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Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Invoking death: How oncologists discuss a deadly outcome

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ARTICLE INFO

Keywords:

Doctor-patient interaction
Decision-making
Cancer
Conversation analysis

ABSTRACT

Existing sociological research documents patient and physician reticence to discuss death in the context of a patient's end of life. This study offers a new approach to analyzing how death gets discussed in medical interaction. Using a corpus of 90 video-recorded oncology visits and conversation analytic (CA) methods, this analysis reveals that when existing parameters are expanded to look at mentions of death outside of the end-of-life context, physicians do discuss death with their patients. Specifically, the most frequent way physicians invoke death is in a persuasive context during treatment recommendation discussions. When patients demonstrate active or passive resistance to a recommendation, physicians invoke the possibility of the patient's death to push back against this resistance and lobby for treatment. Occasionally, physicians invoke death in instances where resistance is anticipated but never actualized. Similarly, death invocations function for treatment advocacy. Ultimately, this study concludes that physicians in these data invoke death to leverage their professional authority for particular treatment outcomes.

Cancer is second only to heart disease as the most common cause of death in the United States (Xu et al., 2018). While there have been many advances in treatment, fear of death inhabits the world of cancer care (Vrinten et al., 2017). For decades, sociological research has studied death in clinical encounters as an end-of-life (EOL) phenomenon that both clinician and patients are reticent to discuss in prognostic discussions (Christakis, 2001; Cortez et al., 2019), disclosing the terminality of illness (Glaser and Strauss, 1965), breaking bad news (Clark and LaBeff, 1982; Lutfey and Maynard, 1998; Maynard, 1996), communicating care procedures for dying patients (Kaufman, 2005), and coming to terms with a terminal diagnosis (Timmermans, 1994). While past research points to a deep and longstanding cultural orientation to death as a thorny topic of discussion in medical practice, this paper takes a different tack and examines how clinicians can capitalize on patients' fears of death to secure acceptance of treatment recommendations that patients have otherwise been reticent to agree to.

Treatment recommendations represent the heart of doctor-patient negotiation because there must be agreement on both sides in order for the recommendation to be taken up. Physicians are the primary gatekeepers to treatment through their authority to prescribe medications and order procedures (Starr, 1982; Stivers, 2002a). Yet, these recommendations alone only get clinicians so far if the patient is not on board. There is a normative orientation to patient acceptance of treatment (Stivers, 2005b) and a legal mandate for informed consent (Kaufmann, 1983). Further, patients are the gatekeepers of their bodies with respect to the implementation of any given physician

recommendation. Physicians and patients have been shown to be at odds over treatment recommendations for many reasons, ranging from diagnostic resistance (Ijäs-Kallio et al., 2010), to a desire for alternative medication (Stivers, 2005b). In this sense, patients retain a degree of power in the medical consultation.

In the oncology arena, physicians frequently recommend treatments that can require significant costs with respect to patients' finances and time, in addition to carrying burdensome side effects (Levit et al., 2013). Nonetheless, physicians have been found to present cancer treatments in a variety of ways that seek patient acceptance and will intensify their advocacy for treatment when patients delay acceptance. In particular, physicians advocate for these treatments by arguing that treatment will help patients to secure a better quality of life and/or a longer life (Tate, 2018). Conversation analysts have found, in the context of the growth of terminal cancer, that oncologists bypass prognostic discussions in favor of "treatment-talk": discussing additional options to treat the disease (Singh et al., 2017). Further, in a single-case analysis of a surgical breast cancer consultation, Gill (2019) found that death in a negative formulation ("Breast cancer *won't* kill ya in the breast") provided an interactional on-ramp for the oncologist to advocate for treatment through addressing its possible misconceptions.

This article offers a new approach to analyzing how death gets brought up in medical interaction by opening up existing analytic boundaries to include any type of positive mention, or invocation, of death (e.g., "You *could* die" or "This *may* be deadly") during physician-patient encounters. By re-conceptualizing the existing orientation

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<https://doi.org/10.1016/j.socscimed.2019.112672>

Received 11 April 2019; Received in revised form 30 October 2019; Accepted 7 November 2019

Available online 12 November 2019

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towards death in conversation to include how death gets invoked throughout the clinical encounter, this analysis finds—counter-intuitively—that physicians do talk about death, but it is not in the EOL context that sociologists up until now have anticipated. More precisely, this analysis reveals that physicians invoke death by leveraging it in a persuasive context when patients push back on their recommendations for treatment.

1. Background

Patients are becoming increasingly involved in their own health care. This is due to multiple forces leading to the erosion of paternalistic medicine. Healthcare policy has shifted towards a model of shared decision-making (SDM) mandating physicians to increase information flow to patients and to secure their participation in decisions (Charles et al., 1997, 1999). Known as the gold standard in medical decision-making, SDM was among many of key reforms to the U.S. healthcare system when the Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama in 2010. Many states have also endorsed collaborative decision-making practices and have put forth policies intended to encourage patient involvement in medical decisions (Frosch et al., 2012). In large part, SDM has been gaining prominence in health policy because it is argued to be beneficial to patients. It has been presented as a cornerstone of the patient-centered care paradigm (Barry and Edgman-Levitan, 2012) and is often linked to the ethical practice of medicine because it relies on patient self-determination (Elwyn et al., 2012). Researchers have correlated SDM's implementation with more active patient involvement, greater patient confidence, and less invasive treatment options (Stacey et al., 2011).

Patients too, in their own way, have pushed physicians to share their authority over treatment. Health information is readily available on the internet (Boyer and Lutfey, 2010; Wald et al., 2007), and this has contributed to the concept of the Internet health consumer (Frist, 2014). This has been argued to result in the “democratization” of health information through its accessibility to not just healthcare professionals but also to patients (Anspach, 2011). The Internet has created a space for a new and unprecedented amount of medical information and is often cited as a reason for patients' desire to participate in their own care (Sainio et al., 2001; Xiang and Stanley, 2017). Further, patients often join online social support groups to obtain information about their healthcare (Chung, 2014). Because the Internet transcends local boundaries, patients are increasingly able to access information about treatment independently of their physicians (Frosch and Kaplan, 1999). Patients are argued to experience a new level of engagement when they visit the doctor, equipped with treatment options they researched online in preparation for their visit (Conrad and Stults, 2010).

Ultimately, SDM conceptualizes treatment decisions as collaborative because physician and patient are jointly invested in the decision (Légaré and Thompson-Leduc, 2014). The model calls for physicians to provide information regarding all available treatment options, risks and benefits, and impacts on patients' well-being, while patients offer their preferences, values, beliefs, and burden tolerances (Charles et al., 1999). As patient involvement is encouraged from a policy perspective for its benefits, it also represents an erosion of physician authority through promoting patient autonomy and choice. Of course, physicians continue to possess particular knowledge specific to their profession, especially the transcendent ability to keep patients alive (Timmermans and Oh, 2010). Moreover, they too have preferences and beliefs about what is best for their patients, sometimes with significantly greater experience to draw on about the possible efficacy and side effects of a treatment. Given this, treatment decision-making arguably involves a complicated balance of powers between patients increasingly exercising their agency and physicians maintaining their professional expertise.

Patient agency and physician authority can come into conflict at the point that a physician makes a specific treatment recommendation. Treatment recommendations normatively require patient acceptance

(Costello and Roberts, 2001; Stivers, 2007): once a physician has issued a recommendation, acceptance from the patient is due. Evidence for this is found when acceptance is absent just following a recommendation and physicians work to persuade patients to accept the recommendation (e.g., explaining why the treatment is likely to be effective or justifying the treatment with exam findings). Further, patients who do not readily accept frequently go on to actively resist the recommendation by questioning it or even by challenging it or requesting an alternative (Stivers, 2005b).

When patients resist treatment recommended by a physician, physicians are placed in a difficult position: they have advocated for what they believe is the best treatment for their patients, but patients do not want to pursue that route, or they may want an alternative which the physician may believe is inappropriate or less desirable. This can trigger physicians pursuing patient acceptance or even reversals in treatment recommendations (Stivers, 2007). Exploring the case of parent pressure for antibiotics in a context of a child's upper respiratory infection, Stivers (2002a) examined how physicians balanced their own medical agenda—avoiding inappropriate antibiotic prescribing—and preserved patient (in this case, parent) participation in decision-making. Stivers (2002b, 2002a) also found that parents used distinct tactics to pressure physicians for antibiotics to treat their child for viral infections. This could come in the form of either overt or covert interactional practices that physicians perceived as pressure and that ultimately shaped the way they recommended treatment.

Both passive and active patient resistance to physicians' recommendations can be a way for patients to exercise agency over the treatment decision. In a study of adult acute primary care visits, Koenig (2011) found several grounds for patients to passively and actively resist treatment. Patients could passively resist because they were unclear about specialized vocabulary, when physicians did not clearly design their turn as a recommendation, or if patients were unsure about the meaning of the recommendation. On the other hand, Koenig found that when patients upgraded from passive to active resistance, they asserted more self-advocacy. A shift to active resistance, Koenig argued, could happen because patients took issue with diagnostic grounds for the treatment, were troubled by possible side effects of the treatment, or wanted to co-construct the recommendation so it was more aligned with their own desires for a remedy.

This paper will show one way that this tension plays out is through physician use of an interactional bargaining chip when patients resist the treatment recommendation. Surprisingly, that bargaining chip is talk of a patient's possible death. Up until recently, research on death discussions has taken a decidedly straightforward approach to studying the relationship between death and the medical institution: to study dying patients and the behaviors that inhabit such experiences. Typically, death and dying are subjects that clinicians avoid. I contrastively find that death and dying are actually invoked, but in a way that is very different from what prior sociological research would have suggested. I argue that physicians mobilize their medical authority and invoke death to as a trump card to persuade patients towards a particular treatment regimen rather than invoking death in a context where the patient is near the EOL. In what follows, I will offer support for these claims.

2. Data and methods

The data come from a corpus of 90 video-recorded interactions between oncologists and patients collected in cancer clinics between 2014 and 2017. Research protocols were IRB-approved and participants provided written informed consent. Oncologist participants, drawn from a convenience sample, spanned two sub-specialties, gynecologic oncology and urologic oncology. Two participants were urologic oncologists, three were gynecologic oncologists. One participant, a gynecologic oncologist, was female. Practice years ranged from 9 to 26 years. The 82 patient participants likewise came from a convenience

sample drawn from the participating oncologists' weekly clinics. Eight patients were captured twice during data collection. Of the patient sample, 17 were male being treated for a urologic cancer or pre-cancer, and 65 were female being treated for a gynecologic cancer or pre-cancer. The uneven split between male and female patients was due to the relative infrequency of the urologic cancer clinic as compared to the gynecologic cancer clinic during my time in the field.

The data was analyzed for mentions of death and/or dying according to conversation analytic (CA) methods (Heritage, 1984; Sidnell and Stivers, 2012) in which oncologist-patient clinic visits were captured using a small video-recording device in the exam room. Video-recorded visits were transcribed and analyzed for mentions of death and/or dying according to CA methods and notations (Hepburn and Bolden, 2012). Conversation analytic approaches to medical interaction maintain the crucial stance that medical practice is inherently a social activity subject to the same conversational norms as ordinary interaction. Accordingly, through an understanding that interactants co-construct and collaborate to complete an interactional project, CA offers critical insight into the physician-patient relationship and the means through which that relationship achieves particular therapeutic outcomes (Timmermans and Tavory, 2012). Those outcomes at times can be effective, and at others, demonstrate room for improvement. CA serves as an important methodology for analyzing patterns in interaction which can then be shown to be ordered and systematic in usage by co-participants, known as a *practice* (Sidnell and Stivers, 2012). In order to uncover and label a way of communicating as a practice, it must be a repeated communication behavior for doing some action which has distinct and patterned consequences for subsequent behaviors (Heritage, 2010). CA has allowed social scientists to identify meaningful patterns and health-related consequences of medical behaviors such as physical examinations (Heritage and Stivers, 1999), patient presentations of illness (Stivers, 2005a), patient disclosures (Bergen and Stivers, 2013), and treatment recommendations (Tate, 2018). In this analysis, CA is used as a primary methodology for identifying distinct practices through which oncologists discuss death and dying with their patients. Mentions of death from clinicians happened more frequently than initially expected. In the course of identifying and examining death mentions in these data, I found that one of the primary places death got invoked was in the treatment recommendation context. In analyzing 61 treatment recommendations, physicians brought up death 17 times across 13 patient visits.

3. Results

I argue that physicians invoke their patient's death in contexts where patients have failed to accept a treatment recommendation. In this context, this practice works as a strong persuasive tactic to pursue patient acceptance of the treatment recommendation. In what follows I offer evidence for this claim through the context in which doctors make death invocations and their uptake.

3.1. What is an invocation of death?

When I discuss invocations of death, I mean to capture the range of ways that physicians mention a patient's death. An invocation of death only involves positive invocations of dying rather than a reassurance of not dying. Examples of death invocations include: "If the cancer comes back we *won't be able to cure you*", "If we don't treat this cancer it *will be deadly*", and "Chemotherapy is better *than the alternative*".

The following encounter (Extract 1) offers a reference to the patient's death in discussing her future health outcome should she decide not to pursue the recommended treatment. In this case, a woman in her mid 30's has just had surgery to remove cancer that has been found on her cervix. As part of this surgery, the surrounding margins were tested to investigate the degree of spread. It was found that the cancer had spread to a nearby lymph node. After the physician recommends

treatment, the patient demonstrates resistance. The physician produces the treatment recommendation as a proposal (lines 01–04 & 06), that she recommends a combined chemotherapy and radiation course followed by more chemotherapy.

(1a)0128

```
01 DOC: fresh .hhhh (.) we talked about (.) your s:: your type of
02 cancer:? (.) what the: best treatment should be: and the: team
03 agreed that the best treatment would be a combination of
04 chemotherapy and radiation at the same time an[d then followed
05 PAT: [really?
06 DOC: with chemotherapy. .pthhhh because the: overall:m (.) this is
07 DOC: very rare (.) this clear cell: cancer of the cervix is a very
08 rare kind.
```

In overlap with the recommendation for follow-up chemotherapy, the patient targets the proposed initial course of chemotherapy and radiation with a newsmark (Jefferson, 1978). This requests confirmation, nominally, but it also fails to indicate acceptance by instead looking for confirmation and expansion, a practice that physicians consistently hear as resistant (Stivers, 2005b).

Following this, the physician responds in a canonical way—accounting for the recommendation in pursuit of acceptance beginning in line 06. She notes that the kind of cancer this patient has is "very rare" (lines 06–07) and continues to describe the severity of this type of cervical cancer (in which 15 lines from the transcript are omitted in these excerpts). Next, the physician underscores the potential consequences of not committing to the treatment regimen (Extract 1b). The death invocation is made in line 06, where the physician explains that if the patient does not treat the cancer, it will come back "and if it comes back it will be deadly." This invocation makes a direct reference to the patient's death. In this case, death is invoked as directly responsive to the patient's overt resistance and demonstrates an outcome should she decide not to pursue the physician's recommended treatment course.

(1b) 0128

```
26 (0.4) um (.) if we don't do: the radiation and chemotherapy:
27 (0.8) it's (0.4) 'w-° (0.4) we may end up with e- a lot of
28 problems: okay it's a very serious diagnosis to have anyway?
29 and because there was some cancer already in the lymph node? (.)
30 > .hhh (0.2) if we don't do it (.) we:: it will come back (.) and
31 > if it comes back it will be deadly.
```

A more oblique and less imminent invocation of death is offered in Extract 2. In this encounter, the patient has recently undergone surgery to remove a tumor on her ovary and she is at the clinic to follow up with the physician about her treatment plan. The physician asks whether the patient has been able to consider her treatment options, and she states that she does not want to pursue treatment anymore. Following a physical examination, the physician continues:

(2)0108

```
01 DOC: Questions about chemotherapy?
02 PAT: No I ( )
03 DOC: [You're just not gonna do it huh.
04 (2.4)
05 DOC: Cuz we've talked about it before that I really [I worry that
06 PAT: [I kno:w,
07 DOC: > this cancer could come back and if we don't do it now we may
08 > not get a chance to- cure you.
```

The physician launches a question about whether the patient has questions about chemotherapy (line 01). Here, the physician is attempting to keep the chemotherapy option on the table by giving the patient an opportunity to ask questions about the treatment before outright rejecting it. The patient's no-response in line 02 indicates further treatment resistance, which the physician confirms in line 03, "You're just not gonna do it huh." Following a period of silence, (line 04) the physician indicates she is concerned that the cancer which was removed could come back. Further, she states, "we may not get a chance to-cure you" line 07–08. Death is invoked in lines 07–08 when the physician tells the patient that if the cancer comes back, it will be incurable, an oblique invocation. Ovarian cancer, if left untreated, is deadly. Therefore, by telling the patient about the possibility of the cancer's recurrence, she is implying that the patient could die. However, the patient's death is framed as less imminent and the possibility of its recurrence is framed in less concrete terms than in Extract 1.

3.2. The function of death invocations

I argue in these data physicians invoke the patient's death in a persuasive context and I offer two types of evidence for this claim. First, we can examine the phase of the visit in which we encounter death invocations. All death invocations in these data were produced in the context of recommending treatment. Further evidence that physicians invoke death to persuade patients to acquiesce to treatment is not only that they invoke death during treatment discussions, but they do so specifically in the context of patient resistance to treatment. Recall that the two prior extracts involved patient resistance to treatment prior to the death invocation. In these cases, it is only after the patient resists that physicians turn to a death invocation as they further advocate for their recommendation. An example is shown in Extract 3. Here, the patient adopts an actively resistant stance towards treatment by indicating that she is leaning towards not pursuing treatment. In turn, the physician links the possibility of the patient's death to her initial resistant stance towards the recommendation. This patient has a diagnosis of Stage IIA fallopian tube cancer and the physician proposes that the patient pursue chemotherapy, which has a good chance of treating her cancer. Following initial resistance, where the patient indexes that she is “not completely opposed to doing” chemotherapy but that she is “tending toward not doing it” (line 06), the patient elaborates on the nature of her resistance. This virtual refusal (see [Heritage, 1984](#)) constitutes resistance of the recommendation to do chemotherapy. resist. She offers an account for her actively resistant position (lines 08–11), citing a friend who had chemotherapy in one place and then the cancer came back again somewhere else. Omitted from this excerpt is further detail of this friend's experience.

(3a) 0209

```
01 PAT: Yiknow I'm not completely opposed to doing the- (.) the: um.
02 (0.2)
03 SIS: Ch[emotherapy,
04 PAT: [.h chemotherapy?
05 DOC: Mhm,
06 PAT: I'm tending toward not doing it.
07 DOC: Mm: (.) .tchhh eh=
08 PAT: =Because, (0.6) well (.) I- I guess m- I'm tending toward because
09 like (.) yiknow I'm looking at this lady and she (.) had cancer
10 and she had chemo: and then she had cancer again in a different
11 place.
```

Rather than accepting the patient's resistant stance towards treatment, the physician responds by pursuing acceptance through continuing to advocate for chemotherapy.

(3b) 0209

```
33 DOC: Um the reason is that this cancer .hh without chemotherapy:
34 there's likely microscopic cells the naked eye cannot see, .hh
35 and there's a chance those microscopic cells will become active
36 at some point, (.) en: grow an- and recur.=
37 SIS: =a[nd we don't want that.
38 PAT: [Even though you took it- you don't think it was: like [u:m:.
39 DOC: [I
40 don't think it had spread but- but .hh we always assume there's
41 microscopic cells there.=we have to assume. (.) u:m so: that's
42 the much safer side of valor?.hh u:m if it were me I would do
43 the- I would without a doubt in my mind do the chemotherapy?
44 .hh I'm gonna play devil's advocate here and say eighteen weeks
45 of your life (.) one day a week i:s much less than: dying from
46 a recurrence in >three or four< years.
```

He first contradicts the patient by establishing that without chemotherapy, the cancer has a possibility of coming back (lines 35–36). The patient continues to resist the treatment recommendation in questioning whether the cancer could even come back after the surgery that removed it all: “even though you took it-you don't think it was: like u:m:” (line 38). Despite giving the interactional floor to the physician once he comes in via overlap (line 39), we can assume the patient is pursuing additional questioning about the remnants of the microscopic cells in her body relative to the surgery she just had.

The physician treats the patient as challenging the idea of chemotherapy which he addresses by offering an account (lines 39–41): “I don't think it had spread but- but.hh we always assume there's microscopic cells there. We have to assume. (.) u:m so: that's the much safer side of valor?” It is at this point, where the patient still has not offered acceptance, that the physician provides a second treatment

recommendation: “.hh u:m if it were me I would do the- I would without a doubt in my mind do the chemotherapy?” (lines 42–43). Notably, the construction of this recommendation, “if it were me, I would”, proposes the course of action the physician would take if he were in this position and anticipates a question that the patient may have (e.g. “What would you do if you were in my shoes?”). This personal-level endorsement further pushes the physician's position in favor of treatment. Following the recommendation, the physician invokes death by putting the chemotherapy treatment in perspective for the patient (lines 44–46): “.hh I'm gonna play devil's advocate here and say eighteen weeks of your life (.) one day a week i:s much less than: dying from a recurrence in three or four years.” In this case, the physician does not immediately invoke death as a resource to secure patient acceptance of a treatment. Rather, there are multiple efforts to persuade the patient prior to this invocation. This adds corroborative evidence that persuasion is indeed its function.

So far, we may assume that physicians turn to death invocations for treatment acceptance only when patients index up front that they are against treatment. Yet in Extract 4, death is invoked as responsive to a variety of questions from the patient that challenge different aspects of recommendation. We meet this patient after having been diagnosed with Stage IV uterine cancer that has metastasized to her lung. The physician recommends that the patient have both a hysterectomy and a bilateral salpingo-oophorectomy,¹ and recommends that she see another medical oncologist about her lung cancer. Following the treatment recommendation for surgery (lines 01-07), which makes acceptance normatively relevant ([Stivers, 2005b](#)), the patient instead demonstrates initial treatment resistance by mobilizing one of a series of challenge questions beginning in line 08: “.pthh where else for example.” This particular question takes issue with whether cancer could have spread in her abdomen, challenging the surgery's warrant. After the physician explains that it could have spread to her “belly”, the patient continues to resist passively in the missed opportunity spaces² for acceptance in lines 10 and 12 where she embodies surprise in raising her eyebrows and cocking her head but offers no other vocal response. Next, the physician pulls back on his certainty slightly (line 13) by alluding instead to the *possibility* of the cancer having spread to her belly.

(4a) 0301c

```
01 DOC: So (.) y- see Doctor Hamlin and see if he agrees with me:, (.) We
02 should take out the uterus and the cervix?.hh the tubes and the
03 ovaries? .hhh through an incision that'll come down like this,
04 (.) Fix your hernia at the same time, (0.2) Why not. (.) Fix it
05 at the same time.=.hh and then look around everywhere else and
06 do biopsies,.hh and see if it's anywhere else. (.) At the same
07 time,
08 PAT: > .pthh where else for example.
09 DOC: In the belly.
10 PAT: ((Cocks head and raises eyebrows))(0.4)
11 DOC: Anywhere in the belly.
12 PAT: ((Eyebrows still raised))(0.2)
13 DOC: Possible.
14 PAT: > Why- doesn't it show .hh on the: nuclear pet scan.
15 DOC: Cause scans are not a hundred percent- (0.2) accurate. (.) It's-
16 it's probably accurate [but no guarantee. (.) So while we're
17 PAT: [((Nods head))
18 there why not take a few samples.
```

The patient continues to actively resist by asking another question that challenges the physician's claim of the cancer's spread: “Why-doesn't it show.hh on the: nuclear pet scan.” (line 14). In mobilizing the negative results of the PET scan, the patient continues this resistant line questioning whether this cancer has spread to other parts of her abdomen and thus the warrant for the surgery. In response, the physician pushes back by leveraging uncertainty, that the scans are “not a hundred percent” and there is “no guarantee” (lines 15–16). He counters these resistant questions by again advocating for taking tissue samples in the abdomen (lines 16–18).

¹ Removal of the fallopian tubes and ovaries.

² An interactional space in which response is due; a lack of response is a trouble source for which speakers may be held accountable (see [Schegloff, 1992](#)).

In Extract 4b, the patient maintains her actively resistant stance towards treatment

(4b) 0301c

01 PAT: > .pthhh u- uh:. you have done many of surgeries like that.
 02 DOC: Yeah.
 03 PAT: > Making a man from a woman.
 04 DOC: I've done [that too.
 05 RES: [Hheh heh heh heh no:: you're [still a woman;,
 06 DOC: [Not for you.
 07 PAT: Yes: (so: [ma-)
 08 DOC: [Not for you,
 09 PAT: .hhh so now it is for me.=
 10 DOC: =(Coughs) no [not for you. It's not the [same operation.
 11 PAT: > [() [hh uh will you then,
 12 > .h give some uh: (.) hormone therapy so: that I-
 13 DOC: May:be- no- not for hormones no not likely.
 14 PAT: > .hh and ((starts to smile)what if I grow a beard and mustache,
 15 DOC: You have to live two years before that happens. (.) If you have
 16 this ((points to lung)) it could be:. Threaten your life within
 17 six months to two years.

with additional challenges. The patient further resists by confronting the physician's experience with this surgery (line 01): "U- uh: you have done many of surgeries like that." The patient demonstrates continued resistance in line 03 by referring to the surgery with an extreme categorization, "Making a man from a woman." The resident provides a humorous treatment of the patient's inquiry in line 05, though the patient shows no indication of humor in her categorization. This suggests that the resident is attempting to make light of the situation in response to the extreme categorization. In contrast, the physician treats the patient's categorization seriously and confirms that sex reassignment surgery is not the surgery this patient will be having. The patient's overt resistance continues (lines 11–12): ".hh uh will you then,.h give some uh: (.) hormone therapy so: that I-" to which the physician tells her he will "not likely" be giving her hormones after surgery (line 13).

The patient sustains her resistance by continuing to push the point of losing her womanhood with surgery in characterizing side effects. Notably, she begins to smile at the start of this turn, suggesting she is joking about this inquiry "and what if I grow a beard and mustache," (line 14). The physician does not reflect the patient's humor and continues to treat the matter seriously. In response, he pushes back on this continued resistant position by invoking the patient's death: "You have to live two years before that happens." (line 15). This indirect invocation implies that the patient could die from her untreated cancer and thus links her resistance to the possibility of death. The physician elaborates on this (lines 15–17), "If you have this ((points to lung)) it could be:. Threaten your life within six months to two years." Here, the possibility of death is made more imminent. While the patient does not explicitly resist the treatment plan up front as in the previous case, the questions—each with a challenging piece to them—persist when acceptance to the recommendation is due. The physician pushes back on this resistance by alluding to the patient's death from the metastasis of her cancer. The invocation of death here functions as a way of creating urgency in accepting the recommended treatment.

As a matter of course, we might wonder whether invoking death to get patients to acquiesce to treatment is a practice reserved for only the most extreme cases of resistance. However, physicians invoke death as a resource to get patients to acquiesce to treatment even when resistance is relatively mild. An instance of this is shown in Extract 5 (shown earlier as Extract 1). This patient has been diagnosed with aggressive cervical cancer that has spread to her lymph node, a worrisome progression. The physician begins with a treatment recommendation (lines 05–07), which is subsequently resisted. After invoking the consensus of her colleagues about the proposed treatment, the physician recommends chemotherapy and radiation to treat this patient's cervical cancer (lines 05–07). This is quickly resisted in the patient's response at line 08, "really?" in which she produces a challenge to the recommendation in overlap with the physician with a newsmark (Heritage, 1984; Jefferson, 1981), which can be mobilized for disagreement (see Schegloff, 1997). While this newsmark is indeed a challenge to the recommendation, it functions as a less overt form of resistance because it does not challenge specific parts of the treatment

recommendation.

(5a) 0128

01 DOC: .hh yesterday we had our big conference? member I said I was
 02 gonna present your case at the big conference and I did? .hh and
 03 I'm glad you're >sort of< here so we can talk about it very
 04 fresh .hhh (.) we talked about (.) your s:: your type of
 05 cancer:? (.) what the: best treatment should be: and the: team
 06 agreed that the best treatment would be a combination of
 07 chemotherapy and radiation at the same time an[d then followed
 08 PAT: > [really?
 09 DOC: with chemotherapy. .pthhhh because the: overall:m (.) this is
 10 DOC: very rare. (.) This clear cell: cancer of the cervix is a very
 11 rare kind..hhh your clear cell cancer >member I said< oh

The physician completes the recommendation and then begins to respond to the patient's overt resistance by launching an account for the treatment in response, that the patient's clear cell cancer is rare (lines 09–11): ".pthhhh because the: overall:m (.) this is very rare. (.) This clear cell: cancer of the cervix is a very rare kind". The following extract (5b) offers more discussion about the severity of the patient's cancer, which gets no uptake from the patient. As a response to continued resistant behavior, the physician begins to discuss what would happen if the patient did, in fact, decide not to pursue the treatment recommendation. First the physician registers that if the recommendation is not followed, the patient could end up with complications (lines 01–04): "Um (.) if we don't do: the radiation and chemotherapy: (0.8) it's (0.4) °w-° (0.4) we may end up with e-a lot of problems: okay". Multiple opportunity spaces exist in this turn for the patient to respond with either some degree of initial acceptance or acknowledgement, as shown by the micropauses in lines 01 and 02. Next, the physician uses a response mobilizing "okay" at the end of a possible turn completion in line 04, which is not responded to. She continues with even more explicit evidence for treatment, "it's a very serious diagnosis to have anyway? and because there was some cancer already in the lymph node? (.)" (lines 04–05). Both the action this turn seeks to accomplish—to demonstrate the disease's severity—and its lexical features, an upwardly-intoned "anyway?" and in the following TCU "lymph node?" are response mobilizing (see Stivers and Rossano, 2010).

(5b) 0128

26 (0.4) um (.) if we don't do: the radiation and chemotherapy:
 27 (0.8) it's (0.4) °w-° (0.4) we may end up with e- a lot of
 28 problems: okay it's a very serious diagnosis to have anyway?
 29 and because there was some cancer already in the lymph node? (.)
 30 > .hhh (0.2) if we don't do it (.) we:: it will come back (.) and
 31 > if it comes back it will be deadly.

Despite this, the patient does not respond and in so doing continues to passively resist (Heritage and Sefi, 1992). In the next TCU, the physician invokes death in lines with a conditional phrase: "if we don't do it (.) we:: it will come back (.) and if it comes back it will be deadly" (lines 05–06). Here, the patient's death is framed as likely should she not wish to pursue treatment, thus the physician orients to her lack of uptake as resistance. What ultimately occasions this invocation of death is the patient's overt resistance of the treatment as shown by her challenge of the recommendation in Extract 5a and by her withholding of acceptance in Example 5b. The possibility of the patient's death, should she decide to not pursue the proposed treatment regimen, is linked to her resistance and thus functions as a way to persuade the patient to accept the proposed treatment.

While most of the time death is invoked to leverage treatment for the patient's cancer, in one instance in these data death is invoked to leverage treatment for a health issue *not* related to the patient's cancer treatment. This case adds further support to the argument that death invocations in these data are generally used in persuasive contexts. In Extract 6, we meet this patient in the middle of chemotherapy and radiation for her cancer. While in the excerpt shown below no treatment resistance occurs in her talk, it can be argued that the patient's visible morbid obesity instantiates resistance to a healthy lifestyle. In other words, she is embodying resistance. This has had consequences for her overall health and her heart. In the following excerpt, the physician speaks to this resistance.

(6) 0208

01 DOC: > .hh uhm I n- >yiknow< eating is really the: the na- the thing
 02 > you should worry about [I know the nausea impacts you, .hh
 03 PAT: [Okay,
 04 DOC: > yiknow weight loss is gonna be important for you? .h
 05 PAT: [Mhm, [Yes:
 06 DOC: [En so we- I do want ya to[:. at least when this is all said and
 07 > done w- focus on that to.=because we know with your heart issues
 08 > .hh and um: your overall health tha- that's probly: .hh to be
 09 > perfectly frank the more likely thing you'll die from.
 10 PAT: [Okay,
 11 DOC: [.hh en so I think it's important that we focus on that too?
 12 .hh but: I think- en that's why I'm: I'm really encouraged by
 13 the fact that I heard you say that you're gonna k-find healthy
 14 things to eat [and juices en- en that's really good.
 15 PAT: [Yes:.

The physician initially acknowledges the patient's resistance in line 01, where he tells the patient that eating is what she should be “really” worrying about. Here, the “really” implies that the patient has not been worried up until this point. Then the physician tells her that weight loss will be important for her (line 04). The emphasis on “is” in this turn is contrastive with the implied position that weight loss has not been important to the patient. The physician continues with a treatment recommendation— that once her treatment is over, she should focus on weight loss (lines 06–07). He accounts for this by telling her that between her heart issues and overall health, that these things are “the more likely thing you'll die from” (line 09). Thus, the patient's resistance via her continued obesity—which has caused her heart and other health issues—occasions this physician's invocation of death. Death is invoked as a resource to advocate for treatment, in this case weight loss. Should the patient not comply with the recommendation to lose weight, she will be likely to die from her obesity according to the oncologist.

3.3. A deviant case

Thus far I have shown how invocations of death are recurrently found in the context of treatment resistance. I have argued that by virtue of this context and what physicians are otherwise doing in their turns, we can see that these invocations have a primary function to advocate for particular treatment. This was a consistent pattern in the data. For additional analytic leverage, we now turn to one case that did not follow this pattern. In this case, a death invocation was not made in response to resistance. However, I will show it nonetheless supports the analysis that death invocations are done as a means of persuasion to follow treatment.

Consider Extract 7. In this encounter, the patient has been continuing maintenance treatment for ovarian cancer by taking an oral multikinase inhibitor. Recently her CA-125 level has risen rapidly, which suggests further cancer growth and inefficacy of the current treatment regimen. She is seeking treatment for this with her oncologist, who is new to treating this patient. She had been previously working with another oncologist and it is unclear why she has switched to this oncologist – whom she has seen just once before. In Extract 7a, after discussing getting the records from the patient's previous doctor, the physician recommends treatment (lines 07–09). The treatment recommendation is proposed to the patient, “so I think carboplatinum will be fine for you like we talked last time.” (lines 07–08) which subsequently does not get resistance. The patient offers initial acceptance in line 10, “Yeah.” just following the physician's reminder that “.hhh carboplatinum is a c-chemotherapy drug.” (line 9). Following more explanation of the serious side effects of the chemotherapy (lines 09, 11 & 12), the patient acknowledges these side effects (line 13). She still does not show evidence of resisting the treatment. The physician continues with more side effects (line 14), which the patient continues to acknowledge (line 15). Following this, the patient begins to complain about her experience with her chemotherapy port the last time she had infusions: she went to the emergency room because it became infected. She continues to explain (in 114 omitted lines of transcript) that the nurses, who would come to the house to help her clean the port at home, did not notice this infection. She categorizes her experience with

the port as a stressful one. She continues to recount the issues she had with her port in Extract 7b.

(7a) 0123

01 DOC: Okay great. (.) So I do have those records. [Okay.
 02 PAT: [Yeah >yeah< I mean
 03 he was on vacation fer .hh (.) Ith- uh bout a month, (.) en (.)
 04 en a lotta times on vacation. .hh [a:n-
 05 [Okay,
 06 PAT: (.) so.
 07 DOC: > Okay so I think carboplatinum will be fine for you like we
 08 > talked last time. .hhh carboplatinum is a c- chemotherapy
 09 > drug.[=It does not make you lose your hair, .hh but it=uh is a
 10 PAT: [Yeah.
 11 DOC: real drug. It (.) can cause (.) bone marrow side effects? like
 12 low blood counts?
 13 PAT: Yes,
 14 DOC: Anemia low platelets.
 15 PAT: Mhm,

The patient elaborates on the nurse's inaction in adequately recognizing the infected port (lines 01–03), to which the clinic nurse registers surprise (line 04) and the physician registers empathy (line 05) (Heritage, 2011). The patient next revitalizes her experience of having to go to the hospital to get it removed (line 06), to which the physician responds with more empathy (line 07). The patient then offers an upshot of getting the port removed, “.pt but then it was gone.hh ye(h)ah, (0.4) You could shower properly en stuff like that.” (lines 08–09), a position with which the physician aligns in overlap, “Yeah it feels good when it's off.” (line 10). After providing a yes-response to this, the patient contrasts this bright side of her past treatment with an overall negative assessment of treatment: “.pt I mean how can it be wonderful ah ha HA HA.hh it can't” (lines 11 & 13). In response, the physician indirectly invokes death: “But (.) sometimes it's better than the alternative.” (line 16). Here, we can infer that the “alternative” to which the physician is referring is the alternative to the thing the patient has been complaining about: her past treatment.

(7b) 0123

133 PAT: Finally >of course< I kept tellin her it's all red >en it< red
 134 .hh no one paid attention everywhere I went. .hh finally they
 135 realized it was in- (.) infected,
 136 NUR: [“Oh”
 137 DOC: [.tch aw I[‘m sorry ()
 138 PAT: [There I was gettin it off, .hh hhh
 139 Sorry,
 140 PAT: .pt but then it was gone .hh ye(h)ah, (0.4) You could shower
 141 properly [en stuff like that.
 142 DOC: [Yeah it feels good when it's off,
 143 PAT: > Yeah. (0.2) .hh so. [.pt I mean how can it be wonderful ah ha
 144 DOC: [Alright.
 145 PAT: > HA HA .hh (.) it can't.
 146 DOC: Not really.
 147 PAT: .tch
 148 DOC: > But (.) sometimes it's better than the alternative.[>Alright
 149 PAT: [YES,
 150 DOC: have a good da:y, (.) Ple:ase call, (.) if you have questions,

In this case, it can be assumed that the alternative to treatment is the no-treatment option. Not treating ovarian cancer will result in virtually certain death, therefore this is an indirect death invocation. Given that the possibility of death is produced against the backdrop of just having recommended treatment which involves the very thing the patient complained about, a chemotherapy port, it can be assumed that this physician is anticipating resistance to treatment. Thus, death is invoked here not because the patient resisted the treatment recommendation, but to advocate for pursuing treatment.

4. Discussion

This analysis has sought to better understand how death is being broached in the context of oncology treatment. Sociologists have studied death discussions for decades and have found that the terminal nature of a patient's disease is something that physicians have continued to confront with hesitancy and difficulty. Yet, I have argued that when existing parameters to look at death mentions are expanded to include those outside the patient's EOL, physicians *do* put their patient's death on the table. Like Gill's (2019) case study, one of the primary places I found death invoked was in recommending treatments. When it was positively invoked in this context (e.g, “This is a deadly cancer” or “You may die from this”) I found that it was being used to push patients

towards accepting a particular treatment course. Contrastively, Gill found that a negative formulation of death (e.g., “This cancer *won't* kill you”) was used as a tool to address a potential source of misinformation in the service of recommending treatment. Ultimately, I conclude that physicians in these data positively invoke death as a bargaining chip to leverage their authority for particular outcomes. The most frequent way that physicians invoked death was in the context of patients' resistant behavior. When patients demonstrated active or passive resistance, physicians invoked the possibility of the patient's death to push back against this resistance advocate for acceptance of treatment. Occasionally, physicians invoked death in instances where resistance was anticipated but never actualized. Similarly in this deviant case, death invocations functioned in order to lobby in favor of treatment.

Many argue that increased patient involvement and the simultaneous erosion of physician authority has even led to an interactional tension between physicians and patients (Maynard and Heritage, 2005; Tate, 2018; Waitzkin, 1991). In some cases, patient involvement in treatment decisions can be particularly tricky for physicians to manage because patients may actually advocate for their own preferred treatment or question the proposed treatment plan, in effect challenging the physician's professional expertise (Stivers, 2007). Treatment recommendations have been found to be interactionally negotiable events whereby both physicians and patients put their preferences for treatment on the table. This is argued to be the case because when patients resist treatment it can trigger physician persuasion for treatment acceptance (Stivers, 2005b, 2007). For instance, Stivers (2002a) looked at how physicians negotiated the competing demands of their own medical expertise—avoiding inappropriate antibiotic prescribing—while also maintaining parent/patient participation in decision-making. In another study, Stivers (2005b) found that when parents resisted treatment recommendations, physicians did not simply fold and accept that position. Instead, they used different resources to seek acceptance of the treatment recommendation. Physicians would provide accounts for the recommendation, restate the recommendation, provide lists, or explicitly request acceptance of the recommendation.

Ultimately, these practices were used to counter patient resistance. These data similarly show that physicians in the context of oncology counter resistance, but they do so by invoking the possibility of the patient's death. In thinking about these findings, one could argue that the practice of invoking death is a way to provide grounds for treatment. However, invoking death in response to resistance is a more extreme way of accounting for treatment than what Stivers (2005b) found. Further, that physicians invoke death as a resource for treatment acquiescence even in relatively mild instances of treatment resistance demonstrates a practice which fundamentally targets—in a most extreme way—the biggest fear of patients in oncology.

This behavior also reflects physicians' priorities in oncology and an orientation to their professional role, which is to treat. Of late, conversation analysts have confirmed this. For instance, Singh et al. (2017) found that in the context of terminal cancer growth, oncologists bypassed opportunities to discuss prognosis and instead discussed additional options to treat the disease. Gill (2019) found that oncologists would advocate for treatment by using death in a negative formulation to anticipate possible misconceptions about the treatability of a patient's cancer. Along with this analysis, these studies reflect physicians' emphasis on not just treating, but that treating both works and can prolong life. One could argue that treating cancer is potentially effective, the right thing to do, and the best option going forward for patients. Further, one could argue that physicians in these data are acting ethically by informing patients about a real outcome—dying—if they do not accept their medical advice.

What is also notable about the practice of invoking death is a lack of acceptance of patients' positions in the context of oncology. In this context, SDM and patient involvement have been heavily advocated for (Levit et al., 2013; Politi et al., 2012). We might therefore assume that oncologists would be more likely to accept patients' positions of

treatment resistance. In these data, they do not. Indeed, it has been found that physicians generally push back against resistance a variety of contexts such as pediatrics (Stivers, 2005b) and neurology (Toerien et al., 2011) to seek acceptance of the treatment recommendation. However, the possibility of a patient's death has not been found to be mobilized as a resource to counter resistance like in oncology. We might conclude that death is put on the table because the stakes for not treating are the highest possible—death—and physicians are capitalizing on this issue. This is apparent not only in that they invoke death as linked to resistance, but also that they use it as leverage relatively early after patients demonstrate resistance rather than using less extreme accounts for treatment, such as treatment statistics, their own successful experiences in treating patients, or explicit requests for acceptance.

5. Conclusion

Perhaps this can be explained by how physicians are socialized throughout their years in training. Physicians learn particular norms and internalize certain attitudes central to the institution of medical practice. Physicians have been found to share a collective sense-making of error (Bosk, 2003) and collectively manage and control uncertainty (Fox, 1957; Light, 1979). Fundamental to physician's everyday practice is solving patients' medical problems. Notably, as members of a profession, physicians are share a sense of peer accountability (Starr, 1982). Oncologists have regular tumor board meetings where particular cases are presented and teams of experts discuss various treatment avenues. Peer accountability is arguably highest at these meetings, where expertise is put on full display. Additionally, the normativity of treatment throughout different disease stages is reinforced by the structure of these meetings as physicians work with each other to discuss primarily curative treatments. Mrig and Spencer (2018) provide one explanation for this by concluding that our culture's deeply-held understanding of being at “war” with cancer places inherent value on the belief in treatment at all stages of cancer.

All doctors take an oath to maintain beneficence, or doing what is in the patient's best interest at all times. In the realm of more complex diseases like cancer, beneficence may mean strongly advocating for treatment because the possibility of a prolonged life, or a cure, is kept on the table. It may also mean stepping back and letting the patient decide whether the recommended treatment is best for them while knowing that they might die if they do not pursue treatment. These data demonstrate that treating cancer is a normative orientation throughout different stages of the disease. When patients show a departure from this normativity with resistance, physicians mobilize death as the ultimate consequence for this departure.

6. Limitations

This study has several limitations. It is a qualitative study which used a convenience sample due to the sensitive nature of the disease and its treatment. Women are represented more than men in the patient sample, and men more than women in the physician sample. The physician sample is small and derived from two large urban academic medical centers. Their behaviors may not be representative of the larger population of physicians. Additionally, the disease types, while both cancer, are different in their pathology and progression. These issues may have differential effects on treatment discussions. Retrospective interviews with physicians, focusing on the sensemaking processes behind behaviors, may shed important light on the reason for invoking death for treatment outcomes. Future research is warranted in this emerging area, and could focus on more diverse clinical environments and drawing a larger sample, ideally from nationally representative patient and physician populations.

Funding

This article was supported by the National Research Service Award under grant award 5TL1TR002388 (PI: David Meltzer, MD, PhD). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of NCATS/NIH.

Acknowledgements

I am grateful to Kathleen Cagney, Deborah Carr, Tanya Stivers, Stefan Timmermans, Virginia Gill, Patricia Ganz and John Heritage for feedback on earlier versions of this paper.

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