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"The oncologist told me": Reported speech as a patients' resource to volunteer concerns in oncological visits

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ABSTRACT

Based on the "patient centered approach", growing emphasis within policies has been put on patients' active participation in medical encounters. Consistently, research has investigated patients' initiatives during medical visits in a wide array of settings and specialties. Among these, oncological care constitutes a setting where patient participation is particularly crucial as well as challenging. However, previous studies in this setting have focused mainly on doctors' interactional work, with few works exploring patients' expressions of fears, uncertainties, and hopes. The present study contributes to this underexplored line of inquiry by showing how oncological patients take the initiative and make relevant their concerns through reported speech (RS). Based on a corpus of 106 video-recorded oncological visits collected in Italy and adopting conversation analysis, the article shows how patients use RS to volunteer some information they have previously been told by other, non-present physicians. Through RS, patients cautiously make relevant specific aspects of their case that have not been addressed in the ongoing interaction and appear to constitute a concern for them (e.g., presence of metastases, treatment side effects, hospitalization length). In response, the physician addresses the patient's concern, either by confirming the reported information or by distancing themselves from it, thus providing their opinion on the matter.

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1. Introduction

In recent years, growing emphasis within policies has been put on patients' active participation in their healthcare pathway and, particularly, in medical encounters (Boyer and Lutfey, 2010). Based on the so-called "patient-centered approach" (Mead and Bower, 2000; Castro et al., 2016), patient involvement in information-sharing and decision-making is now viewed not only as an ethical issue, but also and primarily as a means to maximize patients' trust, satisfaction, therapeutic compliance, and chances of healing (Bauer et al., 2014; Hillen et al., 2011). Conversation analytic research has been pioneer in investigating the diverse ways in which patients actively participate in clinical encounters. By relying on the "basic forms of mundane talk" (Drew and Heritage, 1992: 19) and orienting to the asymmetries in knowledge and participation that characterize medical interaction (Heritage and Maynard, 2006),

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patients have been shown to navigate the constraints of institutional conversation, finding ingenious ways to have their voices heard. Patients' "interactional initiatives" (Drew, 2001: 263), i.e., sequence-initiating actions and non-conforming answers, have been shown to be key sites where patients' concerns are conveyed, lay perspectives are displayed, and interactional projects are implemented. For example, research on primary and acute care encounters has shown that patients express concerns by expanding their answers to the physician's questions (Stivers and Heritage, 2001; Margutti and Galatolo, 2013) or by offering unsolicited 'pain informings' during physical examination (McArthur, 2018; Heath, 1990). Similarly, patients make indirect requests for treatment or tests by volunteering personal information (Gill et al., 2001), inquiring about the availability of the desired test (Gill, 2005), or mentioning previous talk with the same doctor (Robinson, 2001). Patients have also been shown to produce extended responses to some types of diagnostic statements (Heath, 1992; Peräkylä, 2002, 2006) and challenge physicians' diagnostic claims (Ijäs-Kallio et al., 2010; Yang and Wang, 2021). Patients may also issue "lay diagnoses" (Beach, 2001; Ten Have, 2001) or candidate explanations for their symptoms (Gill, 1998; Gill and Maynard, 2006; Heritage and Robinson, 2006), thus subtly pressuring doctors to interpret their problems in certain ways (Gill et al., 2010) and recommend specific treatments (Stivers, 2002a, 2002b).

Patients' initiatives in medical encounters have been studied in a wide array of settings and medical specialties, including pediatrics (Stivers, 2007), psychotherapy and psychiatry (Bolden et al., 2019; Ekberg and LeCouteur, 2015), prosthesis clinics (Margutti and Galatolo, 2013; Galatolo and Fasulo, 2022), prenatal checkups (Nishizaka, 2010), hospice and end-of-life medical encounters (Pino and Parry, 2019). Among these diverse specialties, oncological care constitutes a setting where patient participation is particularly crucial as well as challenging (Lutfey and Maynard, 1998; Roberts, 1999; Gill 2019; Costello and Roberts, 2001; Pino et al., 2021; Fatigante et al., 2020). The life-threatening character of cancer combined with the length, complexity, and impact of treatments on patients' life make patient involvement in the encounter particularly relevant (Costello and Roberts, 2001; Beach, 2013; Beach and Dozier, 2015). Furthermore, patient participation in oncological visits is facilitated by the chronic nature of their condition. Throughout the treatment and healing processes, which most of the times are long and feature many medical encounters in a variety of specializations (e.g., surgery, radiotherapy, cardiology), oncological patients tend to become 'experts' in their disease, acquiring a substantial amount of medical knowledge that allows them to play quite an active role in the visits (Margutti et al., 2023). However, and surprisingly, previous research on oncological interactions has focused mainly on *doctors*' interactional work (Tate, 2019; Tate and Rimel, 2020; Fatigante et al., 2020; Cortez et al., 2019; Alby et al., 2017; Gutzmer and Beach, 2015), with few works analyzing patients' initiatives, particularly those related to the expression of fears, uncertainties, and hopes (Beach and Dozier, 2015). Among these, Beach et al. (2005) have illustrated how patients visually and vocally display their fear of cancer. By exhibiting "interactional trepidations" (Beach et al., 2005: 895) when volunteering information about their medical history or symptoms, patients provide multimodal cues to their underlying fears − which, however, remain largely unaddressed by oncologists. More recently, Drew (2013) has documented that oncological patients may resist doctor's claims that downgrade the threat potentially posed by cancer, thus subtly conveying fears about their own conditions.

Based on a corpus of 106 video-recorded oncological visits collected in Italy and adopting conversation analysis (Sacks et al., 1974), the present study contributes to developing research on patient initiatives by showing how patients use RS to volunteer some information they have previously been told by other, non-present physicians, and which appears to constitute a concern for them. Therefore, compared to previous research (e.g., Heritage et al., 2007; Heritage and Robinson, 2011), this study illustrates a particular and unexplored kind of patients' 'unmet concerns': issues that *have already been addressed* by other physicians, on which patients get a second opinion. Through RS, patients manage to shape the medical agenda while visibly orienting to the interactional and epistemic asymmetries characterizing the medical encounter. The article also illustrates how the physician addresses the patient's concern expressed through RS: by confirming or − more rarely − distancing themselves from the reported information, physicians give their opinion on the reported issues.

The excerpt below provides an example. It occurs during the history taking phase of the first radiotherapy visit, and involves a patient affected by prostate cancer.

Ex. 1 − Basically I'm inoperable

BL_P1_V1_191121_03.05−04.03
D = Physician (radiotherapist); P = Patient (prostate cancer); C = Companion (wife)

```
1      D:    ascolti e:- >ad[es]so< con l'urina <come va>?
             listen          now      with urine how is it going?

2      P:                    [sì]
                             yes

3            6 lines omitted: P replies by providing information concerning his current urinating condition. He states that he has
             recently seen an improvement.
```

```
4       P:    ə::::  >(a)ri<- (.) ho (.) un'autonomia d- che va dalle due alle tre +o:re.
                            I have    an autonomy*   that ranges from two to three hours
        d:                                                                    +nods-->

5             (0.6)

6       P:    ə:: mentre prima+ era una cosa:h,
                  instead before it was a
        d:               -->+

7       D:    mh=
              mh

8       P:    =i-impressioNAnte >cioè< nell'ul-nell'ultima parte::h, (0.5) diciamo (0.5)
                big   issue    I mean      in the last part        let's say

9             in: autunno ecco di:°::  m::: (.) mh° (0.2) diciamo fine agosto:: e:h::
               in autumn  I mean of                      let's say end of august

10            andando avanti.
                 onwards

11            (1.7)

12      P:    e:: quindi m:i trovo n:ella condizione >naturalmente< di proseguire +quello
                 so   I find myself in the condition naturally     to continue    that
        d:                                                                    +nods-->

13      P:    che è il mio iter,+ °che sarà° è s:icuramente la radio+[terapia,]+ ə::
              which is  my path   that will be is certainly    radiotherapy

14      D:                                                           [mh mh]
                                                                      mh mh
                            -->+                                  +---nods---+

15            (0.3)

16  →   P:    anche perché ə:h: a detta di: Paolo Villa ma anche del suo +collega,+
              also because   according to Paolo Villa but also   your   colleague
        d:                                                              +--nods--+

17            (0.7)

18      P:    mi ha detto che sostanzialmente sono inope^ra:[bile =
              he told me that    basically      I'm  inoperable
        d:                                               ^lowers head

19      D:    .hhh &SÌ. >oddio<& ə- +<a giudicare: da &quello che +ho le&tto[::,+>=
                   yes  I mean      based on      what       I read
                   &looks at the computer screen&looks at P&looks at C--&looks at P -->>
                                        +repeatedly indicates both computer screen and P with
              open hands+

20            =[lei ha] fatto anche una risonanza vero?
               you have had  also    an MRI     right?

21      P:    [°sì°]
               yes
```

*The term "autonomy" ("autonomia") refers to the patient's ability to spend time where he does not need to use the toilet.

D's initial question about P's current urinating conditions (line 1) is followed by an extended answer (lines 3−6, 8−10, 12−13, 16−18). After describing his current conditions (line 3−4) and comparing them with his previous, worse conditions (lines 6, 8−10), P expands his answer by volunteering what he describes as the most likely suitable treatment for him, i.e., radiotherapy (lines 12−13). Following D's continuer (line 14), P provides an account for his claim on radiotherapy (lines 16−18) by reporting that he has been deemed "inoperable" by both "Paolo Villa" (i.e., his urologist, mentioned at the beginning of the visit) and D's "colleague" who previously visited him. Yet, he also makes relevant an issue that has not been mentioned until then, which appears to constitute a concern for him (i.e., his being inoperable), prompting D to give his opinion. Indeed, in response, D addresses such a concern: he confirms what has been reportedly said by his colleagues about P's inoperable conditions, although claiming that this is based on the medical reports ("based on what I read", line 19), thus distancing himself from an unreserved confirmation.

As this example epitomizes, RS is a resource whereby patients take the initiative and shape the medical agenda. By reporting other physicians' words, patients foreground aspects of their "unique and personal" case (Drew and Heritage 1992: 51) that have not been addressed in the ongoing interaction and appear to constitute a concern for them. Furthermore, by reporting other doctors' evaluations of their conditions, patients display that checking the consistency − as well as their own understanding − of the information they received in previous consultations is one of their main concerns. In response, patients obtain the physician's opinion, mostly in the form of confirmation of the reported information, although sometimes the reported claim is not fully endorsed.

Before analyzing other examples (Section 4), the following sections provide an overview of previous research on RS in social interaction (Section 2) and describe the data and methodology of the present study (Section 3).

2. Reported speech in social interaction

Since Goffman's multifold articulation of the notion of 'speaker' (Goffman, 1974, 1981), there has been extensive research on RS adopting a conversation analytic approach (for an overview, see Holt and Clift, 2007; Prior, 2015). Investigating both direct and indirect RS in a variety of contexts, CA research has shown the diverse actions that participants carry out by reporting someone else's words, as well as the different interactive contexts in which this is done. Research has shown that RS is typically used to provide evidence and give an "air of objectivity" to what is being said (Holt, 1996: 230). Reported speech has also been shown to play an epistemic function: by displaying the speaker's first-hand access to the object of the talk (e.g., an assessment), it subtly lays a claim of epistemic primacy (Heritage and Raymond, 2005), working as a powerful evidential that the speaker "got there first" (Clift, 2007: 149). Research has also shown that RS has moral relevance as it can be deployed to distance the current speaker from the words being told. However, according to the contextual circumstances in which it is used, RS can achieve rather different ends. For instance, speakers can rely on RS to shift their footing, staging themselves as the mere 'animator' − rather than the 'author' or 'principal' − of the reported claim (Goffman, 1981; Goodwin, 2007). In these cases, the endorsement of the utterance and the speaker's personal responsibility for it are reduced (Ekberg, 2021), which allows the speaker to accomplish actions that would otherwise be sanctioned or considered inappropriate (Buttny, 1997; Galatolo, 2007).

It is worth highlighting that, beyond such common features, the notion of RS has been described as taking two distinct formats: direct reported speech (DRS) and indirect reported speech (IRS), each playing specific functions and occurring in different sequential contexts. Since the investigation of the different uses of DRS and IRS is beyond the scope of this article, we shall use the acronym RS as a superordinate term to refer to all the cases analyzed in this article.

Studies on RS in interaction have documented a variety of ordinary as well as institutional contexts where this rhetorical device is used. As for ordinary interaction, RS has been found in activities such as complaining (Drew, 1998; Holt, 2000; Heinrichsmeier, 2021), storytelling (Golato, 2000; Holt, 2000, 2016, 2017; Berger and Pekarek Doehler, 2015), children's disputes (Goodwin, 1990), assessing (Clift, 2007; Couper-Kuhlen, 2007), and accounting (Couper-Kuhlen, 2007). RS has also been investigated in a range of institutional interactions, such as court examinations (Galatolo, 2007, 2015), broadcast news interviews (Clayman, 2007), talk shows (Hutchby, 2019), pediatric and prenatal visits (Caronia et al., 2023; Nishizaka, 2010), health professionals' backstage meetings (Juhila et al., 2014; Bangerter et al., 2011; Dickenson and Smart, 2018), and psychotherapeutic sessions (Ekberg, 2021; Fasulo, 1997). Overall, these studies converge in showing that RS constitutes a resource whereby participants navigate the constraints posed by the 'institutional character' of the interaction, thereby embodying context-relevant identities and displaying their orientation to epistemic, deontic, and interactional asymmetries. Surprisingly, despite such a considerable amount of research, no study has dealt with reported speech in oncological encounters. Contributing to filling this gap, the present article illustrates how patients in oncological visits rely on RS to volunteer medical information they have previously been told by other physicians. As we will show, through this resource patients manage to convey their concerns and verify the information obtained in previous consultations, while maintaining the epistemic and interactional asymmetries that are constitutive of these medical encounters.

3. Data and methodology

The data used in this study are drawn from a corpus of 106 video-recorded oncological visits collected within a project devoted to investigating doctor-patient interactions in oncological care. The data have been collected at five hospital units (a urology unit, two breast units, a radiotherapy unit, an oncology unit) located in five medium-sized cities in the North of Italy

between 2021 and 2023. Participants' consent was obtained according to Italian law n. 196/2003 and EU Regulation n. 2016/679, which regulate the handling of personal and sensitive data.[1]

The data collection involved 37 physicians, 56 patients (all adults, male and female), 6 nurses, and 32 companions. The visits concern various treatment specialties (i.e., radiotherapy, surgery, chemotherapy, hormone therapy), cancer types (e.g., breast, prostate, brain, lymph nodes), and stages of patients' treatment (i.e., first visits for treatment, pre-/post-treatment visits, follow ups). A crucial feature of these visits is the fact that all patients have a more or less long history as cancer patients: in most cases, they have already received the cancer diagnosis and some information about treatment in previous oncological encounters or screening tests (not recorded); in other cases, patients have already undergone surgery or treatment, with more or less effective results, for the same or other cancers. Therefore, these are patients who have attended many oncological encounters and talked to various experts, having thus acquired substantial knowledge of their specific condition.

The analysis has been carried out inductively. After repeated observation of the data, we noticed that patients frequently volunteered medical information about their own conditions by reporting what they had been told by other, non-present, medical personnel.[2] For the purposes of the present study, we identified as occurrences of RS those cases where patients 1) deployed a *verbum dicendi*, and 2) indicated some medical personnel as the source of the reported information (e.g., "Doctor X", "the oncologist", "the nurse") or used personal pronouns unequivocally referring to them (e.g., "she", as in ex. 5 below). We identified and collected 31 instances of RS occurring throughout the various phases of the visit. The excerpts were then transcribed and analyzed, based on conversation analysis conventions and the multimodal notation system proposed by Mondada (2018).[3] The coding of the examples and the analysis of each excerpt was repeatedly conducted by the authors, both collectively, in data sessions, and individually, often involving comparison across data. The analysis has revealed that patients rely on RS to accomplish a recurrent type of action, i.e., volunteering information about their own case that has not been discussed in the interaction, thus conveying their concern about it, and making it relevant for the doctor to address it.

4. Reported speech in oncological visits: patients volunteering concerns and doctors' responses

This section illustrates the phenomenon of patients' reported speech in oncological visits. It analyzes sequences where patients use RS to volunteer information previously provided by non-present doctors, and the co-present physician replies by either confirming the reported information or – more rarely – distancing themselves from it, thus providing their opinion on the matter. For clarity reasons, the following sub-sections will focus on: a) where and how patients take the initiative through RS, as well as – relatedly – what they do by relying on this resource (Section 4.1.), and b) how doctors respond by endorsing to different extents the reported talk (Section 4.2.).

4.1. Patients volunteering concerns through RS

In our data, RS is part of patient initiatives, constituting a sequence-initiating action or part of a nonconforming, expanded answer (Raymond, 2003). However, patients' RS-initiatives also display their cautiousness and orientation to the interactional asymmetries that characterize doctor-patient talk in various ways. First, patients mainly use RS at the end of the ongoing activity (i.e., when the physicians display that they are about to move on to next activity), thus avoiding interrupting the activity led by the physician (Robinson, 2003). Furthermore, patients' RS-initiatives typically feature elements that maximize the sequential relevance of the incoming turn (e.g., conjunctions) as well as elements that display patients' understanding of their own conduct as somewhat transgressive (e.g., hesitations, apologies).

In terms of actions, patients rely on RS to put forward aspects of their "unique and personal" case (Drew and Heritage, 1992: 51) that have not been mentioned by the co-present physician. Through this resource, patients convey their concerns about the reported information, verify such information, and thus double-check their own understanding of it. Importantly, in reporting other doctors' claims, patients also do epistemic and moral work: they stage themselves as knowledgeable about their own conditions; yet, at the same time, they present such knowledge as second-hand and derivative (Pomerantz, 1980), thereby constituting the co-present physician as the main expert on the medical information reported.

The excerpt below provides an example. It is the continuation of the exchange in ex. 1, and occurs a few minutes after it. So far, the physician has been reading the patient's medical records to stage his cancer.

Ex. 2 – Small trace
BL_P1_V1_191121_12.30–12.49
D = Physician (radiotherapist); P = Patient (prostate cancer); C = Companion (wife)

---

[1] Written informed consent for publication of anonymized screenshots was also obtained from the participants.

[2] For the aims of this study, we focused only on the cases where patients report other clinicians' talk. However, our corpus also includes few occurrences of patients reporting claims made by friends, relatives, colleagues, as well as retrieved from the internet.

[3] Transcripts are presented on two lines: the original Italian version is followed by an idiomatic translation in American English. To help the reader identify the correspondence between words in the two languages, in the English lines we mainly maintained the Italian word order, provided that this did not hamper the overall comprehensibility of the interaction.

```
1      D:      mtch sì perché sostanzialmente al di là della *prostata +#non vedono
                    yes because basically    apart from  the prostate they don't see
               *>>looks at PET scan report in his hands------*
                                                                   +places PET scan
               report on the table-->
       fig                                                         #fig. 1
2      D:      <a:ltr+o>.*# =
               anything else
                  -->+
                       *turns toward computer screen-->>
       fig               #fig. 2

3  →   P:      =SÌ. %ə::h:m (0.4) c'era una-un- una traccia piccoli:na%# dicevano
                yes  ehm       there was a a    a small [DIM.] trace    they said
                    %takes PET scan report and moves it closer--------%looks at PET scan
               report-->
       fig                                                         #fig. 3
4      di qualche cosa °che però n::° =
               of something    that  however [INITIAL CONSONANT SOUND OF NEGATIVE PARTICLE]

5      D:        =%sì ma dicono non correlato con la patologia >delle piccole< cisti
                 yes but they say not related to the pathology   some small   cysts
       p:      -->%folds PET scan report and leaves it on the table-->

6      D:      a livello del fe%ga[to]
               at the level of the liver
       p:                   -->%

7      C:                           [mh] [°mh mh°]
                                    mh    mh mh

8      P:                           [sìh sìh] saranno delle cisti sicuramente.
                                    yes yes they will be some cysts for sure
```


Fig. 1. D places the PET scan report on the table.
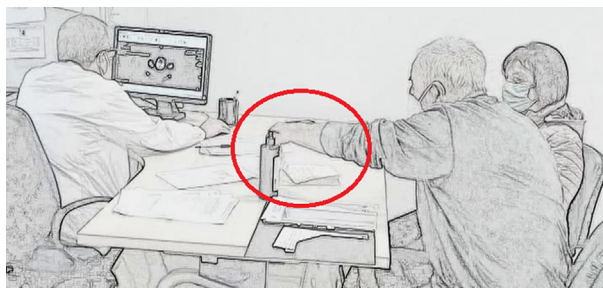

Fig. 2. D turns toward the computer screen.

Fig. 3. P looks at the PET scan report.

In lines 1–2, D issues a diagnostic assessment based on the PET scan he has examined ("apart from the prostate they don't see anything else"). This assessment is good news as it frames P's cancer as localized in the prostate, without any metastasis. As such, this news may be heard as downplaying the seriousness of P's case, in stark contrast with P's previous recount of his own conditions (see ex. 1). Concurrently, D multimodally conveys the end of the staging activity by placing the PET scan report on the table and turning toward the computer screen (lines 1–2, Figs. 1 and 2). In this sequential environment, P takes the initiative and produces a mitigated disagreement with D's diagnostic assessment (Pomerantz, 1984; Peräkylä, 2006). After a pro-forma agreement followed by some hesitation ("yes ehm", line 3), P uses RS to add some diagnostic information that has not been mentioned by D ("there was a small trace they said", line 3). By reporting the words said by the medical personnel responsible for the PET scan ("they said"), P expresses his own concern about the possibility of having some metastases. The use of RS allows him to convey his fear as a reasonable one, being based on the words uttered by other physicians. At the same time, through RS, P presents his own knowledge as second-hand, i.e., based on other physicians' assessments (note that P enacts his access to the source of his knowledge, i.e., the PET scan report, line 3, Fig. 3). By referring to other physicians' claims and showing some hesitation, P demonstrates his orientation to D's epistemic primacy on the issue, making relevant the latter's final say on the matter.

P's concern expressed through RS is immediately addressed by D (lines 5–6). Clarifying that the "small trace" mentioned by P is in fact an innocuous liver cyst being unrelated to cancer disease, D's turn appears effective in reassuring both P and his wife (see their replies in lines 7–8).

As the next example illustrates, patients' reports of other physician's talk may also be part of extended turns, being included in a short narrative, and featuring different types of RS (DRS and IRS) as well as different voices being reported. In this case too, RS constitutes a resource whereby patients make a concern relevant and have the physician deal with it, while preserving interactional and epistemic asymmetries. The excerpt below is taken from a radiotherapy visit with a patient who has undergone surgery (i.e., quadrantectomy) to remove breast cancer. In response to the physician's recommendation for postsurgical radiotherapy, the patient volunteers her concern on the suitability of this treatment by reporting the exchange she had with another physician (i.e., Doctor Cirri, her oncologist).

Ex. 3 – She explained to me
BL_P6_V1_71221_PAN_13.23–14.08
D = Physician (radiotherapist); P = Patient (breast cancer)

```
1     D:     allora lei è stata opera:ta, ha fatto un intervento conservativo
             now     you had surgery      you had  a  preservative operation

2            nel senso     appunto che  hanno lasciato  il seno,  <↓quin'quello
             that is to say indeed  that they  left     the breast  so

3            che  va fatto   in questo caso è  la radioterapia postoperatoria.
             what is to be done in this case  is    postsurgical radiotherapy

4            (.)

5     P:     sì.
             yes
```

```
6      D:     cioè (.) <andiamo a trattare il parenchima mammario residuo>. %#mhm?
              that is   we will   treat     the residual mammary parenchyma    mhm
                                                                              %looks
              down at documents-->
       fig                                                                   #fig. 4

7      P:     mhm mhm?
              mhm mhm

8             (0.5)

9   →  P:     che  mi ha s%piegato,       scusi se la interrom[po=
              that [SHE]* explained to me  sorry if I interrupt you
       d:              -->%looks at P-->>

10     D:                                                     [↑sì,
                                                               yes

11     P:     =un po'  la dottoressa Cirri<>che le ho chiesto< ma anche la
              briefly  doctor       Cirri   to whom I asked   but also the

12            radio&#terapi:a   devo  fa:&[re¿ $#(.)$ così piccolo::, insomma- pensavo.
              radiotherapy  do I have to do          so small     I mean I thought

                     &leans forward and opens hands showing puzzlement&

       fig          #fig. 5

                                         $makes 'grain gesture' with hand$

       fig                               #fig. 6

13     D:                                 [sì.
                                           yes

14  →  P:     .hh e   lei mi ha spiegato  che  appunto   va fatto
              .hh and she explained to me that indeed    it has to be done

15            >perché< (0.2) i:n=
              because        to

16     D:     =un tempo [lo togliEvano però,]
              once they used to remove it but

17     P:              [ i n  < PAROLE   PO]:ver[e> è quella che]= sostituisce=
                        to    put   it     simply  it is  what  substitutes

18     D:                                     [>in parole po-<]
                                               to put it sim-

19     P:     =la mastectomia,
              the mastectomy

20     D:     sì. un tempo facevano la mastectomia    adesso si è visto
              yes once they used to perform a mastectomy now we have seen

21            nel corso degli anni, che appunto i risultati  son sovrapponibili,
              over the years      that indeed the results are equivalent

22            (0.3) fa[cendo appu]nto   un intervento conservativo, e   dopo  una=
                    by indeed performing a preservative operation   and  then   a
```

```
23      P:              [mhm. mhm.]
                          mhm mhm

24      D:      =radioterapia post-operatoria. ↑mh? quindi riduce il rischio di
                 postsurgical radiotherapy     mh   so    it reduces the risk of a

25              recidiva soprattutto a livello    del quadra::nte ↓dove c'era la
                 relapse especially  at the level of the quadrant where the disease

26              malattia.
                 was located

27      P:      mhm, mhm.
                 mhm mhm

28              (0.2)

29      D:      va bene
                 alright

30      P:      be::ne.
                 alright
```

*Since the subject of the sentence (i.e., Doctor Cirri) is postponed (see line 11), we added the personal subject pronoun "she" in the gloss to make the transcript understandable to readers who do not speak Italian.

Fig. 4. D looks down at the documents.

Fig. 5. P leans forward and opens her hands showing puzzlement.
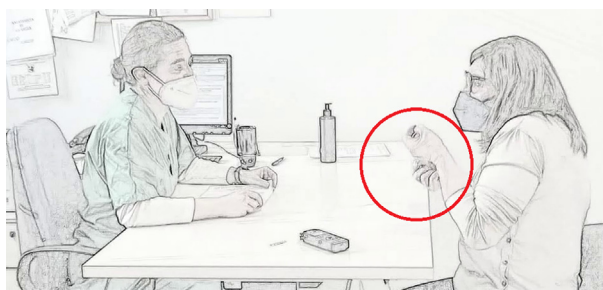
Fig. 6. P makes 'grain gesture' with her hand.

The excerpt begins with D briefly summarizing P's cancer history (lines 1–2) and then delivering the recommendation for postsurgical radiotherapy (line 3). This recommendation is presented as a logical consequence of P's surgery ("so", line 2), it is designed as a pronouncement (Stivers et al., 2017), and framed as mandatory ("what is to be done", line 3). All these aspects contribute to casting P as having little choice on the radiotherapy treatment, as if the decision on the matter had already been made by D and was merely being communicated. Also note that the recommendation conveys the physician's framing of the patient as a "routine case" (Drew and Heritage, 1992: 50). Basing the treatment recommendation on the kind of surgery undergone by P ('conservative operation so postsurgical radiotherapy'), this recommendation conveys a protocol-like treatment procedure, which may sound depersonalized and potentially disregarding the specificities of P's case. The lack of reference to aspects of P's specific case (other than the type of surgery she had) may convey that D is overlooking other aspects such as cancer type, dimensions, and P's health conditions. As we will see in a few turns, such unsaid specificities and related concerns will be brought up by P. After P's acceptance (line 5), D continues by providing a brief medical explanation of the radiotherapy treatment ("that is we will treat the residual mammary parenchyma", line 6). The treatment recommendation ends with D seeking P's reply through the final tag particle "mh?",[4] delivered with a marked raised intonation contour. In lines 6–7, with D lowering her gaze (see Fig. 4) and P acknowledging the medical explanation provided,[5] the sequence reaches its closure, as also evidenced by the gap in line 8.

In this sequential environment, P takes the initiative by volunteering a narrative on the exchange she had with "Doctor Cirri" (i.e., her oncologist, lines 9–19). Unlike ex. 1 and 2, this occurrence of RS is particularly long and elaborated as P does not merely provide the information given by the quoted doctor; rather, she issues a short narrative recounting the exchange between herself and Doctor Cirri. In this case, P deploys a combination of DRS, IRS and reported thought (Haakana, 2007), whereby she makes relevant two issues that have been mentioned only rapidly – if at all – by D, i.e., cancer dimensions and, relatedly, the suitability of the radiotherapeutic treatment being recommended.

P's turn is opened by the turn-initial relative conjunction "*che*" ("that", line 9), which is used here with a generalized and indistinct function[6] to connect the ensuing turn with the preceding one. Through this conjunction, P maximizes the sequential relevance of her incoming turn, conveying it as linked to prior talk and, more specifically, as an expansion of the prior sequence. By referring back to the treatment recommendation, "*che*" allows P to introduce what she knows about it. The following apology ("sorry if I interrupt you", line 9) demonstrates P's understanding of her own initiative as a breach, conveying her orientation to the interactional asymmetry characterizing the doctor–patient relationship. In lines 11–12, P reports part of the original dialogue with the non-present physician: first, P quotes her own words, reporting the question she asked to Doctor Cirri ("but also the radiotherapy do I have to do?") followed by the report of her own thought ("so small I mean I thought"). This self-quotation allows P to voice her own concern about the suitability of the radiotherapy treatment, especially in relation to the "small" dimensions of her cancer.[7] Through DRS, P conveys her doubts about radiotherapy through both prosody (see the vowel stretch and emphasis in "*radioterapi:a*" and "*fa:re¿*") and bodily enactment (see Fig. 5). The following reported thought ("so small I mean I thought", line 12) allows P to make relevant the small dimensions of cancer, which D left totally unsaid. Note that P emphasizes such smallness through the prosodically marked assessment "so small" as well as through the hand-gesture visually representing something as small as a grain (line 12, Fig. 6). Such an embodied conduct contributes to conveying P's concern about whether radiotherapy is necessary for her, making it relevant

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[4] The tag particle "mh?" here works like the "huh," in Stivers and Rossano (2010), in final position, following an assessment. They state that it "morphologically marks the turn as seeking response" (p. 11).

[5] Tokens like "mm" and "hm" in response to treatment recommendations have been defined as "passive resistance" in previous research (Koenig, 2011; Heritage and Sefi, 1992; Stivers, 2005). However, in this case P's "mhm mhm?" is sequentially referred to D's explanation of the procedure (in line 6) rather than the recommendation itself (in lines 2–3). Therefore, it is hearable as an acknowledgement of D's explanation rather than as a reply (in terms of acceptance or resistance) to the treatment recommendation.

[6] See the notion of "*che polivalente*" ("multipurpose that", Sornicola, 1981) in Italian. The phenomenon characterizes the variety of spoken and colloquial Italian.

[7] It is worth noting that, in this case, P relies on direct reported speech. Enhancing the vividness of what is being told (Tannen, 1989; Holt, 2000), direct reported speech is particularly effective in conveying P's concern.

for D to take a stance on this issue. P's self-reported question is immediately answered by D, who straightforwardly confirms the suitability of the treatment ("yes", line 13). Through IRS of Doctor Cirri's response (lines 14–15, 17, 19), according to whom postsurgical radiotherapy is to be done as it "substitutes the mastectomy", P communicates that her concern has already been addressed and solved, thus conveying that she is inclined to accepting the radiotherapy treatment (see also the initial acceptance, line 5). In sum, the long and elaborated RS allows P to volunteer her own concern about the suitability of postsurgical radiotherapy while, at the same time, presenting this concern as already solved. In this way, P casts herself as a competent and reasonable patient, who, despite having concerns, knows the reasons for the treatment and is ready to accept it when necessary. Similarly to ex. 1 and 2, the report of other physicians' claims allows P to show her knowledge about her own conditions, while also framing such knowledge as second-hand and derived from a more knowledgeable source. Furthermore, by reporting Doctor Cirri's talk, P offers it to the scrutiny of the co-present doctor, prompting her to take a stance on it. At this point, and despite D's repeated attempts to take the turn earlier (see her overlapping turns in lines 16 and 18), P finally concludes her turn, leaving the floor to D.

In her long reply (lines 20–26), D confirms Doctor Cirri's words as correct ("yes", line 20). Then, she expands on the concern made relevant by P, i.e., the suitability of postsurgical radiotherapy. By explaining that radiotherapy "reduces the risk of a relapse", D accounts for the treatment recommendation, conveying it as authoritative. D's reply seems to be effective in addressing P's concern: in the following turns, P demonstrates her understanding ("mh mh", line 27) and further verbalizes treatment acceptance through the final "*be::ne.*" ("alright", line 30).

As ex. 2 and 3 have shown, RS is typically used by patients at the end of the ongoing activity, as a resource to volunteer specific aspects of their cases that have not been discussed and would remain unaddressed due to the physician's transitioning to the next activity. As for turn design, patients' RS-initiatives feature elements displaying their orientation to the doctor's epistemic primacy on the medical issue reported, such as hesitations, lay language, and RS itself, which frames the patients' knowledge as second-hand, as opposed to the physician's expert knowledge. As for the action accomplished, by submitting other medical staff's claims to co-present doctors, patients make the latter's opinion relevant, prompting them to address their concerns. In this way, patients get to verify the information previously given by other health professionals and their own understanding of it.

4.2. Doctors providing their opinion on the reported issue

As we have seen so far, patient initiatives including RS of other medical staff make relevant for the co-present physicians to take into account the reported issue and give their opinion by either endorsing or distancing themselves from the reported talk. In our data, patients' RS is most frequently followed by the physicians' confirmation of the reported information (see ex. 1–3). The excerpt below provides a further example. This is a pre-treatment visit: the patient is seeing the radiotherapist and a nurse to receive further information concerning the radiotherapy she is about to start. So far, the nurse and the radiotherapist have been extensively describing the side effects caused by radiotherapy. The patient has demonstrated her understanding of such information through nodding and continuers.

Ex. 4 – The oncologist told me
BL_P10_V2_141221_07.35–08.32
D = Physician (radiotherapist); P = Patient (breast cancer); N = Nurse

```
1      D:    detto questo:, direi che durante il trattamento radia:nte,
              that said    I'd say that during the radiotherapy treatment

2            (0.5) e::hm (0.3) può fare una vita (.) ASSolutamente norma:le,
                   ehm        you can live a life    absolutely normal

3            quello che: a- va evitato sono delle fonti di calore
             what      a-must be avoided is    heat sources

4            °estremamente importanti >vicino alla mammella (ovvia)<mente,°
              extremely   intense     close to the breast    obviously

5            .hh e-degli sforzi muscolari molto importanti col braccio (.) omolaterale
             .hh e- very hard muscular  efforts    with the arm          ipsilateral

6            al: punto in cui:: lei fa il trattamento radia:nte,
             to the point whe:re you'll be having the radiotherapy treatment

7            e direi <°nient'altro ecco°> non [prender] botte nel se:no,
             and I'd say nothing else I mean do not get hit in the breast,
```

```
8     P:                                            [°<okay>°]
                                                    okay


9     D:      °queste: queste cose qui.°
              these   things right here.


10            (0.3)


11    P:      okay
              okay


12    D:      e: direi nien*t'al*tro: nell'ac$[uto:], e:hm:$ più o meno così.
              and I'd say nothing else in the acute, ehm more or less like this.
       n:                        *shakes head*


13    P:                                          [mh]
                                          $----nods----$


14            (0.2)


15    N:      (v)a bene dahi=
              alright   come on


16  → P:      =%l'oncologa% mi >avea< detto che mi-m:i potrebbe dare <stanchezz:a.>
               the oncologist    told me       that it could    make me tired
              %looks at D%looks at N-->


17            (0.3)


18    D:      °è [possibile.° =
              it's possible


19    P:         [è v:%e::ro? =
                  is it true?
                    -->%looks at D-->>


20    N:     = questo l$o dà. [sì s:ì]$
             this will occur. yes yes
                        $-----nods-----$

21    D:                     [(è possibile.)]
                              it's possible.

22    P:     okay.
             okay


23    D:     [(è possibile).]
              it's possible

24    N:     [può fa:rlo.]
             it may occur

25    P:     okay
             okay

26    D:     certo.
             sure

27    P:     °va bene.°
              alright
```

In lines 1–9, D warns P about the behaviors she should avoid during and immediately after the radiotherapy treatment. By minimizing the effects of radiotherapy on P's life ("you can live a life absolutely normal", line 2), by presenting her recommendations as commonsensical ("obviously", line 4), and by ruling out extreme behaviors that P would probably avoid anyway ("heat sources extremely intense close to the breast", "very hard muscular efforts", "get hit in the breast", lines 3–5 and 7), D implements a no-problem trajectory, depicting radiotherapy as almost problem-free and conveying her view of P as a routine, unproblematic case. Concurrently, D repeatedly conveys that she is reaching the end of the treatment recommendation activity by claiming that she has nothing else to say ("I'd say nothing else", line 7; "these things right here", line 9; "I'd say nothing else in the acute, ehm more or less like this", line 12). Through a series of minimal acknowledgments (lines 8, 11 and 13), P aligns with the projected closing of the activity, which is finally ratified by N. Through the turn in line 15 ("alright come on"), N marks an activity transition (Robinson and Stivers, 2001), establishing the end of the treatment recommendation.

At this interactional conjuncture, P takes the initiative: she self-selects to report what she has been told by her oncologist (line 16). Through RS, P adds a potential side effect that has not been mentioned by D, thus conveying her concern about it and making it relevant for D to address it (see also P's request for confirmation in line 19, "is it true?"). As in ex. 1–3, RS is followed by some reply from the medical personnel: both D and N address P's concern. D confirms the information given by the quoted oncologist by specifying that tiredness is a "possible" side effect (lines 18, 21, 23). N also confirms it: after presenting the side effect as certain ("this will occur", line 20), she aligns with D by downgrading certainty ("it may occur", line 24). In this way, D and N convey their concordance with the information reportedly provided by their colleague: tiredness is a potential side effect of radiotherapy.[8]

In the examples so far, we have seen that patients' concerns conveyed through RS are mostly followed by medical staff's reply in the form of confirmations (ex. 1 and 4) often accompanied by explanations (ex. 2 and 3). However, this is not always the case: physicians in our data sometimes found it difficult to fully endorse the reported medical claim, especially when this entailed taking a firm stance about future, unpredictable events. The excerpt below, occurring during a pre-surgery visit, provides an example. We join the conversation when the physician is giving practical information concerning surgery (i.e., excision of sentinel lymph node, type and duration of surgery).

Ex. 5 − Two or three nights
MO_IES_P3_V2_070423_18.05−18.22
D = Physician (surgeon); P = Patient (breast cancer); C = Companion (friend)

```
1       D:      %ovviamente e- si ricovera (.) un giorno e il giorno stesso facciamo
                obviously  you'll be hospitalized one day and the same day we'll do
                %>>looks at P-->

2               l'interve:nto.
                the surgery

3               &(0.5) %#(0.6)&

        p:      &nods--------&
        d:          -->%looks down at documents-->
        fig              #fig. 7

4       D:      e:: al con[te%:mpo]
                and at the same time
                          -->%looks at P-->>

5   →   P:                [m'ha det]to che riman(go) due tre <notti>=
                          she* told me that I'm to stay here for two or three nights

6       D:      =s::ì: è pos[si]bile che: rimanga:,
                yes   it's possible that you'll have to stay

7       P:                  [°eh°]
                              eh

8               (.)

9       P:      poi fa[[i)]]
                then you'll do
```

---

[8] The professionals' hedged responses also appear oriented to avoiding conceding that their previous claims about side effects had been overly optimistic.

```
10      D:              [due] notti [(tre) notti vediamo come sta]
                        for two nights (three) nights we'll see how you feel

11      P:                              [poi- andrebbe (tutto        )] eh. dipende da come se-
                                        then it would (all           )  eh  it depends on how

12              mi se[nto.
                I feel

13      D:              [togliamo anche i::l linfonodino nell'asce:lla
                        we're also going to remove the small lymph node in the armpit
```

* "She" refers to Doctor Mami, i.e., the surgeon whom P met in the first surgical visit. The name of Doctor Mami has been mentioned explicitly in the previous turns (not transcribed).

Fig. 7. D looks down at the documents.

In lines 1−2, D gives some information on pre-surgery hospitalization, specifying that surgery will be done on the same day when P is admitted to hospital. By prefacing the turn with the adverb "obviously", D conveys the procedure as a well-established one, characterizing P as a routine case. Through the falling intonation contour (line 2) and the lowering of the gaze on the documents (line 3, Fig. 7), D multimodally displays he has ended the informing statement. Indeed, in line 4 he starts delivering new information. At this point, P takes the initiative through RS: she overlaps with the surgeon's turn in line 4 in such a way as to be able to add to the information about her forthcoming hospital stay (line 5) before the surgeon can continue and potentially move the talk on to some other matter. By reporting what she has been told by her surgeon ("she", line 5, i.e., Doctor Mami, whose name was explicitly mentioned in previous turns, not transcribed), P makes relevant her concern about the length of post-surgery hospitalization, which has not been mentioned by D. By using a present tense in Italian ("*rimango*") and by indicating quite a precise number of days ("two or three nights"), P frames this information as certain, making relevant D's opinion on it. The patient's concern is addressed by D in the following turn (line 6); however D's response does not fully endorse the information reportedly given by the other surgeon. After an initial confirmation ("yes", line 6), D formulates P's turn by presenting the two-or-three-night postsurgical hospitalization as "possible" (line 6). Then, he describes the hospitalization length as dependent on P's health conditions ("we'll see how you feel", line 10). In this way, D conveys the overall correctness of the information reportedly given by his colleague, while also conveying the uncertainty about hospitalization length related to P's unique and unpredictable post-surgical conditions. In the following turn, P accepts such an uncertain reply, acknowledging that her health conditions will constitute a variable for the length of her after-surgery hospitalization ("eh it depends on how I feel", lines 11−12).

As we have seen, RS appears to be effective as a patients' means to communicate concerns and verify (the understanding of) previously-received medical information: whenever patients in our data express their concerns through RS, they obtain the physician's opinion on the matter being reported. However, as illustrated in ex. 5, physicians do not always provide a full confirmation of the reported medical information. These cases typically concern the (un)predictability of the patients' conditions in the future, such as post-surgery health status. The analysis shows that, albeit not in full disagreement with the reported information, physicians hesitate to confirm clearcut evaluations of the patients' future conditions and cautiously avoid proffering precise predictions about the patient's "unique and personal case".

5. Concluding discussion

The analysis has shown how oncological patients rely on RS as a resource to volunteer medical information about their own case, which other, non-present, medical personnel (e.g., their oncologist, ex. 3 and 4; their urologist, ex. 1; a surgeon, ex.

5; a radiologist, ex. 1 and 2) gave them and which has not yet been mentioned in the ongoing interaction. The analysis has also shown a recurrent interactional site where patients' RS mainly occurs: the activity closure, i.e., when the physicians (and nurses, when present) show that they are reaching the end of the current activity, and approaching the transition to the next one. This timing of the patient's initiative appears to be crucial in order not to disrupt the unfolding of the medical interaction, largely led by the physician. In the extracts of our collection, in fact, patients typically intervene when they are sure that the ongoing activity has reached its closure and that, therefore, their concern will otherwise remain 'unmet'. Once the end of the activity is unequivocally reached, patients rapidly intervene (see the short gap in line 8, ex. 3 or the latching in line 16, ex. 4), even at the cost of overlapping with the doctor (see line 5, ex. 5). In so doing, patients display their orientation to seizing the last opportunity to introduce some information which is relevant to the topic being discussed, just before the topic is changed, without challenging the overall interactional asymmetry that is proper to this institutional setting. In the very rare cases where patients intervene at a moment when activity closure and transition are not evidently imminent (as in ex. 1), patients still show their orientation to avoiding disrupting the unfolding of the physician-led medical interaction. For instance, in ex. 1 the patient's RS-initiative occurs as an expansion following the patient's answer to the physician's question.

Therefore, it can be argued that, through RS, patients manage to shape the medical agenda, finding a way to convey their (previously-discussed but still) 'unmet' concerns and have the co-present doctor give their opinion on the reported issue. By offering other physicians' claims to the doctor's scrutiny, patients also appear oriented to double-checking the information they possess. What seems to constitute a concern for these patients is not only the issue itself (e.g., whether they have some metastases, ex. 2), but also – and more subtly – to verify other physicians' statements, establishing their reliability as well as their own understanding of this information.

RS appears to be an effective resource for 'fishing' for the doctor's opinion on issues concerning the patient's specific case: as a matter of fact, in our data, the physicians always address the concern made relevant by the patients. However, they do not always fully endorse the information reportedly given by other doctors. This is particularly the case when patients report certain evaluations concerning their future personal conditions (e.g., surgery recovery time, ex. 5). Clearly enough, these are hardly predictable events, very much dependent on the patient's unique and personal features and health conditions. In these cases, a "non-alignment" (Drew, 2013) between doctors' and patients' perspectives can emerge. Such non-alignment typically concerns the different and contrasting views of 'personalization' held by the interactants. Through the deployment of RS, patients demonstrate their orientation to obtaining extensive and detailed information about their specific case (e.g., the exact length of post-surgery hospitalization). Conversely, doctors show an orientation to avoiding giving specific, 'personalized information' mainly due to the high unpredictability of the patients' individual reactions to medical procedures and treatments.

In conclusion, the article has shown that, for patients, RS is a very flexible interactional tool, whereby they manage to reconcile two potentially conflicting issues. On the one hand, it serves the patients' agency ends to shape the medical agenda and focus on their own unmet concerns. RS also constitutes a resource whereby patients display their knowledgeability concerning their specific case, exerting their epistemic rights. By explicitly referring to the knowledge they have accumulated through the many steps of their treatment pathway, patients stage themselves as 'experts' about their diagnosis (ex. 2), treatment recommendation (ex. 1, 3, 5), and side effects (ex. 4), projecting an image of themselves as competent interlocutors. On the other hand, it is worth noting that the design and position of RS displays the patients' prevailing orientation to maintaining the institutional asymmetries characterizing the medical encounter (Drew and Heritage, 1992; Heritage and Maynard, 2006). In terms of participation, patients appear oriented to leaving the 'leading role' to the physician: despite taking the initiative, they typically intervene only when the doctor ends their talk and projects the activity closure. Even by taking the initiative, patients display their orientation to cooperating with the doctor by relevantly contributing to the activity. Finally, concerning epistemics, patients display their orientation to the primacy of the physician's expertise over their own 'lay' knowledge. Indeed, not only do they quote other physicians, but they also accept the physician's reply without questioning it, even when it does not fully confirm their previously held knowledge on the matter.

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Vittoria Colla: Writing – review & editing, Writing – original draft, Visualization, Formal analysis, Data curation, Conceptualization. **Piera Margutti:** Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Daniele Urlotti:** Writing – review & editing, Visualization, Data curation. **Valeria Barbieri:** Visualization, Data curation.

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