible in-breath, indicating imminent speakership, which he transforms into an agreement token “yes”. This functions as an *attention-getting device* (Schegloff 1972: 357) engendering all the professionals’ shift of attention away from each other or their documents and towards PA6 (see also image 2). PA6 then addresses PTH directly while looking at her: “you mean do pauses and do not run around for an hour?” (lines 19, 21). By prefacing his alternative formulation of PTH’s initial goal-proposal (line 1) with “you mean”, PA6 casts it as a *personal position report* (Asmuss and Oshima 2012: 71).

As argued by Asmuss and Oshima (2012: 71), both proposals and personal position reports constitute solutions to a specific problem (here, the formulation of a goal) and thus make “acceptance or rejection relevant”; however, whereas the former is “framed in a general form”, the latter casts ideas as “private or personal preferences” and thus presents them as “downgraded or mitigated versions of proposals.” By treating PTH’s initial proposal (line 1) as a personal opinion, instead of an expert proposal, PA6 thus downgrades the author’s epistemic authority in the matter. Moreover, by using interrogative intonation at the end of his turn, PA6 asks PTH to confirm it as such. Interestingly, PTH readily accepts PA6’s alternative formulation, even before the latter has completed his turn (lines 20, 22). She thus attributes to PA6 not only high entitlement to contribute to the interaction at hand, but also to downgrade her own epistemic authority.

4 Summary and discussion

This paper focuses on patients’ accomplishment of initiatives in interdisciplinary entry meetings. The initiatives discussed here all occur in situations in which the

professionals come together to formulate the patients' rehabilitation goals or short-term goals.

First, we focused on two conversational environments in which patients' initiatives occur: the professionals are involved in either (i) disagreement regarding the exact formulation of the goals (Extracts [1a], [2a]), or (ii) displaying difficulties in moving on to the formulation of the goals ([3a], [4a]). We showed that in both environments, the progress of the activity at hand – the formulation of goals – is at stake. Moreover, our analysis revealed that in all extracts ([1a]–[4a]), the professionals are oriented towards each other, or to their documents, do not deploy any devices (embodied or not) to select the patient as a next speaker and integrate him/her in the ongoing conversation (Keel and Schoeb *In press*), and might even use the third-person pronoun “she” when referring to the patient (Extract [2a]), thus virtually excluding the patient from the discussion.

These initial findings are in line with Stivers and Robinson's argument, which states: “when problems in activity progress arise, participants have methods for dealing with this systematically” (Stivers and Robinson 2006: 386–387). In order to ensure the progressivity of a question–answer sequence, participants systematically manifest, for example, a “preference for the provision of an answer over the preference for the selected next speaker to respond” (Stivers and Robinson 2006: 386–387). Confronted with compromised progress in the goal-formulation activity, patients thus seem to prioritize the preference for progressivity over the preference for the selected next speaker to respond, and identify these moments of stagnation to launch an initiative of their own.

Second, the analysis of the b-part showed that the patient's initiative is immediately met by the professionals' shift of attention away from their documents or each other (see discussion above) and towards the patient. With their initiative, patients engender a modification of the professionals' ways of orienting to them. Patients can thus have a significant impact on the participation framework. Moreover, patients' initiatives seem to draw on issues of epistemic access (Extracts [1b] and [2b]) and authority (Extracts [3b] and [4b]). The initiatives in Extracts (1b) and (2b) accomplish assertions which are in disagreement with the professionals' specification of a rehabilitation goal. These assertions concern patients' private, personal realms – their closet situation at home (Extract [1b]) or their mobility in the past (Extract [2b]) – to which they are thus evidently considered having primary epistemic access. The initiatives in Extracts (3b) and (4b) highlight the patient's epistemic authority (Extract [3b]), or challenge the professionals' presumed epistemic authority as experts in their fields (Extract [4b]). Indeed, in Extract (3b), the patient's initiative, a proposal of a goal, is formatted as a reminder, and in Extract (4b), the patient's initiative transforms PTH's initial goal proposal into a downgraded personal position report.

Our second finding is in line with studies on multi-party (business) meetings or dyadic encounters between healthcare professionals and patients that show how institutional roles, and the participative and epistemic rights and obligations attributed to them, are not set in advance, but are continuously negotiated and transformed by the participants interactively and locally (Asmuss and Oshima 2012; Clifton 2009; Markaki and Mondada 2012: 48). As mentioned in the introduction, hospitals' best practices usually aim at achieving – and stress the importance of – increased patient participation in discharge processes. In contrast, we argue that recommendations aimed at greater patient participation are by definition addressed to healthcare professionals, and framed in a professional-centered way. Professionals are expected to give more importance “to silence, listening and nonverbal communication (eye contact)” (Bensing et al. 2011: 291) to facilitate the patient's participation in the consultation. As a result, recommendations might not sufficiently take into account the crucial role that patients (might) play in real healthcare interactions.

By focusing on patients' interactional initiatives and the conversational environment in which they occur, our paper is “directed at describing and explicating the competences that ordinary speakers use and rely on when they engage in intelligible, conversational interaction” (Heritage 1984: 241). It reveals not only opportunities for patients' participation and their methods of successfully making their voices heard, but also emphasizes the resources they use to bring in their point of view. As such, it might contribute to healthcare professionals' reflection upon and better understanding of their own practices, and eventually contribute to an improvement of the healthcare services they provide.

Appendix. Conventions for transcription (Jefferson 2004; Mondada 2007a)

[]	A left/right bracket indicates the beginning/end of overlapping talk.
(1.0)	Numbers in parentheses indicate a timed pause (measured in tenths of seconds).
(.)	A dot in parentheses indicates a brief interval (+ /– a tenth of a second).
WORDS	Upper case indicates extra loud sounds relative to the surrounding talk.
°words°	Degree signs bracketing an utterance or parts of it indicate that the sounds are softer than the surrounding talk. The more degree signs there are, the softer the sound.
>words<	Right/left carats bracketing an utterance or utterance part indicate that the bracketed material is speeded up, compared to the surrounding talk.
((smile))	Double parentheses contain transcriber's descriptions.
::	Colons indicate prolongation of the immediately prior sound.

par-	A dash indicates a cut-off.
=	Equal signs indicate no break or gap (latching talk).
.h	A dot-prefixed row of h's indicates an in-breath. Without the dot, the h's indicate an out-breath.
()	An empty parenthesis indicates that the transcriber was unable to grasp what was said.
(a little)	Parenthesized words indicate a guess at the talk.
?	The question mark indicates upward, questioning intonation.
.	The dot indicates a downward final intonation.
,	The comma indicates a continuing intonation.
↙↗	Arrows indicate shifts into high or low pitch.

Participants' acronyms and symbols for multimodal transcription:

PA: patient	*
NUR: reference nurse	£
OTH: occupational therapist	+
PTH: physiotherapist	%
MDR: medical doctor	\$
STH: speech therapist	&

pa1	identifies the participant doing the described gesture or action.
* / £ / &	a described gesture or action by an individual, indicating the moment at which the action begins in relation to the transcribed talk (or silence) and where it ends. If there is more than one transcribed action, they are listed chronologically.
rh	a gesture or action accomplished by the participant's right hand.
lh	a gesture or action accomplished by the participant's left hand.
-->	the described gesture or action continues across subsequent lines.
#	the exact point within a turn at talk where a figure has been taken.

References

- Anthony, Mary K. & Diane Hudson-Barr. 2004. A patient-centred model of care for hospital discharge. *Clinical Nursing Research* 13(2). 117–136.
- Asmuss, Birte. 2012. Implikationen technischer Arbeitsgeräte für die Koordination und Ko-Orientierung in einer Arbeitsbesprechung. In Heiko Hausendorf, Lorenza Mondada & Reinhold Schmitt (eds.), *Raum als interaktive Ressource*, 317–346. Tübingen: narrVerlag.
- Asmuss, Birte & Sae Oshima. 2012. Negotiation of entitlement in proposal sequences. *Discourse Studies* 14(1). 67–86.
- Barnard, Rachel A., Madeline N. Cruice & Elizabeth D. Playford. 2010. Strategies used in the pursuit of achievability during goal setting in rehabilitation. *Qualitative Health Research* 20(2). 239–250.
- Bensing, Joziwn, Myriam Deveugele, Francesca Moretti, Ian Fletcher, Lysbeth van Vliet, Marjolein Van Bogaert & Michaela Rimondini. 2011. How to make the medical consultation

- more successful from a patient's perspective? Tips for doctors and patients from lay people in the United Kingdom, Italy, Belgium and the Netherlands. *Patient Education and Counseling* 84. 287–293.
- Betz, Emma M. 2011. Word choice, turn construction, and topic management in German conversation. In Michael T. Putnam (ed.), *Studies on German-Language Islands*, 415–454. Amsterdam/Philadelphia: John Benjamins.
- Bovend'Eerd, Thamar J.H., Rachel E. Botell & Derick T. Wade. 2009. Writing SMART rehabilitation goals and achieving goal attainment scaling: A practical guide. *Clinical Rehabilitation* 23(4). 352–361.
- Clifton, Jonathan. 2009. Beyond Taxonomies of Influence. *Journal of Business Communication* 46(1). 57–79.
- Collins, Sarah, Paul Drew, Ian Watt & Vikki Entwistle. 2005. "Unilateral" and "bilateral" practitioner approaches in decision-making about treatment. *Social Science & Medicine* 61(12). 2611–2627.
- Depperman, Arnulf. 2012. Turn-design at turn-beginnings: Multimodal resources to deal with tasks of turn-construction in German. *Journal of Pragmatics* 46(1). 91–121.
- Drew, Paul. 2001. Spotlight on the patient. *Text & Talk* 21(1/2). 261–268.
- Efraimsson, Eva, Birgit H. Rasmussen, Fredricka Gilje & P. O. Sandman. 2003. Expressions of power and powerlessness in discharge planning: A case study of an older woman on her way home. *Journal of Clinical Nursing* 12. 707–716.
- Efraimsson, Eva, P., O. Sandman & Birgit H. Rasmussen. 2006. "They were talking about me" – elderly women's experiences of taking part in a discharge planning conference. *Scandinavian Journal of Caring Sciences* 20. 68–78.
- Foss, Christina & Dag Hofoss. 2011. Elderly persons' experiences of participation in hospital discharge process. *Patient Education and Counseling* 85(1). 68–73.
- Gill, Virginia Teas. 1998. Doing attributions in medical interaction: Patients' explanations for illness and doctors' responses. *Social Psychology Quarterly* 61(4). 342–360.
- Gill, Virginia Teas. 2005. Patient 'demand' for medical interventions: Exerting pressure for an offer in a primary care clinic visit. *Research on Language & Social Interaction* 38(4). 451–479.
- Gill, Virginia Teas & Douglas W. Maynard. 2006. Explaining illness: Patients' proposals and physicians' responses. In John Heritage & Douglas Maynard (eds.), *Communication in medical care interaction between primary care physicians and patients*, 115–150. Cambridge: Cambridge University Press.
- Gill, Virginia Teas, Anita Pomerantz & Paul Denvir. 2010. Pre-emptive resistance: Patients' participation in diagnostic sense-making activities. *Sociology of Health & Illness* 32(1). 1–20.
- Gill, Virginia Teas & Felicia Roberts. 2012. Conversation analysis in medicine. In John Sidnell & Tanja Stivers (eds.), *The handbook of conversation analysis*, 575–592. Oxford: Blackwell.
- Goffman, Ervin. 1981. *Forms of talk*. Oxford: Blackwell.
- Golato, Andrea & Zsuzsanna Fagyal. 2008. Comparing single and double sayings of the German response token ja and the role of prosody: A conversation analytic perspective. *Research on Language and Social Interaction* 41 (3). 241–270.
- Heinemann, T. 2009. Participation and exclusion in third party complaints. *Journal of Pragmatics* 41. 2435–2451.
- Heritage, John. 1984. *Garfinkel and ethnomethodology*. Cambridge: Polity Press.
- Heritage, John, Jeffrey D. Robinson, Marc N. Elliott, Megan Beckett & Michael Wilkes. 2007. Reducing patients' unmet concerns in primary care: The difference one word can make. *Journal of General Internal Medicine* 22(10). 1429–1433.

- Huby, Guro, Jenny Holt Brook, Andrew Thompson & Alison Tierney. 2007. Capturing the concealed: Interprofessional practice and older patients' participation in decision-making about discharge after acute hospitalization. *Journal of Interprofessional Care* 21(1). 55–67.
- Huby, Guro, Jennifer Stewart, Alison Tierney & Wendy Rogers. 2004. Planning older people's discharge from acute hospital care: Linking risk management and patient participation in decision-making. *Health, Risk & Society* 6(2). 115–132.
- Ijäs-Kallio, Taru. 2011. *Patient participation in decision-making process in primary care. A conversation analytic study*. Tampere, Finland: University of Tampere.
- Jefferson, Gail. 2004. Glossary of transcript symbols with an introduction. In Gene H. Lerner (ed.), *Conversation analysis: Studies from the first generation*, 13–31. Amsterdam: John Benjamins.
- Jenks, Christophe. 2011. *Transcribing talk and interaction: Issues in the representation of communication data*. Amsterdam: John Benjamins.
- Kangasharju, Helena. 2002. Alignment in disagreement: Forming oppositional alliances in committee meetings. *Journal of Pragmatics* 34. 1447–1471.
- Keel, Sara & Veronika Schoeb. In press. What about patient participation within multiparty health care encounters? Professionals' orientation toward patients and their articulation with the activity structure of interdisciplinary entry meetings in a rehabilitation clinic. *Communication & Medicine* 13(1). 115–134.
- Kydd, Angela. 2008. The patient experience of being a delayed discharge. *Journal of Nursing Management* 16. 121–126.
- Lerner, Gene. 2003. Selecting next speaker: The context-sensitive operation of a context-free organization. *Language in Society* 32. 177–201.
- Levack, William MM, Sarah Gerard Dean, Richard John Siebert & Kath Margaret McPherson. 2011. Navigating patient-centered goal setting in inpatient stroke rehabilitation: How clinicians control the process to meet perceived professional responsibilities. *Patient Education and Counseling* 85. 206–213.
- Levinson, Stephen C. 1983. *Pragmatics*. Cambridge: Cambridge University Press.
- Markaki, Vassiliki & Lorenza Mondada. 2012. Embodied orientations towards co-participants in multinational meetings. *Discourse Studies* 14(1). 31–52.
- Merlino, Sara. In press. Initiatives topicales du client aphasique au cours des séances de rééducation: Pratiques interactionnelles et enjeux identitaires. In Lorenza Mondada & Sara Keel (eds.), *Participation et asymétries dans l'interaction institutionnelle*. Paris: Harmattan.
- Mistiaen, Patriek, Anneke L. Francke & Else Poot. 2007. Interventions aimed at reducing problems in adult patients discharged from hospital to home: A systematic meta-review. *BMC Health Services Research* 7. 1.
- Mondada, Lorenza. 2007a. Transcript variations and the indexicality of transcribing practices. *Discourse Studies*. 9(6). 809–821.
- Mondada, Lorenza. 2007b. Multimodal resources for turn-taking: Pointing and the emergence of possible next speakers. *Discourse Studies* 9(2). 194–225.
- Oloff, Florence. 2016. Comparaison de deux marqueurs d'affirmation dans des séquences de co-construction: "voilà" et "genau". *Testi e Linguaggi* 10. 243–267.
- Peräkylä, Anssi & Johanna Ruusuvuori. 2007. Components of participation in health care consultations. In Sarah Collins (ed.), *Patient participation in health care consultations: Qualitative perspectives*, 167–175. Maidenhead: Open University Press.
- Pilnick, Alison & Robert Dingwall. 2011. On the remarkable persistence of asymmetry in doctor-patient interaction: A critical review. *Social Science and Medicine* 72(8). 1374–1382.

- Pilnick, Alison, Jon Hindmarsh & Viginia Teas Gill. 2009. Beyond “doctor and patient”: Developments in the study of healthcare interactions. *Sociology of Health & Illness* 31(6). 787–802.
- Pomerantz, Anita. 1984. Agreeing and disagreeing with assessments: Some features of preferred /dispreferred turn shapes. In Max Atkinson & John Heritage (eds.), *Structures of social action: Studies in conversation analysis*, 57–101. Cambridge: Cambridge University Press.
- Popejoy, Lori Lea, Kyle Moylan & Colleen Galambos. 2009. A review of discharge planning research of older adults 1990–2008. *Western Journal of Nursing Research* 31(7). 923–947.
- Roberts, Kathryn. 2002. Exploring participation: Older people on discharge from hospital. *Journal of Advanced Nursing* 40(4). 413–420.
- Robinson, Jeffrey D. 2003. An interactional structure of medical activities during acute visits and its implications for patients’ participation. *Health Communication* 15(1). 27–59.
- Robinson, Jeffrey D. & Heidi Kevoe-Feldman. 2010. Using full repeats to initiate repair on other’s questions. *Research on Language and Social Interaction* 43(3). 232–259.
- Sacks, Harvey. 1987. On the preferences for agreement and contiguity in sequences in conversation’. In Graham Button & John Lee (eds.), *Talk and social organisation*, 54–69. Clevedon & Philadelphia: Multilingual Matters.
- Sacks, Harvey. 1992. *Lectures on conversation*, Edited by Gail Jefferson, Vol. I + II. Oxford: Blackwell.
- Sacks, Harvey, Emanuel Schegloff & Gail Jefferson. 1974. A simplest systematics for the organization of turn taking for conversation. *Language* 50(4). 696–735.
- Schegloff, Emmanuel A. 1972. Sequencing in conversational openings. In John Joseph Gumperz & Dell H. Hymes (eds.), *Directions in sociolinguistics. The ethnography of communication*, 346–380. New York: Holt, Rinehart and Winston.
- SIGN (Scottish Intercollegiate Guidelines Network) no. 118. 2010. Management of Patients with Stroke. <http://www.sign.ac.uk/guidelines/fulltext/118/index.html> (accessed 17 June 2013).
- Stivers, Tanya. 2002. “Participating in decisions about treatment: Overt parent pressure for antibiotic medication in pediatric encounters.” *Social Science & Medicine* 54. 1111–1130.
- Stivers, Tanya. 2005. Non-antibiotic treatment recommendations: Delivery formats and implications for parent resistance. *Social Science & Medicine* 60(5). 949–964.
- Stivers, Tanya. 2008. Stance, alignment, and affiliation during storytelling: When nodding is a token of affiliation. *Research on Language and Social Interaction* 41(1). 31–57.
- Stivers, Tanya & John Heritage. 2001. Breaking the sequential mold: Answering “more than the question” during comprehensive history taking. *Text* 21(1/2). 151–185.
- Stivers, Tanya & Jefferey D. Robinson. 2006. A preference for progressivity in interaction. *Language in Society* 35. 367–392.
- Stivers, Tanya & Federico Rossano. 2010. Mobilizing response. *Research on Language and Social Interaction* 43(1). 3–31.
- Stukenbrock, Anja. 2012. Empraxis und Displacement: überblendete Räume in der Koch-Show-Interaktion. In Heiko Hausendorf, Lorenza Mondada & Reinhold Schmitt (eds.), *Raum als interaktive Ressource*, 347–380. Tübingen: narrVerlag.
- Thompson, Andrew. 2007. The meaning of patient involvement and participation in health care consultations: A taxonomy. *Social Science & Medicine* 64. 1297–1310.

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