

On Invoking Third Parties in Vietnamese Medical Communication

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Abstract—This study is concerned with the practice of invoking third parties among doctors and patients in Vietnamese medical consultations. These third parties are relatives of the patient who are also medical professionals. We show that doctors invoke relatives-plus-medical professionals in order to elicit information from patients, while patients adopt this practice in order to circumvent a troublesome administrative requirement; obtain a preferred form of treatment; receive a health-related service from the hospital, while also diminishing accountability for making this request in case it turns out to be irregular; give reasons for selecting the current hospital; or challenge the doctor's expertise. Another possible motive is to receive special attention from the treating doctor. We suggest that doctors and patients are particularly inclined to invoke relatives-plus-medical professionals as third parties because of two social forces within Vietnamese culture: collectivism and social status. We also adduce evidence that, as a determinant of the patient's future treatment for their problem, their familial relationship with the third party overrides this person's status as a medical professional in this cultural context. More broadly, our findings indicate that medical communication is not invariant across cultures, but can be shaped by culture-specific forces.

Index Terms—medical communication, third parties, cultural context, Vietnam, Conversation Analysis

I. INTRODUCTION

One feature of doctor-patient communication that has been noted in the research literature is the practice of invoking third parties (Bergmann, 1992; Gill & Maynard, 2006; Heritage & Robinson, 2006). These individuals have included medical professionals (e.g., general practitioners), professionals from other fields (e.g., social workers or the police), and non-professionals (e.g., family members or friends). In addition, the practice itself has been found to occur at various stages of the consultation. Yet, despite this interest on the part of investigators in this field, it would be fair to say that a dedicated and in-depth examination of the practice of invoking third parties among doctors and patients is still called for. The chief aim of the present study is to address this research deficit.

Moreover, our investigation is situated in the Vietnamese cultural context. Within research dealing with medical discourse generally, this context has so far garnered relatively little attention (for details, see H. T. L. Nguyen et al., 2018). In the current study, we aim to augment the relatively meagre stock of research on Vietnamese doctor-patient discourse in general, and make scholarly coverage of this type of discourse more representative in cross-cultural terms as a result.

Quite apart from this lack of research, the Vietnamese cultural context seems a promising one in which to investigate the practice of invoking third parties. There are two main reasons for this. To begin with, Vietnamese society is collectivist (Bao Dat,¹ 2001; Hofstede, 2001), a consequence of an agrarian lifestyle which emphasises the importance of interdependence among people in cultivating food (V. Q. Tran, To, Nguyen, Lam & Tran, 1998). The influence of this collectivism is particularly keenly felt within family relationships (Kádár & Mills, 2011; Thompson, 1965), especially when important decisions need to be made (Appel, 2013; Kim, Klinge, Sharkey, Park, Smith, & Cai, 2000; T. X. Nguyen, 1994).

The second reason is that Vietnamese society has a deeply-ingrained hierarchical structure (Edwards & Phan, 2013) which will likely reveal itself in doctor-patient discourse as well. And indeed this expectation is borne out in the extant literature. According to Pham (2014), doctors in Vietnam often presuppose that patients meet them to address biomedical concerns only, and formulate their information-seeking moves accordingly. In studies on the patient's perspective, the main finding has been that these participants tend to adopt an inhibited, compliant attitude towards those who are charged with treating them. Fancher et al. (2010) found that the patients in their study rarely expressed their concerns directly unless asked. In G. Nguyen et al. (2007), even though most of the patients reported being

¹ This author's name consists of a middle name plus first name only (i.e., there is no surname). Accordingly, we have cited each of these names in full.

dissatisfied with their communication with their doctors in certain respects, they still gave credence to what their doctors told them about their health. Almost all of the patients in K. Tran (2009) claimed to have only spoken when invited to do so by the doctor. Tran adds that this behavior was motivated by a desire to minimise any imposition on the doctor's autonomy, avoid hurting the doctor's feelings, or reduce the likelihood of any negative evaluation of the patient's low English proficiency.

These two characteristics of Vietnamese society have led us to select a particular type of third party for close scrutiny in the present study. Our view is that the collectivist aspect of this culture especially favours the invocation of third parties who are relatives of the patient. At the same time, the hierarchical structure of Vietnamese society has its own implications for this practice. A third-party medical professional not only enjoys relatively high social status but is also an 'insider' working in the same field (and perhaps even in the same hospital). In this light, third-party medical professionals might be expected to exert more influence over the outcome of medical consultations than high-status third parties from other walks of life. Accordingly, each of the third parties included in this study is a relative of the patient who also happens to be a medical professional² (cf. Bergmann, 1992; Gill & Maynard, 2006; Heritage & Robinson, 2006).

A noteworthy feature of previous work on doctor-patient discourse in the Vietnamese cultural context in general is that, unlike Bergmann (1992), Gill and Maynard (2006) and Heritage and Robinson (2006), no study has adopted Conversation Analysis as its framework (for a comprehensive overview of how CA³ has been applied to medical communication, see Gill & Roberts, 2013). In this respect, the current study fills a significant methodological gap.

II. THIRD PARTIES IN MEDICAL COMMUNICATION

Studies which deal, at least in part, with the practice of invoking third parties among doctors and patients have been quite varied in certain respects. In one study, this practice is employed by health professionals. Bergmann (1992) discovered that psychiatrists invoke third parties within *discreetly exploring utterances* in intake interviews as a strategy for eliciting information from prospective patients about their⁴ mental state. Along with the patient's behavior in the interview, this information is used by the medical professional to decide if the patient should be hospitalised. In Extract 1, a psychiatrist is talking to a married couple, and must determine if the wife should be committed. He has just concluded a telephone call with the referring doctor (data from p. 138).

Extract 1

- 1 Dr. F (I just) got the information, (0.8)
 2 (that you're) not doing so well.
 3 Ms. B Yea::h well that is [the opinion
 4 Dr. F [Is that correct?
 5 Ms. B of Doctor Hollmann.

In his initiating move in lines 1-2, the psychiatrist indicates that his knowledge of the patient's state comes from another source ('(I just) got the information'), and is therefore not necessarily accurate. Bergmann suggests that, in framing his knowledge in these terms, the psychiatrist is inviting the patient to supply an authoritative account of her health condition. The provenance of his knowledge is then identified in Ms. B's response in line 3.

Other studies are concerned instead with the invocation of third parties by patients. Two motives for engaging in this practice have been identified. In Gill and Maynard (2006; see also Gill, 1998), it is used when the patient embeds an explanation for their symptoms within a *frank question* which, in addition to dealing with sensitive information, limits the doctor's possible range of responses. Gill and Maynard point out that, each time this type of question is put to the doctor in their data, this occurs during a phase of the consultation where they are not gathering information. Consider Extract 2. Notice that Ms. N mitigates her question about the cause of her depression by invoking her health aide, and also that this question does not receive an edifying response (data from p. 127).

Extract 2

- 1 Ms. N You know do you think I'm getting depressed at these times
 2 because'v my period? A friend- er my health aide pointed
 3 that out.
 4 (1.0)((Dr. puts down his pen)
 ((10 lines omitted where patient further
 describes her depression and not feeling well))
 14 Dr. D No Anna I've never had a very good- (1.2) feeling for what-
 15 makes you go down in the dumps

In Heritage and Robinson (2006), patients invoke third parties in order to present their health concerns as reasonable and well-founded, while simultaneously also diffusing responsibility for taking the step of seeking treatment. This is exemplified in Extract 3. In the past, this patient has received treatment for a carcinoma on the back of her neck, and she

² Note that we do not refer to the third party as 'a medical professional who also happens to be a relative of the patient.' In our analysis of Extract 6 later on, we will see that the ordering used in the main text more accurately reflects the comparative importance of these two attributes of the third party in determining the outcome of the consultation.

³ The following abbreviations are used in this article: CA - Conversation Analysis; CLA - classifier; COP - copula; D - doctor, HON - honorific; INT - interrogative; P - patient, PRT - particle; PST - past tense; RM - relative-plus-medical professional.

⁴ Throughout this paper, we use the gender-neutral pronoun 'they/their etc.' if the referent's gender is unspecified.

has just found a suspicious bump (referred to as a “mole” in line 7) at, or near, the same location as before (data from p. 59).

Extract 3

- 1 P I'm here on fal[se pre-pretenses.<I think.
 2 D [.hh
 3 D [<Yes.
 4 P [ehh! hih heh heh heh!
 5 ((Five lines omitted))
 6 P I asked my husband yesterday 'cause I could feel: (0.8) (cause)
 7 I: could feel this li'l mo:le coming. An:d: uh (0.5) (he) (.) I:
 8 hh thought I better letchya know-<uh well I asked my husband' f
 9 it was in the same place you took off thuh (0.5) 'thee (mm)

The patient expresses uncertainty about the legitimacy of her concerns overtly in line 1. This is followed up in lines 6 and 8, where she diminishes her own accountability for seeking medical attention by invoking her husband.

The studies cited above have three key limitations. In the first place, there is the fundamental problem that the invocation of third parties in doctor-patient communication has only been sparsely investigated. Indeed, to the best of our knowledge, the only published study to have examined its use by medical professionals of any sort (in contrast to patients) has been Bergmann (1992).

Second, this dearth of scholarly attention is exacerbated by the fact that, even when researchers *have* shown interest in this phenomenon, it has been afforded only subsidiary importance within studies concerned with other issues. Bergmann's overriding objective is to show that, instead of treating a discreetly exploring utterance as a gambit which invites the prospective patient to talk about their problems in their own words, the patient may instead regard it as a bid to unearth evidence of conduct that is, in some sense, improper. Whether or not the utterance invokes a third party is beside the point. Gill and Maynard (2006) analyse how the patient puts forward an explanation for their medical problems during the information-gathering phase of the consultation, and how the doctor responds to this potential disruption, while Heritage and Robinson (2006) explore the ways in which the patient justifies their decision to see a doctor. Within each of these last two studies, the invocation of a third party is merely one of several means of achieving a particular end.

Lastly, note that the focus of Bergmann's (1992) study is psychiatric care. This is a concern if we allow for the possibility that the behavior of this group may not be representative of medical professionals more generally: while the information that psychiatrists need to elicit is, by its very nature, highly sensitive, this is not always true of general practitioners. In this light, the invocation of third parties by doctors in particular seems even more deserving of further investigation.

In the present study, we seek to address these limitations of previous work in this specific area.

III. METHODOLOGY

The data for this study comes from 66 primary-care visits at two public hospitals in Vietnam.⁵ The visits were recorded between June and August 2016. Ethical clearance for the study was granted by the University of Southern Queensland. Fifteen doctors and 66 patients took part in the study. The data was collected from audio recordings, and all of it was transcribed in the original Vietnamese by the first author using ELAN software. The extracts included in the present paper were then translated into English by both authors. Finally, all participants were de-identified using pseudonyms. The CA transcription notation used in this study is based on the one found in Jefferson (2004), except that one symbol (i.e., the hash (#) sign) has been added. The participants in this project often produced certain words so quickly that they were almost inaudible (e.g., the word *không* ('no') in *Tôi không biết* ('I don't know'), when this formulaic chunk was used). In a case like this, the swallowed utterance or part thereof is enclosed within hashes (e.g., *Tôi #không# biết*) in the data extracts.

IV. RESULTS AND ANALYSIS

In this section, we look at the invocation of RMs by doctors and then by patients. All instances of RM invocation by the patients occurred when the patient expanded their response to an elicitation by the doctor. This section includes every instance that occurred in the 66 visits.

Doctors invoking RMs

In Extract 4, doctor Chu invokes an RM working in his hospital in order to elicit information from patient Sang. Sang has pain and numbness in her legs.⁶

Extract 4

⁵ In the present paper, we do not discuss all 66 visits, but limit our coverage to the ones which contain examples of the phenomenon under investigation.

⁶ This exchange happened during the history-taking and physical examination stage of the consultation. The discourse which occurred immediately before this exchange was concerned with the problem with Sang's legs.

- 106 Chu *mẹ* *lQ::* *củ::a* *anh* *Cánh* *à?*
 grandma⁷ aunt of older+brother⁸ Canh INT
You are Canh's aunt?⁹
- 107 (1.4)
- 108 Sang *lhr?*
 huh
Huh?
- 109 (0.3)
- 110 Chu *Q* *của anh* *Cánh* *à?*
 aunt of older+brother Canh INT
Canh's aunt?
- 111 (1.6)
- 112 Sang *\$hi hi hi* [*hi hi\$*]
- 113 Chu [*Q::* *của anh*] *Cánh* *à?*
 aunt of older+brother Canh INT
Canh's aunt?
- 114 (0.3)
- 115 Sang *biế::t* *rồi* *mà cứ* [#*hấn#*]- (.) *hắn* *c(h)á-* (.)
 see already but keep he PRT
I'm with you.¹⁰ He-
- 116 Chu [*dạ::*]
 OK
OK.
- 117 Sang *\$hà ha hi hi hi* [*hi\$*]
- 118 Chu [*VỒ*] *ĐÂY* *có* *bị-*= *đợt* *trước* *có* *bị* }
 stay here PST have hospitalisation last PST have
- 119 *rối+loa:::n*
 disorder
You had a problem with your vestibular system in your last stay in hospital.
- 120 Sang *có* *rối+loa:::n*
 PST disorder
That's right.
- 121 (0.2)
- 122 Chu *dạ::*
 yes
Yes.
- 123 Sang *răng* *lại* *bác* *biế::t?*
 how PRT doctor know
How do you know?
- 124 (0.3)
- 125 Chu *dạ:* (.) *có* *nghe* *anh* *Cánh* *kể::i*
 HON PRT listen older+brother Canh tell
Canh told me.
- 126 (0.3)
- 127 Sang *ờ::* (.) *\$hi hi hi hi hi hi hi hi\$* (.) *.hhhhhh*
 mmm
Mmm.

After a lapse of 6.1 seconds (data not shown), doctor Chu abruptly moves to the topic of Sang's nephew, a doctor named Canh. Chu poses a question ending with the particle *à* (line 106) polarised in a positive direction to invite a *preferred next action* (Pomerantz, 1984). After a delay of 1.4 seconds (line 107), Sang's use of an *open-class form* (Drew, 1997), *lhr?* ('Huh?'; line 108), signals that she is having difficulty understanding Chu's talk. This turn treats Chu's question as an *other-initiated repair* (Schegloff, Jefferson, & Sacks, 1977) which suspends the progressivity of the sequence. It is not an answer to Chu's question, but starts off a new question-answer sequence. Chu thus reconstructs his turn as a repair (line 110). After a 1.6-second silence (line 111), Sang laughs instead of answering Chu's question (line 112). This laughter communicates that Sang registers Chu's request as delicate, thus displaying her

⁷ The hierarchical organisation of Vietnamese society is reflected in a large number of kinship terms used for addressing and referring to others (for more information, see H. T. L. Nguyen et al., 2018).

⁸ We use a plus (+) sign to join together two or more words in the Vietnamese transcription. The other options conventionally used for this purpose (e.g., a period or a hyphen) are unsuitable, as both these symbols have values within the CA transcription system. For consistency, we use the same symbol for this purpose in the interlinear morpheme gloss as well.

⁹ In morphosyntactic terms (including the use of ellipsis), Vietnamese and English diverge considerably (H. D. Nguyen, 2009). Our priority in the translations is to strike a balance between the naturalness of the English on one hand and faithfulness to the original on the original. For the sake of clarity, we also occasionally add some information that is left implicit in the original.

¹⁰ In other words, the patient is able to follow what the doctor is telling her.

reluctance to disclose this information to Chu (Haakana, 2001). This triggers Chu's repeat of his own question for the second time (line 113). At this point, Sang acknowledges her receipt of his question (line 115); however, this conforms to neither the question's action nor its *topical agenda* (Raymond, 2003), as her response does not contain 'yes' or 'no', or answer Chu's question. Having received Sang's *non-answer response* (Enfield, Stivers, & Levinson, 2010), Chu makes a bald assertion about her health condition, and ends by stretching his talk at *rôi+loq:::.....n* ('a problem with your vestibular system'; lines 118-119). Sang then confirms Chu's presupposition (line 120), but expresses uncertainty about how Chu could have obtained this information (line 123). In response, Chu attributes this information to Canh (line 125).

In this extract, doctor Chu invokes an RM (i.e., doctor Canh; line 106) as a fishing¹¹ device to elicit information from Sang. Once he has elicited this information, Chu is able to convince her of the veracity of this information as well (line 125), since it came from an RM.

Patients invoking RMs

In the first extract to be considered in this section, patient Cam invokes her daughter-in-law, Linh, who is a doctor in a large hospital in the community, in explaining why she has not brought the necessary medical documentation to the consultation. Cam has had back and leg pain for four months, and has sought treatment for these difficulties at another hospital before. Extract 5 takes place right after doctor Hung has asked Cam to show him any medical papers related to her previous treatment.

Extract 5

- 94 Cam *đó::(.) bác cho::: mẹ (.) mai mẹ*
so doctor allow grandma tomorrow grandma
- 95 *đem [đi #cũng#] được [hi]?*
bring to PRT can INT
- 96 Hung **So, could I bring the medical papers to you tomorrow?**
[/da:] [sáng] mai mẹ *đem tới rồi để+cho*
yes morning tomorrow grandma bring to then so+that
- 97 *con coa:::i rồ::i [à:::-]*
offspring look and uh
- 98 Cam **Yes. Bring them in tomorrow morning so that I can have a look at them and-**
[khi] ma:i mẹ có hỏi cô Linh mà cô
in morning grandma PST ask doctor Linh but doctor
- 99 *Linh nói /thôi mẹ ưa đem+đi #cũng# được mà không #cũng# được (.)*
Linh say anyway grandma like bring PRT can but no also can
- 100 *thôi*
anyway
- 101 Hung [da:]
OK
OK.
- 102 Cam [mẹ] mới đầu khá::m đi khá:m thì mẹ [đi rừ::a] cho
grandma just first visit come visit so grandma walk like+that for
- 103 *thong+ [thá:]*
without+difficulty
- Lines 98-100 & 102-103: I asked doctor Linh this morning, but she said it didn't matter whether I brought them in today or not. She said that as this was my first visit, I left them at home so that I could come here on foot without having to carry them as well.
- 104 Hung [da rồ::i]
HON OK
[ma:i]
tomorrow
- 105 **That's OK. Tomorrow will be fine.**
(0.3)
- 106 Cam *mẹ đi+bộ từ /trê:::n (0.4) cuối đườ:ng Nguyễn [Huê:::] (.) về đây*
grandma walk from on end street Nguyen Hue to here
- 107 **I walked from the end of Nguyen Hue Street to this hospital.**
[da]
OK
OK.

Having told Hung that she left the papers at home (data not shown), Cam proposes an alternative solution to this problem at lines 94-95. Hung's uptake registers her proposal as acceptable (lines 96-97). In this turn, he only states the reason why the papers are needed, without making any complaint about Cam's actions. However, Cam's next turn reveals that she has interpreted Hung's utterance as a complaint (Sidnell, 2012). In *khi ma:i mẹ có hỏi cô Linh* ('I asked doctor Linh this morning'), Cam implies that she is not at fault for leaving the papers at home: she has merely acted on the advice of her daughter-in-law, who is a medical expert. In this account (lines 98-100 and 102-103), Cam reports the advice of Linh, *mẹ đi rừ::a cho thong thả*: ('I could come here on foot without having to carry them as well'), to imply that she has difficulty walking. On receiving Hung's acceptance of her suggestion (line 104), Cam then expands her talk

¹¹ 'Fishing' is a term coined by Pomerantz (1980) to describe a technique that the doctor uses to collect information when they have limited knowledge of the patient's health condition ahead of the consultation.

to offer further justification for her actions (line 106). She discloses the location of her home, and through a self-initiated repair, replaces /tr ê::: :n/ ('on') with cuối ('end') to emphasise the long distance from her home to this hospital. The implication is that, while walking itself is difficult enough for a patient with leg pain, carrying papers such a long distance will be especially so.

On their own, Cam's physical limitations would not be sufficient justification for leaving the papers at home. However, she is also able to invoke an RM in support of her actions. From her point of view, this makes them defensible.

Whereas Cam in the previous extract invoked an RM in order to avoid having to do something, in Extract 6 patient Luong uses the same strategy to obtain something that she wants. She has pain in her back running down her legs.

Extract 6

- 111 Quynh có khi+mô CHẤM+cứu uống thuốc BẮC /không?
PRT ever acupuncture take medicine Chinese INT
Have you ever had acupuncture together with Chinese medicinal herbs?
- 112 (0.2)
- 113 Luong khô:ng (0.5) thuốc /Bắ:c là qua mua Thọ Xuân Đườ:ng
no medicine Chinese COP go buy Tho Xuan Duong
No. I bought Chinese medicinal herbs at Tho Xuan Duong.
- 114 Quynh à mu:a Thọ Xuân Đườ:ng, (.) là uố:ng thôi chơ+đâu có châm /hây?
oh buy Tho Xuan Duong COP medication only not PRT acupuncture INT
Oh, you bought some medication at Tho Xuan Duong. So you've only had Chinese medicinal herbs, not acupuncture?
- 115 Luong khô:ng (.) uố:ng thôi
no medication only
No. Medication only.
- 116 (0.3)
- 117 Quynh rồ::i (.) [đạ]
OK OK
OK. OK.
- 118 Luong [#khô:ng#châm]
no acupuncture
No acupuncture.
- 119 (0.2)
- 120 Quynh [đạ: rồ::i]
HON OK
OK.
- 121 Luong [nói tóm+lại] là châm mà sợ #khô:ng#châm (0.3) châm
say briefly COP acupuncture COP worried not acupuncture acupuncture
I just don't like acupuncture. I'm worried that it might cause high blood pressure.
- 122 là a- sợ á:p huyế:t #hắ:n#lê:n
COP uh worried pressure blood it high
I just don't like acupuncture. I'm worried that it might cause high blood pressure.
(108 lines deleted)
- 230 Luong bạ #con#Lan vẹ qua châm mà có qua mô:i
day Ms. Lan tell come acupuncture but PRT go not
A few days ago, Lan told me to come to her house for acupuncture, but I didn't go.
- 231 (1.1)
- 232 Quynh đạ
OK
OK.
(58 lines deleted)
- 290 Quynh có điề:u+kiệ:n đế+mà vớ đầ::y châm =từ Mai Dich [vớ] đây
have able to come here acupuncture from Mai Dich to here
Can you come here for acupuncture? Is it far from here to Mai Dich?
- 291 xạ /không?
far INT
Can you come here for acupuncture? Is it far from here to Mai Dich?
- 292 Luong [kh ô:ng]
no
No.¹²

¹² This utterance is a response to only the first of Quynh's questions in lines 290-291.

- 293 (0.5)
294 *đừng châm nữ:a (0.7)*
no acupuncture PRT
No acupuncture.
- 295 *kê:: mà mua thuốc uố:ng thôi?*
prescribe to buy medication take just
Just prescribe me some medication.
- 296 (0.2)
297 Quynh *mu::a (.) thút ún thôi háy?*
buy medication take just INT
Just medication?
- 298 (0.3)
299 Luong *đi mua thuốc uống [thôi chơ::] không [châm]*
go buy medication take just but no acupuncture
No acupuncture. Just medication.
- 300 Quynh [nế::u+nhr::] [ngoài] Ai Dịch có trạm y+tế:
if in Mai Dich have station medical
- 301 *gần aị (0.4) chị chịu+khó qua đó #hả#châm kết+hop đi (0.5)*
near PRT older+sister try go there they acupuncture together PRT
- 302 *thì vừa châm+cứu vừa thuốc Bắc #cho# [mau lành]*
COP both acupuncture and medicine Chinese for quickly better
If you live near a medical station in Mai Dich, try going there for acupuncture together with Chinese medicinal herbs, and you'll get better quickly.
- 303 Luong [trạ:m #hả#] *cần i+này*
station it near PRT
- 304 (0.2) *dà: mô tư::(.) sau nưong trước+mặt dà: a+nì (0.9)*
house PRT at behind backyard front house PRT
It's quite near, behind my backyard- in front of my house.
- 305 *dà:: #con# La:n aị*
house Ms. Lan PRT
That's Lan's house.
- 306 (0.4)
307 Quynh *dạ::*
OK
OK.
- 308 (0.2)
309 Luong *á::*
mmm
Mmm.
- 310 (0.3)
311 Quynh *níc+là cái chị Lan làm ở đây là ở gần chị*
mean PRT older+sister Lan work in here COP live near older+sister
- 312 *phải+ /KHÔNG?=
INT
You mean, Lan who works here lives near you. Is that right?*
- 313 Luong *=GÁ:N (.) cả hai mẹ con gần nhau luôn+đây*
near both two mother offspring near each+other PRT
Yes. We two live near each other.
- 314 Quynh *ri::a+thi:: nhờ: chị /La:n (.) háy? (0.2)*
so ask older+sister Lan INT
So how about asking Lan?
- 315 [nhờ chị Lan chị::] *châm thêm*
ask older+sister Lan older+sister acupuncture combine
Ask Lan to do acupuncture for you.
- 316 Luong [nhờ La::n đượ]
ask Lan can
I can ask Lan.
- 317 *mà chừ::: (.) mua- mua- mua= mua thuốc:c uố:ng #cũng# đượ::c*
but now buy medication take also enough
But medication is enough.
- 318 (0.3)
319 Quynh *dạ:::*
OK
OK.

In the first sequence about Luong's previous treatment for her legs (lines 111-121), doctor Quynh asks if Luong's leg pain has been treated with acupuncture along with Chinese medicinal herbs (line 111). This elicitation displays Quynh's orientation towards her recommendation of acupuncture and Chinese medicinal herbs for Luong's problem. Anticipating Quynh's agenda, Luong rejects the option of acupuncture on the grounds that she thinks it may cause high

blood pressure (lines 121-122). After 108 lines concerned with Luong's problems with her back and her blood pressure (data not shown), Luong rejects the acupuncture option again, this time invoking the third party, Lan, to support her rejection of this option (line 230). Luong's use of the recognitional form (i.e., Lan's personal name) implies that the referent is known to Quynh at this point. Quynh treats Luong's invocation of Lan as a form of resistance. In delayed fashion after 1.1 seconds (line 231), she shows her disaffiliation through a weak token, *đạ* ('OK'; line 232). As the consultation develops, Quynh returns to her previous agenda by recommending acupuncture (in combination with Chinese medicinal herbs) for the third time (lines 290-291). Luong continues to actively resist the acupuncture treatment option (line 292). After two pauses (lines 293 and 295), Luong states the reason for her rejection of Quynh's treatment option, and requests an alternative, *mua thuốc uống* ('some medication'; line 296). Once again, Luong reaffirms her treatment preference (line 301) in her response to Quynh's request-for-confirmation question (line 299). Despite this resistance, Quynh sticks to her treatment recommendation (lines 301-303). In response, Luong mentions the location of the village hospital (lines 304-305 and 307), which triggers two utterances from Quynh: one (line 314) seeks Luong's confirmation, and one (line 315) acts as a recommendation. Luong responds to Quynh's recommendation using a *pro forma agreement* format (Schegloff, 2007), *nhờ Lan được* ('I can ask Lan'; line 316), as if to suggest that she will act on this recommendation. A *pro forma agreement* format means the speaker initially commits to the future course of action but later shows their disagreement. As it happens, Luong quickly reverts to her initial position (lines 317).

The exchange in Extract 6 indicates how patient Luong actively resists Quynh's treatment recommendation by refusing to take acupuncture. This is significant on two related levels. In general terms, it represents a triumph of the lay voice over the expert voice—a result which crucially depends on Lan's status as an RM. More particularly, this exchange also tells us something about the relative importance of collectivism and social status in determining treatment outcomes in this cultural context. As we saw above, Quynh's preferred treatment plan is that Luong should supplement her existing regime of medication with acupuncture. Luong's response is to associate the acupuncture option with another medical professional, Lan. This association then enables her to use her familial relationship with Lan to forestall Quynh's preferred treatment agenda and, ultimately, supplant it with her own. In short, as a determinant of her future treatment for her health problems, Luong's familial relationship with Lan takes precedence over Lan's status as a medical professional.

At the same time, Quynh's concession is problematic from a medical perspective (Stivers, 2006). In taking this step, she puts the final treatment decision in the hands of Luong on the basis that her health is her own responsibility: as a health provider, Quynh's role is only to give her advice, and not to impose her own treatment agenda on her. This step necessarily also has the effect of diminishing Quynh's accountability for any problems that might result from Luong's future treatment.

In Extract 6, Luong invoked an RM in order to obtain her preferred treatment option. The patient in Extract 7 also wants something, but this time it is a particular type of service. In her exchange with doctor Si, patient Nhu invokes her niece Tuyen, who is working in the same hospital, in an attempt to get the hospital to decoct some Chinese medicinal herbs for such an outpatient as her.

Extract 7

- 47 Nhu TUI là- là (.) là- (.) O của #con# TUYỀN (0.6) mà rằng ngày ni hẳn nghỉ::
I COP aunt of CLA Tuyen but why day this she off
- 48 rồi (0.5) mà hẳn- hẳn nói:::i là (0.6) là- là ở+đây có sắc thuốc
PRT but she say COP COP here PRT decoct medication
- 49 (0.3) °đó:::°
PRT
I'm Tuyen's aunt. But she's off today. She said that this hospital can decoct medication for patients.
- 50 (0.7)
- 51 Si ↑à:: (.) sắc thì ngoại+trú::: (.) giống+như dì là không- có chế+độ
oh decoct COP outpatient like aunt COP not have regulation
- 52 sắc được
decoction PRT
Oh, according to our regulations, we don't decoct medication for outpatients like you.
- 53 Nhu hà:::
oh
Oh.

At lines 47-49, Nhu prefaces her turn with the information that Tuyen is her niece, notes her absence, and then raises the issue of medication decoction. She pauses several times between turn construction units to express her uncertainty about the veracity of the second and third pieces of information, while also stretching her talk at *nghỉ::* ('off'), *nói:::i* ('she [i.e., Tuyen] said'), and *°đó:::°* to corroborate her claim. In response (lines 51-52), Si's upward-intoned *↑à::* ('oh'), plus details of the hospital regulations in second position, indicate that Nhu's sequence-initiating action has occasioned a *marked shift of attention* (Heritage, 1998). This aims to express a rejection of Nhu's presupposition. Nhu's stretched upshot, *hà::* ('Oh'; line 53), then signals a *change-of-state token* (Heritage, 1984), and treats Si's information as new.

Nhu's first-pair part in this sequence (lines 47-49) is noteworthy in two respects. First, this turn is prefaced with information that seems irrelevant to the consultation: *tui là O của con Tuyền* ('I'm Tuyen's aunt'). She raises her pitch

on the name, *TUYẾN*, to draw attention to the fact that this is new information (Kidwell, 2013). In addition, Nhu's use of the final particle *°đó::°* affords her claim the function of an announcement. Because she attributes the information about medication decoction to her niece, Nhu is able to disclose this information to Si in this forthright manner, which in turn legitimises her request that the hospital decoct medication for her.

So far in this section, we have seen patients invoke RMs in order to avoid something (Extract 5) or obtain something (Extracts 6 and 7). Neither of the remaining two extracts falls neatly into either of these categories. In each case, the patient explains why he has sought treatment in the current hospital rather than somewhere else. Consider Extract 8. Binh has suffered from seizures for four months, and was hospitalised for 20 days at a hospital in the city where the seizures started. Since he came to Vinh City three months earlier, Binh has not sought any treatment at all. This extract is concerned with doctor Yen's elicitation of information about his previous treatment.

Extract 8

- 96 Yen *bơ- (0.2) bơ- bở về Vì:nh (.) về Vì:nh là CHU:A điều+trị chi ↑hết?*
so return Vinh return Vinh COP not treatment any at+all
So you haven't had any treatment since you returned to Vinh?
- 97 Binh *chư:a chi hết*
not any all
None at all.
- 98 Yen *rôi:*
OK
OK.
- 99 Binh *bữa+ [ni mới đi-]*
today PRT go
- 100 Yen *[mà giờ]+c [hừ::]*
but today
But today-
- 101 Binh *[qua đây]*
to here
Lines 100 & 102: **Today is the first time I've looked for treatment.**
- 102 (0.2)
- 103 Yen *chừ: mới qua đây_i=*
today PRT go here
You haven't looked for treatment until today.
- 104 Binh *=ô: con- (0.2) con THU: là chá:u (0.2) kêu bằng bác*
mmm Ms Thu COP niece address COP uncle
Mmm. Ms Thu is my niece.
- 105 Yen *dạ:: ↑rôi*
HON OK
OK.

Doctor Yen opens the sequence with a question in the form of a declarative (lines 96-97). An utterance of this type formulates a 'B-event' (i.e., known to B, but not to A; Labov & Fanshel, 1977), and counts as a request for information to which the patient has primary access. If it is negatively polarised, the use of a declarative question favours a 'no' response (Boyd & Heritage, 2006), and this is what Binh supplies (line 98). Yen registers her receipt of Binh's information with *rôi:* ('OK'; line 99), without seeking any information. However, Binh adds further details to support his response (line 100). After several lines of *post-start-up overlap* (Gardner & Mushin, 2007) and *terminal overlapping talk* (Jefferson, 1984), Yen resolves the overlap using a *marked self-retrieval* (Jefferson, 2004) at line 104. This resolution leads Binh to invoke an RM, his niece Thu, who also happens to work in this hospital (data not shown).

In this extract, Binh's invocation of an RM, Thu, accomplishes two possible social actions. To begin with, he justifies his decision to seek treatment at the current hospital. Binh returned to Vinh three months ago, but has not sought treatment anywhere for his seizures: this tells us that his seizures have not been serious enough to require urgent attention. In turn, we can conclude that Binh decided to seek treatment today on Thu's recommendation. Second, consider how Binh invokes his niece at line 105. He stutters at *con-* ('Ms.') and pauses for 0.2 seconds, before raising his pitch and stretching at the name of his niece, *THU:*. The stuttering and pause indicate that Binh is having difficulty disclosing the information that Thu is his niece. More to the point, however, the pitch-raising and stretching communicate Binh's desire to draw Yen's attention to his relationship with this RM in the hope that Yen will look after him especially conscientiously.

Whereas Binh leaves his reasons for choosing the current hospital implicit, Duc in Extract 9 makes them explicit to doctor Tung. In addition, as we shall see shortly, the situation depicted in this extract is more complex than the one in the previous extract in certain respects. This extract is taken after Duc presents his back problem.

Extract 9

- 37 Tung *mà vó: (.) bệnh+viện ↑mô?*
so go hospital what
So, what hospital did you go to?
- 38 (0.8)
- 39 Duc *tôi: (.) đi chơi Ninh Bình?*
I go holiday Ninh Binh
I went on holiday in Ninh Binh.
- 40 Tung *Ninh BÌNH ↑ha?*
Ninh Binh INT
'Ninh Binh?'
- 41 Duc *dạ (.) thì tôi đau trong nó rồi tôi meo+ra cho ông+thông+gia ↑tôi*
yes COP I pain in there then I email to daughter-in-law+father I
Yes. The pain started when I was there, so I emailed my daughter-in-law's father-
- 42 (0.2)
- 43 Tung *dạ: [::]*
OK
OK.
- 44 Duc *[(vi) ông]+thông+gia tôi chuyên (0.4) chữa ci- ci: (.) cột+sống*
because daughter-in-law+father I specialise treatment CLA spine
45 *này ↑mà*
this PRT
because he specialises in spinal treatment.
- 46 Tung *dạ:*
OK
I see.
- 47 Duc *thì ông meo+vô cho rồi thuốc này- (0.2) thuốc nó thuốc*
COP he email to PRT medication this medication that medication
48 *(.) thì tôi [mua tôi] uống thế+là*
then I buy I take and
In his email, he recommended various kinds of medication. I bought them and took them, and-
- 49 Tung *[dạ]*
OK
OK.
- 50 Duc *nó: (.) thuyên+giảm ngay là tôi: (0.5) hôm+qua tôi ra*
it decrease immediately COP I yesterday I come+back
51 *hôm+qua tôi ra bằng (.) xe+nằm*
yesterday I come+back by coach
the pain decreased immediately. So I was able to come back here by coach yesterday.
- 52 (0.2)
- 53 Tung *dạ::*
OK
OK.
- 54 (0.3)
- 55 Duc *đế- đế:: (.) đế:n (0.6) khám hôm+qua họ bảo nhập+viện #xong# tôi*
come check-up yesterday they tell hospitalise then I
56 *về hỏi ch- ông tư+vấn ông thì ông bảo là: (0.5) cứ vào+viện*
leave ask him advice he then he tell COP try hospitalise
57 *đi kết+hợp bên (.) ↑thuốc+men với bên (.) ↑châm+cứu xem+thứ ra+răng*
PRT combine PRT medication with PRT acupuncture see how
When I came to this hospital yesterday for a check-up, they advised me to stay for treatment. Then I asked him for advice, and he told me to stay here and combine medication with acupuncture, and see how it went.
- 58 Tung *dạ:*
OK
OK.

The talk included in this extract begins at the start of the consultation proper. As necessary background, note that Duc has just tried to take some medication in the presence of doctor Tung, but has been told not to. On witnessing this, Tung presupposes that Duc must have sought treatment elsewhere before coming to the present hospital (line 37). Duc responds with a narrative that spells out the reason why he chose this hospital (lines 39, 41, 44-45, 47-48, 50-51, and 55-57). In this narrative, he invokes his daughter-in-law's father, a specialist in spinal medicine (lines 44-45). Duc reveals that this RM has recommended some medication for him, and has advised him to seek treatment in this hospital (lines 47-48 and 55-57). However, this receives no assessment from Tung except an acknowledgement token (line 58).

Duc's invocation of an RM expresses an ambivalent attitude towards Tung. On one hand, by invoking someone who happens to be a clinical expert in the relevant medical field, Duc justifies purchasing medication for his back pain at another health centre before this consultation, and even attempting to take this medication right in front of his new

attending doctor. On the other hand, Duc's invocation of the RM also provides him with a rationale for seeking treatment for a doctorable health issue in the present hospital, where, needless to say, he will be in the care of someone else again. In short, by opting to seek treatment here, Duc reveals a certain willingness to put his faith in Tung. It is also possible that, in invoking an RM in this situation, Duc hopes to receive better care from Tung than otherwise, as noted in our analysis of the consultation featured in Extract 8.

V. CONCLUSION

As we have seen, the participants in this study have diverse motives for invoking an RM in a medical consultation. Our data contains one instance in which this is done by the doctor. In Extract 4, Chu invokes an RM in order to elicit information from patient Sang, so our findings are in line with Bergmann's (1992) in this regard at least. At the same time, the information Chu elicits is not sensitive in nature, whereas in the earlier study the information elicited by the psychiatrists was indeed sensitive. This constitutes evidence that medical professionals invoke third parties as an elicitation strategy regardless of whether the information is sensitive or not. Needless to say, however, this conclusion is based on a limited pool of data. We need more work to be done before firm conclusions about the role played by informational sensitivity in this situation can be drawn.

Our analysis of the patient data has yielded three further results. First and foremost, the practice of invoking an RM in this cultural context empowers the patient to behave more assertively in a variety of medical scenarios than they might otherwise do (Fancher et al., 2010; G. T. Nguyen et al., 2007; K. Tran, 2009). One patient manages to circumvent a troublesome administrative requirement (Extract 5), while another invokes an RM in order to obtain a preferred form of treatment (Extract 6). In Extract 7, the patient wishes to receive a health-related service from the hospital, while also diminishing their accountability for making this request in case it turns out to be irregular. Still other patients adopt this practice in giving reasons for selecting the current hospital, and possibly also in the hope of receiving special attention from their treating doctor (Extracts 8 and 9). In Extract 9, the patient also invokes an RM in order to challenge the attending doctor's expertise.

Moreover, these motives for invoking third parties differ from the ones observed in earlier research conducted in the Western cultural context.¹³ Recall from Section 1 that the patient in Gill and Maynard (2006) invokes a third party in order to mitigate a frank and constraining question about her health condition. In Heritage and Robinson (2006), this practice serves to validate the patient's health concerns, and to diffuse their accountability for taking these concerns to the doctor as well. We ascribe this difference in observed motives to two interrelated properties of our study: the cultural context for the study, and the type of third party we have chosen for scrutiny. As foreshadowed in Section 1, our view is that a collectivist mentality plus a strongly-defined social hierarchy work in concert to promote the invocation of RMs in particular as third parties in Vietnamese medical communication.

Our third result is that, beyond merely promoting the use of this strategy, these two social forces appear to interact with each other in a particular way when an RM is invoked. In Extract 6, we saw that patient Luong's familial relationship with Lan overrode Lan's status as a medical professional in shaping the direction of her future treatment for her health problem. While data such as this is encouraging, the available evidence must be deemed only suggestive at this point. Further research on the putative effects of collectivism and social status on treatment outcomes is undoubtedly required.

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¹³ While the patients in Extract 3 (from Heritage & Robinson, 2006, p. 59) and Extract 7 both invoke third parties in order to diffuse accountability for their actions, they do this for different reasons.

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