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Abstract

In applying linguistics to the task of analysing how agentivity is construed through verbal interaction, scholars often equate social agency with grammatical agency, and in particular with the grammar of transitivity. The difficulty I want to address in this paper is that we may miss other important, systematic and contrastive patterning in the agentivity with which social actors and other entities are depicted, because such agentivity is realized through a range of dispersed linguistic resources. Systemic Functional Linguistics can provide a useful framework for co-ordinating the contribution of these resources to the overall construal of agency in a text or set of texts. It does this best when it focusses on bringing out the particular stratal alignments that characterise different contexts. The paper draws on a study of treatment decision-making in HIV medicine as an example of a social context where choices in the construal of agency make a crucial difference to choices of professional and institutional practice. In this study the construal of agency was taken as a chief source of evidence about whether doctors and patients engage in shared decision-making, and it was also seen as a strategy which doctors and patients can use to open up or close down opportunities for shared decision-making. A key finding was that doctors and patients in HIV medicine often construe the agency of one participant as a resource for the agency of another, rather than construing the agency of one participant as competing with the agency of the other. In particular, it is where doctors and patients construe each other as semiotic agents that shared decision- making seems most likely to occur.

Keywords

decision, hiv, making, agency, modelling

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MODELLING AGENCY IN HIV TREATMENT DECISION-MAKING

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ABSTRACT

In applying linguistics to the task of analysing how agentivity is construed through verbal interaction, scholars often equate social agency with grammatical agency, and in particular with the grammar of transitivity. The difficulty I want to address in this paper is that we may miss other important, systematic and contrastive patterning in the agentivity with which social actors and other entities are depicted, because such agentivity is realized through a range of dispersed linguistic resources. Systemic Functional Linguistics can provide a useful framework for co-ordinating the contribution of these resources to the overall construal of agency in a text or set of texts. It does this best when it focusses on bringing out the particular stratal alignments that characterise different contexts. The paper draws on a study of treatment decision-making in HIV medicine as an example of a social context where choices in the construal of agency make a crucial difference to choices of professional and institutional practice. In this study the construal of agency was taken as a chief source of evidence about whether doctors and patients engage in shared decision-making, and it was also seen as a strategy which doctors and patients can use to open up or close down opportunities for shared decision-making. A key finding was that doctors and patients in HIV medicine often construe the agency of one participant as a resource for the agency of another, rather than construing the agency of one participant as competing with the agency of the other. In particular, it is where doctors and patients construe each other as semiotic agents that shared decision-making seems most likely to occur.

AGENCY, HIV TREATMENT DECISIONS, AND EXPLICIT DESCRIPTION

> Against the idea of an active individual whose actions comply fully with the goals of authorities, it becomes necessary, in the interests of self-determination, to articulate another form of agency, one that can negotiate (and where necessary challenge) the subtle ways in which control is exercised in this domain [of HIV medicine]. (Race et al., 2001, p. 6)

This paper reflects on the process of modelling and problematising agency in applied linguistics and discourse analysis. In medicine and other contexts of care, shared decision-making is a valued institutional and professional practice. Research points to patient agentivity as a central factor in styles of medical decision-making, in determining the outcome of treatment decisions, in the success of treatment, and ultimately in the health and wellbeing of patients (e.g., Greenfield, Kaplan, Ware,

Yano & Frank, 1988; Race et al., 2001). The relationships between these factors are by no means simple or unequivocal – for instance, high patient agentivity may increase treatment adherence but reduce treatment uptake in the first place (Donovan & Blake, 1992). But despite these complex causal relationships, there is a consistent thread running through the discourse on medical interaction which can be interpreted as a call for professionals to enhance agency among patients (e.g., Race et al., 2001).

Agency has not, however, been given sufficient explicit theoretical and analytical attention in the literature on medical decision-making (Pappas, 1990). This raises problems which can in part be addressed by drawing on social theory and linguistic theory as fields which have explicitly theorised agency in relation to social life and verbal interaction respectively.

Two problems with agency

There are two problems I wish to identify here. The first problem is that in discussions about medical interaction, agency is typically construed as a zero-sum game: when a patient is held to participate maximally in decisions about their health and health care, the doctor is held to participate minimally, and vice versa (e.g., Charles, Gafni & Whelan, 1999). As I will demonstrate below, such a model does not capture the complex agency relationships between doctors, patients, institutions and other entities. Simplifying and reducing greatly for the sake of space, influential social theories of agency, including philosophy, have also often depicted agency as a zero-sum game in which an actor is only an agent if they are engaged in unfettered, volitional action (e.g., Davidson, 1980). But there are arguably more powerful models which:

a) stress the dialectic between the individual agent and social structures, including institutions (e.g., Bourdieu, 1991; Giddens, 1984);

b) allow the possibility of non-competitive agency, where one person's (or entity's) agency may *enhance* the agency of another rather than detract from it (Harré, 1979, 1991; James, 1890; Vygotksy, 1978); and

c) focus on the semiotic realm of action as a domain in which agentive roles are important (e.g., Bernstein, 1971; Bourdieu, 1991; Hasan, 1989; Wertsch, 1990).

There is no space here to pursue important details or differences in such models, but what they share is a view of agency as a "socioculturally mediated capacity to act" (Ahearn, 2001, p. 112). I will use this definition for the present paper. In addition it is important to locate my position on agency within a theory of action. In brief, I take a view which dissolves the Cartesian distinction (and causal sequence) of cognition and action, and brings these back together in a "unified conception of meaningful activity" (Thibault, 2004, p. 133). A key implication of such a view for the present study is that all action has both material and semiotic dimensions (see, e.g., Thibault,

2004; Vygotsky, 1978) but in any instance of action one of these dimensions may be emphasised over the other, according to the perspectives of the participants and, at times, the analyst. One way of illustrating how this duality works is to consider the way in which language itself construes semiotic action – e.g., English reflects the complexity of the phenomenon of semiosis by treating it both as action and reflection, as something symbolic and discursive *and* as something material (Matthiessen, 1991, p. 105).

Given such concepts of action and agency, how would we expect agency to be construed in HIV medicine? It is a complex context that involves making decisions about powerful, toxic and (at the time of my data collection) relatively untested drug regimens, against the backdrop of the highly politicised field of gay community self-determination. Therefore we would not expect that the construal of agency would be a simple matter of representing which individual did what to whom, although that will always be a good starting point. We would expect such construal to show tensions between individual autonomy and institutionally determined rights and obligations. We would expect it to show the negotiation and collaborative 'authorship' of moves and opinions. And we would expect it to be mediated by a wide variety of symbolic tools such as pathology tests, symptoms, and motifs of identity, as well as through the invaluable symbolic tool of language more generally.

This brings us to the second problem, which will be familiar to applied linguists from many fields. The most widely used research paradigms do not examine the details of how decision-making is realized as language, but treat language as a black box which is somehow, non-analytically, known to contain decision-making. Few discussions of medical interaction relate their descriptions of decision-making as institutional practice to any systematic description of how patterns of verbal interaction realize or foreclose on joint decision-making. The policy and research literature leaves clinicians (and patients) to work out the linguistic strategies for practising shared decision-making (and enhancing agency as a strategy towards practising shared decision-making) by themselves. Thus there is a need for studies which are firmly grounded in an understanding of professional and institutional discourse, and in an understanding of grammar and semantics, preferably a functional grammar that can relate discourse as 'talk' to discourse as 'practice'. The study reported here aimed to begin filling this gap.

Framing social and linguistic agency as meaning potential

Modelling decision-making requires a way of framing the choices that affect its character. Such a frame needs to be able to relate the relevant domains of choice to each other and "bring a motivated order to the plethora of potential discriminations and terms" (Butt, 2000, p. 229). While it may not be possible to examine all these factors simultaneously in detail, it is important to use a framework that can specify the relevant dimensions when necessary. Taking a systemic functional linguistic (SFL) approach, these domains of choice are organized metafunctionally and stratally

(Halliday, 1973; Matthiessen, 1995) as different areas and orders of meaning potential.

Meaning potential refers to the range of significant variation that is at the disposal of a speaker or a discourse community (Halliday, 1973). Viewed from the perspective of the stratum of lexicogrammar, meaning potential represents what a speaker can say. Viewed from the semantic perspective, meaning potential represents what a speaker can mean. From the perspective of context, meaning potential represents what members of a discourse community can do through semiotic action. Some of these significant choices are of course not textualised choices in meaning. Although the framework can handle the integration of linguistic and other modalities of meaning the focus in this paper is on different ways of speaking and the effect of such differences on whether decision-making is shared or unilateral. In such a framework, even small differences in lexicogrammar may count as crucial differences in semantics and context, and this is the case in the study reported here. The cornerstone of this approach is the idea that discourse and context are interdependent phenomena which bring each other into being (Hasan, 1999; Goodwin & Duranti, 1992; Malinowski, 1978).

One of the chief contextual parameters which distinguished *shared* decision-making from other styles was the reciprocal and mutable agentive roles held by doctors and patients (Moore, 2003). So it was important to look closely at what kinds of semantic patterns were involved in construing patients as agents of their own healthcare or not, and at the kinds of lexicogrammatical resources being used to differentially construe these different roles. In particular, it was of interest to explore how this reciprocity and mutability of roles played out in the linguistic realizations of shared decision-making episodes.

Current analytic approaches, including some semantic-level descriptions, tend to describe linguistic resources for construing agency at the grammatical level of organisation and miss some of the additional, dispersed organisation at the semantic level. In particular, the impression is sometimes given that the grammatical system of transitivity exhausts the potential for encoding and enacting agency linguistically. An example of research that makes good use of transitivity analysis, but only transitivity analysis, as evidence about agentivity is Körner, Hendry and Kippax's paper (2004) on the discursive construction of sexual practices and 'risk' in gay men's accounts of exposure to HIV. Körner et al suggest that in discussing prevention, speakers tend to construe themselves as Actor, thus "grammatically tak[ing] responsibility" (p. 133) for crucial processes involved in minimizing or increasing risk. In discussing seroconversion, sexual partners are more likely to be construed as Actor, indicating that agency is attributed differently, according to the perspective from which risk is explored. Other examples of this transitivity-focused approach used in health discourse include work by Cassell (1985), Ostermann, Dowdy, Lindemann, Turp &Swales (1999), and some of my own work (e.g., Brown, Butow, Butt, Moore & Tattersall, 2004). In non-health contexts, examples include work by Ahearn (2001), Duranti (1994), Fairclough (1992), Fowler, Kress & Trew (1979),

Henley, Miller & Beazley (1995), Martin (2000)[1].

There are however a number of ways in which English organises resources for construing agency at the semantic level of abstraction, and in particular for construing semiotic agency, as distinct from agency in the material realm. Elsewhere (Moore, 2003) I set out the rationale for a semantic network that draws together some of the plethora of ways in which interlocutors present themselves and others as agentive or non-agentive and the particular symbolic resources that contribute to building up this sense of agency. This network draws heavily on van Leeuwen (1995, 1996), but I refocus this approach in four related but distinct ways. Firstly, I focus on the *stratal alignment* of semantic categories – i.e., the way in which they respond systematically to patterning at other strata, so that agency in HIV decision-making may be construed in quite different ways from its construal in other contexts. Secondly, I attempt to account for the interrelatedness of the *representation* and the *enactment* of agency, demonstrating how each conditions the other. Thirdly, I stress the *logogenetic perspective,* looking at how agentive roles that are attributed to doctors and patients (and other social and semiotic agents) change from moment to moment, and from phase to phase, even though they may also have a cumulative value across a whole decision or consultation. Fourthly, I stress the *mutual alignment* of doctors and patients with respect to the construction of agency and more general discursive positions that are instantiated as their interaction unfolds.

The prominence of semiotic agency in decision-making contexts

One particular difference – departing from semantic-level descriptions by van Leeuwen (1996), Halliday &Matthiessen (1999), and Hasan (1989) – is that my approach allows Sayers and Sensers (and more generalized symbol sources, which may or may not be animate social actors) to be construed at the semantic level of description as having degrees of activation/passivation and related dimensions of agentivity. Some grammatical-level descriptions also allow Senser/Sayer agency, including Fawcett (in press) and non-SFL approaches such as Talmy (1976) and Croft (1991), cited in Palmer (1994), but this is not generally the case in SFL.

Part of my rationale here draws on Thibault (1993). Thibault, after Halliday, stresses that grammatical systems and functions such as agency are models of experience, and our metadiscourses about the patterns found in languages are related, but not necessarily isomorphic, models of experience. Both depend heavily on (and themselves facilitate) other culturally influential models and analogies which it is important to explicate. From this perspective, English transitivity is essentially a model of "mechanical" cause and effect in the physical world, in which one variable affects another (or not). By contrast the ergative model is a "nuclear" model which concerns itself with whether an event is internally or externally caused. It is not that one model is right and the other wrong, but that both are there, as resources – but also as constraints – for how agency is depicted in the culture (cf. Halliday, 1967/8; Halliday & Matthiessen, 1999). Thibault goes on to map out a third area of meaning

potential relating to agency which concerns itself with whether actors are internally or externally predisposed to act (cf. Harré, 1979, 1991). This aspect of modelling agency is realizationally related not to transitive or ergative patterns in the experiential grammar, but to aspects of the interpersonal grammar, in particular the grammar of modulation, and Thibault identifies two distinct sociosemantic agency roles: the Agent of Process and the Agent of Modulation. These may be conjoined or disjoined in any one clause.

Reflecting on these different models is a useful way of shifting the focus onto modelling the agency of reciprocal and intersubjective relationships. Consider for instance the difference between the messages, *I take vitamins every day* and *I make myself take vitamins every day*. If there is any agency construed in the first message it is the simple agency of the Actor as unfettered 'do-er' of an action: the transitive analysis (Actor+Range) brings this construal out, and the ergative analysis (Medium+Range) shows that there is no external cause of the action. By contrast, the second message construes a more complex agentive situation involving external causality, which the ergative analysis depicts as a kind of Agent+Medium reciprocality within the self (Agent+Medium+Range, cf. transitive analysis of Initiator+Actor+Range).

Thibault's additional category of the Agent of Modulation then brings constructions such as *I'm supposed to take vitamins every day* into this paradigm of contrasts in agency. Despite its similar Transitive/Ergative structure to the first message (Actor/Medium+Range), this third message also construes a complex kind of agency, not involving external, material cause, but involving external "predisposition to act". In Thibault's terms, the Agent of Process (the Actor/Medium, i.e., the person taking the vitamins) is disjoint with the Agent of Modulation here, where the Agent of Modulation is an unspecified social participant or institution obliging the speaker to take the vitamins, traceable grammatically through the implicit, objective modulation of "supposed to". This approach is a crucial step forward, but a number of steps remain to be taken. In particular, the idea of complementary models of agency needs to be extended, across strata and metafunctions where necessary, so that it can account for the construal of agency in other types of social action, not just material action.

To this end I have refigured Thibault's roles as Material Agent and Semiotic Agent respectively, incorporating them as options in linguistic meaning potential, at the level of semantics, which draw on a range of grammatical resources for their realization[2]. The point of these and related options is to set out the meaning potential English offers for representing social actors (and inanimate symbol sources) as having semiotic agency – i.e., to show how speakers manipulate and repattern a grammar that seems designed to inscribe material agency, in order to represent semiotic action as capable of having effects on the world outside of itself.

One benefit of this refiguring for the present study is that we can identify paradigms of contrast at clause level (or at message level, where "message" is a semantic

unit usually directly realized by a clause) in how both semiotic agency and material agency are attributed to doctors, patients, test results, pills, theories etc. A second benefit is that we can show not only how material and semiotic agentive roles may be conjoined or disjoined in any one clause, but also how they may be crucially conjoined or disjoined across larger stretches of discourse, and how their confluence may be tracked logogenetically.

To begin by illustrating key clause/message level contrasts, we can distinguish different agency roles in the semiotic action of remembering:

i) a *passivated, impassive* actor: remembering is construed not as a process or behaviour but as a near permanent attribute of the social actor. There is no semiotic agency here

37_110 P I'm very forgetful, yeah.

ii) an *activated* actor who is *self-activated* in a *non-transactional* action: remembering is construed as a process but it just happens by itself (or not), so again no semiotic agency

I never remember to take my pills (interpolated example)

iii) an *activated* social actor who is *self-activating* in a *transactional* action which is to influence one's memory. Here there is a semiotic agent and a material agent and the two are conflated in the one participant (the HIV+ person)

I have to remind myself to take my pills (interpolated example)

iv) an *activated* social actor who is *other-activating* in the *transactional* action of influencing someone's memory. Here the semiotic agent is a different grammatical and social participant from the material agent

he'll remind you to take your pills (interpolated example)

v) again, there is an *activated* social actor who is *other-activating* in the *transactional* action of influencing someone's memory. But here the participant who is affected by this semiotic process is also grammatically the initiator of the process. The approach taken in this study allows agency to be reciprocally distributed and mediated at the semantic level: there are two semiotic agents here.

I get him to remind me to take my pills (interpolated example)

Arguably, these example messages construct some kind of cline of agentivity. Here the distinctions identified are drawn out through different choices in the experiential grammar, but these roles can also be construed through less congruent resources, particularly the interpersonal systems of grammar such as mood, mood projection and modality, and also through projection (cf. Candlin,

2000). For instance, we can distinguish between (vi) and (vii) as follows:

vi) an *activated, self-activating* social actor engaged in *transactive* semiotic action (getting something into their own head), but who is also *other-activated*

58_469 D you actually have to get it into your head, that this makes YEARS of difference to your life.

That is, the social actor's action is mediated by some other unspecified semiotic agent whose moral/epistemic agency is textualised through the modality of obligation (here "have to"). With a second person Subject, the source of the obligation is externalized from the social actor in question[3].

vii) (same pattern as iii, above) an *activated, self-activating* social actor engaged in *transactive* semiotic action (making oneself sure).

58_460 P I need to make sure that this is the right time

Again there is also the mediation of some unspecified agency textualised through the modality of obligation, but the first person Subject + "need" suggests internal disposition rather than an external agent mediating the actor's semiotic action.

A further example should help show why it is useful to identify a semantic category of Semiotic Agent and allow it to be realized through varied and dispersed grammatical systems. We need to be able to account for the relationship between the way transitivity construes agency in "he'll remind you to take your pills" as described above and the way projection construes similar agentive roles as in example (viii).

viii) an *activated* social actor who is *other-activating* in the *transactional* action of influencing someone's memory

59_631 D and if he really cares a lot about you,
|| he's going to be wanting to say to you,
|| "have you taken your pills?"

Operationally then, a social participant (animate or not) is considered a Semiotic Agent in this study if they are construed semantically as causing or facilitating some event, where either the event or the means of facilitating it is construed as semiotic action.

CAPTURING THE LATENT PATTERNING OF AGENCY IN HIV DECISION-MAKING

In this section I focus on how selections between the kind of contrasts described above are involved in construing the complex social agency that characterises HIV consultations. The data presented here were collected as part of a study of doctor-

patient communication in HIV/AIDS healthcare, comprising 74 audio recordings of consultations between doctors and patients in and around Sydney in the period 1995-1997 (see Moore, 2003; Moore, Candlin & Plum, 2001)[4]. Transcribed consultations were exported into a relational database[5], and coded at contextual, semantic, and grammatical levels of analysis using an SFL approach. Approximately two-thirds (n=47) incorporated decision-making about combination anti-retroviral therapy. Each of these was classified as shared or unilateral decision-making, based largely on the realization and sequence of generic phases, but also drawing on substantive information in the consultation (cf. Brown et al., 2004; Moore, 2003; ten Have, 2001). While the criteria were interpretative, the aim was to frame a more detailed examination of particular episodes and the linguistic patterns involved in their realization as shared or unilateral (cf. Peräkylä, 2002). In decisions classified as shared (64%; n=30), doctors and patients were more likely to represent each other, as well as themselves, as semiotic agents.

Below, Extract 1 is an example of decision-making which is shared, but somewhat equivocally so. Some of the tensions of shifting roles in medicine are apparent. The patient, Michael, and the doctor, Trevor, are reviewing Michael's test results (viral load and T-cells) and deciding whether to change the drugs. The results are mixed. Trevor is convinced the current treatment regimen needs changing; Michael has been trying to suggest at various points that the poor results may be due to him taking the drugs inconsistently. Unusually, it is Michael, the patient, who enunciates a decision to postpone changing the treatment (at turn 197), but the construal of agency in their interaction is more complex than this might suggest.

In order to emphasise how the proposed approach positions the sociosemantic description of agency as a mediating layer between grammatical description and contextual description, I will show grammatical patterning alongside the semantic category of Semiotic Agent, as outlined above. The grammatical categories Agent, Medium and Range are mutually exclusive ergativity roles which are selected for each clause (Halliday, 1994). If the clause is Effective Voice then the first participant is the Agent and the second participant the Medium. Otherwise the clause is Middle Voice: the Medium is the first participant and there is no Agent. The Semiotic Agent on the other hand is modelled here as a kind of semantic prosody which may extend over a sequence of messages. This measure is given by the number of messages over which the social actor/entity in question can be read as having some agentive scope, whether visibly represented in the text of that particular message or backgrounded but contextually available (after van Leeuwen, 1996); it also shows nesting of agency relationships where this occurs as a form of mediation (see Moore, 2003). The numbering system in the extract gives the clause, within clause complex, within turn.

Generic phase	*Clause ID*	*Spkr*	*Text*	*Semantic Level Semiotic Agent*	*Grammatical agency*		
					Agent	*Medium*	*Range*
B E A R I N G S	187_1_1	D	Now, so (what I've got here is)-	D		record	
	187_1_2	D	this is on the 12th of Feb obviously- and			record	time
	188_1_1	P	Yeah, we'll go-			P+	
	189_1_1	D	(reads aloud as he writes)) Plan after discussion. Number one=			plan	
	190_1_1	P	=We were fixing up [[what drugs to drop]].	P+		P+	treatmt plan
	191_1_1	D	That's right.	D+		-	
recap treatmt plan	191_2_1	D	Step one is dis continuation of drugs, first vincristine then ddI if necessary,	D		step in plan	treatmt change
	191_2_2	D	in brackets I've written			D	
	191_2_3	D	leaving him on D4t and nevirapine.	step/plan	plan	P	treatmt
	191_3_1	D	And then number two I've written,	D		D	
	191_3_2	D	"checked CD4-stroke-viral load *again* today plus liver function tests, amylase and haemoglobin for blood count.			D	virus, T-cells, etc
——	191_3_3	D	Send off to Prosser."		D	tests	
markers: evaluate treatmt	191_4_1	D	So now we've got-	D+		D+	semiotic matter
	191_4_2	D	we know			D+	
	191_4_3	D	you've changed one set of drugs;		P	treatment	
	191_5_1	D	we know [[what the viral load is]].			D+	test result
	191_6_1	D	The viral load shows without question	D+ 'VL		test result	
——	191_6_2	D	that .. the antivirals .. aren't working.			treatment	
	191_7_1	D	Yeah.			-	
markers: evaluate adherence	192_1_1	P	Well maybe because at that stage	P		-	
	192_1_2	P	<< like that was a week before,>>			event	time
	192_1_3	P	would it- would it show in that week?	->D' VL		behaviour/ effect	
	193_1_1	D	Yeah.			effect	
	194_1_1	P	When			-	
	195_1_1	D	Yeah.			-	
	195_2_1	D	If had- if you'd *stopped*, for example,			P	
	196_1_1	D	Yeah.			-	
	196_2_1	P	It probably would have shown in that?			effect	
E N U N C I A T E	197_1_1	P	Okay well, we'll leave it for another- nother two weeks	P+	P+	treatment change	
	198_1_1	D	Okay.			-	
	199_1_1	P	Cos I get the dd- D4t today		P	treatment	
	200_1_1	D	Yeah.			-	
	201_1_1	P	()			-	
	202_2_1	D	Yeah.			-	
	203_1_1	P	Give it another bash solid.		P	A bash	
	204_1_1	D	Okay.			-	
	204_2_1	D	All right.			-	
DECISION	204_3_1	D	I think that's reasonable,	D		plan	quality
------	205_1_1	P	which I can do.			P	
PATH WAYS	205_2_1	P	Then we can go .. do another test and just in case it was *just that*.	P+		P+	test
	206_1_1	D	Yeah, okay.			-	
	207_1_1	P	Um.			-	

Consultation Extract: Trevor and Michael (Consultation 37) - page 1

Generic phase	*Clause ID*	*Spkr*	*Text*	*Semiotic Agent*	*Grammatical agency*		
					Agent	*Medium*	*Range*
	208_1_1	D	((laughs)) That's reasonable.	D		plan	quality
embedded context monitor symptoms	208_2_1	D	Is there anything [[to see or feel]]?	D+		symptom	
	209_1_1	P	Um, slight .. colour change, <<that's about it>>, in the lesions.	P		change	
	210_1_1	D	In the ones in the groin?			-	
	211_1_1	P	In the groin, yeah.			-	
	211_2_1	P	They've become oh- I- I- I- I *think* they've become lighter.			symptom	quality
	211_3_1	P	They're not as dark as they used to be.			symptom	quality
	212_1_1	D	Oh, show me quickly then.	D P		P	symptom
	213_1_1	P	You just want			D	
	213_1_2	P	me to get my pants off, don't you? ((laughs))		P	clothes	
	214_1_1	D	Very funny.			-	
	214_2_1	D	Ah, actually ah, we'll this lot *do*.			symptom	quality
	215_1_1	P	Yeah, they seem to be a lot lighter.	P		symptom	quality
	215_2_1	P	One of them's - Oh that one's- that seems to be .. getting smaller.			symptom	quality
	216_1_1	D	Oh, you're right.	D		P	quality
	216_2_1	D	There's two actually.	D		symptom	
	216_3_1	D	Did you point that out to Prosser?	P		P	semiotic matter
	217_1_1	P	Eh?			-	
	218_1_1	D	()			-	
	219_1_1	P	I did.			P	semiotic matter
((28 turns omitted))							
E N U N C I A T E	242_1_1	D	((writing in patient record)) I'll put	D"		D	
	242_1_2	D	he'll probably need a change of antivirals,	D"D		P	treatmt change
	242_1_3	D	but Michael has asked	D"D "P		P	
	242_1_4	D	to postpone this for a two week period"		D?	change	
	242_1_5	D	<<ah, what'll I write?>> ((coughs))	D" D		D	semiotic matter
	242_1_6	D	while he improves his compliance.		P	behaviour	
	243_1_1	P	( )			-	
DECISION	244_2_1	D	No-one else is going to read it.	other clinician		other clinician	
	244_3_1	D	Okay.			-	
ratify & record	244_4_1	D	Um, that sums it up though.	wording	wording	semiotic matter	
	245_1_1	P	Yeah.			-	
	246_1_1	D	All right.			-	
new context	246_2_1		And what about domestic arrangement?			situation	quality
	247_1_1	P	I've moved.			P	
	247_2_1	P	He's moved.			P's lover	
	247_3_1	P	That's it.			-	
	247_4_1	P	History.			relation-ship?	quality

Consultation Extract: Trevor and Michael (Consultation 37) - page 2

Capturing the distribution of agency synoptically

To compare different synoptic pictures of how agency is distributed in the example text, Figure 1 gives frequency statistics for an ergative analysis identifying grammatical Agent (front row); a transitive analysis identifying Actor/first participant regardless of whether Agent or Medium (middle row); and the multidimensional method outlined above, for Semiotic Agent only (back row).

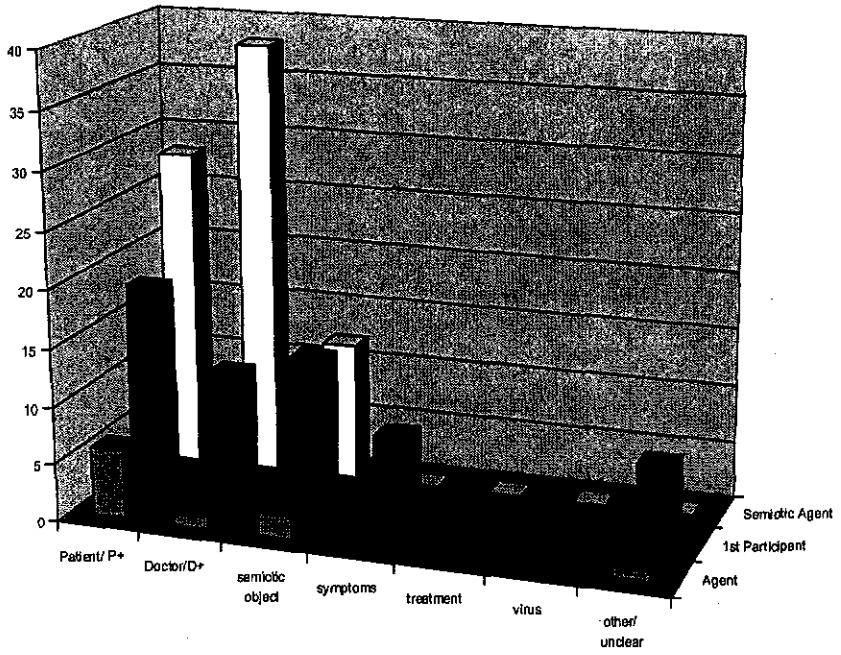

Figure 1: Frequency of clauses/messages in which key social participants and objects are construed as agentive, comparison of methods

If being depicted as the active grammatical participant in the processes construed clause by clause in a text were a direct index of how agency is linguistically attributed to a participant in a context, then the patient in Consultation 37 would be shown to have a much more agentive role than the doctor, based on ergative or transitive analysis. But that would not be a good conclusion to draw. This patient is certainly active, but the doctor is by no means passive. The proposed method of identifying the Semiotic Agent provides a way of capturing this highly agentive role of the doctor, complementing transitive and ergative analyses.

One way in which this can be brought out grammatically is to consider the

kinds of entities taking the grammatical role of second participant (following Matthiessen, 1995), as shown in Figure 2 below.

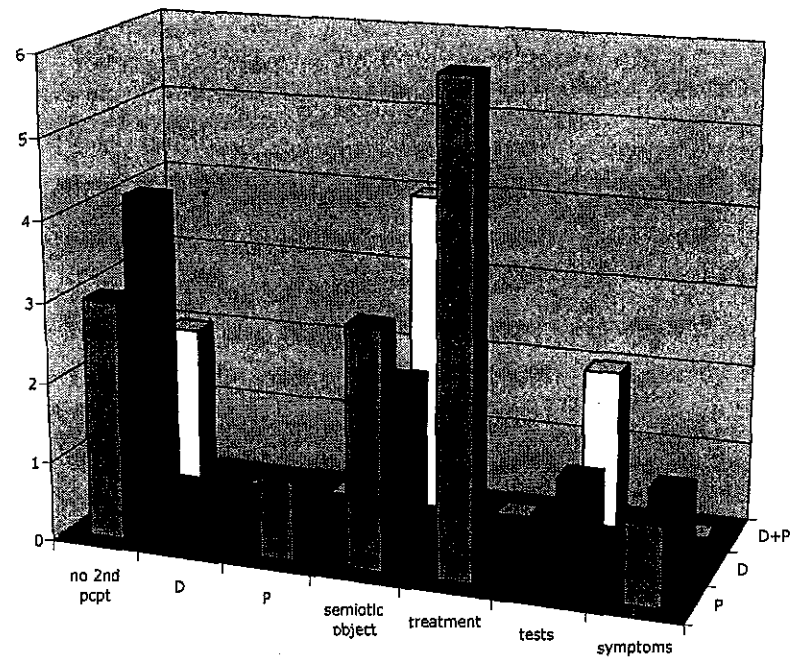

Figure 2: Grammatical role of 2nd participant (long axis), categorised by 1st participant (short axis)

Where the patient is the first participant (front row), and there is a grammatical role for the second participant, this second participant is most frequently the treatment itself. When the doctor is first participant (middle row), he is much more often represented as engaged in activities that have no second participant. Beyond this, he is represented most often as involved with semiotic matter or objects as second participants. Where the doctor and patient are represented as joint first participants, the second participant is always *test results* or *plans* or other kinds of semiotic objects.

We can thus see a tendency in this consultation for the doctor to be represented as involved with the semiotic components of medical care, including perspectives, points, tests and results. The patient is involved with these things in conjunction with the doctor, but is otherwise construed as involved with the more material aspects of health care. Taken together these analyses suggest a shared but reciprocal distribution of types of agency.

It is through the configuration of multiple features that salient contrasts in agency can be seen, roughly as in Hasan's (1985) "cline of dynamism". In the context Hasan was analysing, being represented as engaged in physical activity with an animate goal made for a more agentive depiction than being represented as engaged in mental activity or verbal activity with an animate addressee. However it seems to be emerging that the valeur of such configurations may be context-sensitive. In the context of HIV medicine, it is not enough to be construed as an actor in the material domain: one must be construed as operating in the symbolic or semiotic domain. This should not be surprising for a reflective context like decision-making, and the construal of semiotic agency has been found to be a crucial aspect of linguistic variation in contexts of education and early child development (Hasan, 1989; van Leeuwen, 1995, 1996; Williams, 2001).

Tracking semiotic agents logogenetically

Perhaps the key benefit of co-ordinating different grammatical resources in modelling agency in the manner proposed is that the depicted agency of a social actor, object, symbolic tool or institution can be tracked logogenetically through texts, even through clauses in which they are not textualised as a participant or other ideational element. For example, at turn 191 (shown again below) the doctor moves to close the BEARINGS phase of the consultation and prepares to propose a change of treatment (PATHWAYS phase). For the patient there is a move missing before BEARINGS can be closed off: the evaluation of his treatment adherence. The patient is clearly agentive here in that his semiotic action alters the phasal course of the consultation, helps reconstrue the clinical evidence, and results in a different decision outcome.

Generic Phase	*Clause ID*	*Spkr*	*Text*	*Semiotic Agent*
BEARINGS: markers: evaluate treatment	191_4_1	D	So now we've got-	D+
	191_4_2	D	we know	
	191_4_3	D	you've changed one set of drugs;	
	191_5_1	D	we know [[what the viral load is]].	
	191_6_1	D	The viral load shows without question	D+ 'VL
	191_6_2	D	that .. the antivirals .. aren't working.	
	191_7_1	D	Yeah.	
--------	192_1_1	P	Well maybe because at that stage	P
	192_1_2	P	<< like that was a week before,>>	
markers: evaluate adherence	192_1_3	P	would it- would it show in that week?	->D' VL
	193_1_1	D	Yeah.	
	194_1_1	P	When	
	195_1_1	D	Yeah.	
	195_2_1	D	If had- if you'd *stopped*, for example,	
	196_1_1	D	Yeah.	
	196_2_1	P	It probably would have shown in that?	
ENUNCIATE DECISION	197_1_1	P	Okay well, we'll leave it for another- nother two weeks	P+

In tracking the logogenesis of such decisions it is important to be able to capture how different social agents mediate each other's agency, and the scope of such agency over the flow of interaction. Here it is crucial to show the way the *viral load test's* semiotic agency is at first projected or auspiced by the doctor's semiotic agency, which in turn is construed as undifferentiated joint agency with the patient, and then later auspiced by the agency of the patient, who explicitly seeks a differentiated, reciprocal agency with the doctor. It is not the case that the agency is handed over from the doctor to the viral load test at a certain point in the text, and then passed later to the patient. Instead the three semiotic agents are in a complex relationship which is both sequenced and nested, which the diagrammatic tracking of the Semiotic Agent attempts to reflect[6]. Additionally, there is no fixed relationship here between *representing* oneself as agentive and *enacting* agency: the patient's enacted agency is in part successful because he construes himself as having shared agency with the doctor.

The nature of these complexities requires further research and transdisciplinary reflection, as the final focal extractillustrates (Turn 242 ff, shown again below). Although he has accepted the patient's proposal to leave changing the drugs till later, the doctor, Trevor, reconstrues Michael's contribution as "asking" to postpone (rather than say, "suggesting" we postpone, "preferring" to postpone, or even "Michael is going to stay on the current treatment").

Generic Phase	*Clause ID*	*Spkr*	*Text*	*Semiotic Agent*
ENACT/ ENUNCIATE DECISION record & ratify	242_1_1	D	((writing in patient record) I'll put	D"
	242_1_2	D	he'll probably need a change of antivirals,	D"D
	242_1_3	D	but Michael has asked	D"D "P
	242_1_4	D	to postpone this for a two week period"	
	242_1_5	D	<<ah, what'll I write?>> ((coughs))	D" D
	242_1_6	D	while he improves his compliance.	
	243_1_1	P	( )	
	244_2_1	D	No-one else is going to read it.	other clinician

This choice of action type + mood projection acts in rapport with other choices (cf. Whorf, 1956) to construe the semiotic agency of the decision as largely external to Michael and traceable to Trevor, either as Michael's individual doctor, or as part of the institution of HIV medicine (the likely source of extrinsic modality in "need", and implied source of permission in "ask"; also the implied arbiter in the nominalisation "compliance"; see Candlin, Moore & Plum, 1998). Thus despite the strong sense of joint responsibility and action that runs through this text, there is some level of conflict about the roles that are appropriate for each interactant.

Such conflict can be read as competing interest, and interpreted as a threat to patient autonomy on the one hand or doctor authority on the other. Alternatively, the ever-presence of the institutional other can be taken as a resource which may

enhance the patient's capacity to act to maintain and improve their health, which is arguably how Trevor and Michael construe it. This is perhaps the kind of "alternative model of agency" the HIV researchers Race and colleagues had in mind in the quote with which I opened this paper. Across my corpus of HIV consultations, it is this model of agency which appears to be associated with doctors and patients practising shared decision-making, rather than a model in which patients maximise their own agency through unfettered control, or one in which they fully comply with the goals of authorities.

CONCLUSIONS

As Ahearn points out (2001, p. 112), "scholars often fail to recognise that the particular ways in which they conceive of agency have implications for the understanding of personhood, causality, action, and intention". Linguistically explicit but narrow grammatical approaches do not capture the resources used to construct agentive selves in HIV contexts. We saw this demonstrated in accounting for conflicting construals of agency that make for an equivocal sense of shared decision-making in a "live" discussion about treatment between Michael and Trevor.

The grammar of agency has been given considerable attention within linguistics, and articulated from a number of perspectives, including systemic functional grammar's productive perspective of complementarities in the grammar of agency. As I have argued, and as the textual examples demonstrate, language users draw on linguistic patterning at various levels of discourse organisation in construing agency, not just at the grammatical level; yet the grammar has had to bear the burden of description (Butt, 1988, 2000; *cf.* Martin, 1992).

Attempts to address this problem have made important advances but have often underexploited the explanatory power of making statements at different orders of abstraction, and of allowing the alignment between strata to carry more of the load. I have argued for an approach to the semantics of agency which shows how a range of dispersed phenomena are integrated to construe agency and enact agentive roles. Such an approach allows for contextually sensitive ways of construing agency and hierarchical relations (cf. Iedema, 1997; Thompson, 1999). In the present context, we find that semiotic action is a dominant motif (Jakobson, 1978) through which agency is negotiated.

According to Coupland (2001, p. 16), it should be possible "to develop much more differentiated and hence, arguably, *better social theoretic accounts* of structure and agency, through ... analysis of local practices of talk" (emphasis in original). Despite limitations of this study and of how much I was able to present here, I hope to have shown that a close analysis of the linguistic patterning of agency allows us to identify the importance of doctors and patients construing

the patient as a valid and semiotic agent, in enhancing the valued practice of shared decision-making. At the same time, this study can serve as a resource for problematising what may turn out to be inappropriate models of social agency in crucial sites like health care.

NOTES

1 It should be noted that Martin (2000) calls for a more polysystemic approach.
2 It has not been possible to generalize realization rules for the semantic categories used in this discussion, though see Moore (2003) for more details. I acknowledge this as an important challenge.
3 This interpretation is motivated on the basis that implicit subjective modality of obligation "You need to..." is related to the explicit subjective modality of obligation "I insist that you ..." (see Matthiessen, 1995: 498) and in turn to the imperative mood.
4 The doctoral work and broader study were funded by the National Health & Medical Research Council of Australia. Pseudonyms have been used for doctors and patients.
5 The databases were based on an early version of SysAm by Christian Matthiessen and Wu Canzhong, Macquarie University. Additional customizing by Jason Grossman, Annabelle Lukin and myself.
6 One reading of the doctor's turn 191 is as a series of nested projections; another is as a complex equative (see Moore, 2003, ch. 6).

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