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Olga Zayts and Stephanie Schnurr

"[She] said: 'take the test' and I took the test". Relational work as a framework to approach directiveness in prenatal screening of Chinese clients in Hong Kong

Abstract: In this paper we apply the framework of relational work, or the work individuals invest in maintaining their relationships (Locher and Watts 2005), to the analysis of prenatal screening (PS) for Down Syndrome of Chinese clients in Hong Kong. PS has traditionally followed a nondirective principle that calls for an unbiased presentation of information and women's autonomous decision-making regarding testing. However, in Chinese contexts, healthcare providers appear extremely directive; and women, in turn, explicitly express their expectations of being led in decision-making (Zayts et al. 2013). These observations lend support to previous politeness studies of Chinese institutional contexts wherein hierarchical communication has been described as "listening-centered, asymmetrical and differential" (Gao and Ting-Toomey 1998: 48). More recent politeness studies, however, warn against such stereotyping at a cultural level (Eelen 2001; Mills 2003, 2004; Watts 2003). In this paper, rather than using culture as an *a priori* explanatory variable to account for the directive stance of the healthcare providers, we argue that using the framework of relational work enables researchers to focus on how meaning is created and negotiated at the micro-level of an interaction, and to move away from "grand generalizations" about culture specific behaviors and expectations.

Keywords: relational work, politic behavior, Chinese institutions, Hong Kong, prenatal screening, (non)directiveness

Corresponding Author: Olga Zayts: Department of Linguistics, School of Humanities, University of Hong Kong, Pokfulam Road, Hong Kong, e-mail: zayts@hkucc.hku.hk
Stephanie Schnurr: e-mail: ■

1 Introduction[1]

In this paper we examine the context of prenatal screening (henceforth, PS) in Hong Kong, where pregnant women receive information about tests for Down syndrome and make a decision whether or not to pursue these tests. We focus on the core professional tenet of nondirectiveness that calls for an unbiased and non-imposing presentation of the information needed to enable pregnant women to make a decision reflecting their own values and judgments (White 1997; Marteau and Dormandy 2001). In our previous work on nondirective counseling we have argued that in counseling of Chinese clients in Hong Kong, healthcare professionals often hold back from nondirectiveness because of the institutional context where these encounters take place and the sociocultural expectations of the participants (Zayts et al. 2013). In this paper we take this discussion one step further and propose that the framework of relational work (Watts and Locher 2005) provides a very useful interpretative approach to understand the directiveness of the healthcare providers' discourse and to critically explore the role of cultural expectations and norms in this designated context. In particular, it enables the researchers to focus on how meaning is created and negotiated at the micro-level of an interaction, and to move away from "grand generalizations" about the impact of culture specific behaviors and expectations.

The framework of relational work takes Brown and Levinson's (1987 [1978]) politeness theory as its starting point. It argues that as comprehensive as Brown and Levinson's theory is, it is not a politeness theory *per se*, but a theory of facework that deals with the mitigation of face-threatening acts (Locher and Watts 2005). It does not include those behaviors where face-threat mitigations are not of concern, for example, where participants' behavior is perceived as "appropriate" or "unmarked" (Locher and Watts 2005: 10). What is appropriate in a designated context is discursively negotiated by participants in an interaction through "relational work", or "the 'work' individuals invest in negotiating relationships with others" (Locher and Watts 2005: 10). Locher and Watts (2005) refer to "appropriate" or "unmarked" behavior as "politic"; a term introduced in Watts' earlier work (1989: 135) and defined as "socio-culturally determined behavior[s] directed towards the goal of establishing and/or maintaining in a

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state of equilibrium the personal relationships between the individuals in a social group, whether open or closed, during the ongoing process of interaction."

By applying the framework of relational work to the context of genetic screening, we shall argue that although it contradicts the tenet of nondirectiveness widely endorsed in the genetic counseling profession in Western countries, and may be perceived as "inappropriate", the directiveness of the healthcare providers' discourse is constructed as politic behavior among participants in most of those consultations between Chinese healthcare providers and clients. In what follows we first discuss the research that has looked at what constitutes polite and politic behaviors in institutional encounters in Chinese contexts before outlining some issues with nondirectiveness as the tenet of genetic counseling and providing further details of the context of PS where this study is set. We then proceed to the analysis of three extended examples from three "crucial stages" (Sarangi 2000: 16) of PS that are representative of our data corpus, namely information-giving, advice-management and decision-making, focusing on how the healthcare professionals' directiveness is discursively negotiated and agreed on by participants.

2 Social interactions in Chinese institutional contexts

As Kádár and Bargiela-Chiappini note, in institutional interactions where participants often display asymmetrical relationships "failure to 'be appropriate' (or 'politic', cf. Watts 2003) can easily result in communication breakdown" (Kádár and Bargiela-Chiappini 2011: 1). They further note that in the "status-sensitive East Asian social context, 'polite' – or, technically speaking, 'politic' – behavior is particularly complex in institutional settings" (Kádár and Bargiela-Chiappini 2011: 1).

The sensitivity to the relative power of the interlocutors in social interactions has also been noted in earlier studies (e.g., Gao and Ting-Toomey 1998; Yu 2003). Gao and Ting-Toomey (1998), for example, describe interactions displaying hierarchical relationships between the participants as "listening-centered, asymmetrical and differential" (Gao and Ting-Toomey 1998: 42). These asymmetries are manifested, for example, in the extensive use of directives by interlocutors in a power position (Lee-Wong 1999), and in the indirect language use by the subordinates (Young 1994; Gao et al. 1995). In medical settings the asymmetrical relationships between healthcare professionals and patients/cli-

ents have been highlighted as the "voice of medicine" and the "voice of lifeworld" in a now seminal study by Mishler (1984), which has sparked much subsequent discussion on the subject (see, for example, Elwyn et al. 1999; Cordella 2004; Collins et al. 2005). In respect to Chinese institutional contexts, Bennett et al. (1999) maintain that the socially regulated hierarchical relationship "has obvious consequences for the way people enact their institutions, organizations, and ideologies, including health care" (Bennett et al. 1999: 264). Relevant to the context of prenatal screening where pregnant women make decisions about prenatal tests is another observation in an earlier study by Hofstede (1983), who suggests that the hierarchical relationship and the collectivistic nature of the Chinese culture serve as the key factors determining how and by whom decisions are made. Indeed, studies have pointed to patients' expectations for directive treatment and being told what to do (Johnson and Nadirshaw 2002). For example, patients in Hong Kong, when compared with patients in the USA, have been reported to express stronger negative beliefs about patient participation and were generally less assertive in consultations (Kim et al. 2000).

While these studies seem to support claims that participants display socioculturally influenced behaviors in hierarchical interactions, more recent politeness research warns against making *prima facie* generalizations or stereotyping at a cultural level (e.g., Eelen 2001; Mills 2003, 2004; Watts 2003). In particular, it has been argued that cultural norms may not always be recognized as "politic" and "appropriate" by all interactants. Rather, what is considered to be "politic" is dynamically negotiated among participants as the interaction unfolds. Thus, rather than viewing culture as a static construct, more recent approaches take a more "dynamic view of culture" (Sarangi 1994: 416) and focus on how cultural norms and expectations may be oriented to, reinforced, challenged, contested, and so on by participants throughout an interaction. They move away from culturally motivated generalizations and instead explore how interlocutors actually "mediate, negotiate and modify the values, beliefs, norms, attributes and language that they bring along into the conversation" (Cheng 2003: 10).

The framework of relational work, we believe, provides a useful guideline for such an approach as it encourages analyses that view both politeness and culture as discursive constructs. As such, it allows the analysts to explore how participants' hierarchical relationships and the sociocultural norms of the context in which an interaction takes place are discursively constructed and evoked (or not) at any point in the interaction. The focus is thus on how these contextual aspects are *actually* attended to and negotiated in the moment-by-moment interaction in order to achieve participants' interactional goals and to maintain

their "equilibri[ous]" (Watts 1989: 135) relationship. In other words, rather than using culture as an *a priori* explanatory variable, the framework of relational work enables us to move away from potential (over)generalizations of the impact of culture towards an understanding of how meaning is dynamically created and negotiated among participants in real time through talk.

3 Nondirectiveness as the tenet of genetic counseling

While nondirectiveness has historically been adopted as a guiding tenet in a broader context of genetic counseling, an increasing number of studies have questioned its attainability in practice (see, for example, Gervais 1993; Shiloh 1996; Anderson 1999). The heartfelt dilemma many healthcare professionals have reported is balancing nondirectiveness with providing the best possible support for their clients (e.g., Burke and Kolker 1994; Brunger and Lippman 1995). Being nondirective has been equated with, for example, ignoring clients' needs, or as Bosk vividly puts it, "the dark side of patient autonomy [is] patient abandonment" (1992: 158).

In response to these expressed doubts, several alternative models of genetic counseling were formulated (e.g., a shared decision-making model [Elwyn et al. 2000] and a psychosocial approach to nondirectiveness [Weil 2003]); each in part describing to what extent nondirectiveness should count as a guiding principle of the profession. These studies noted that the principle of unqualified nondirectiveness may not *always* be in the client's best interests. Kessler (1997), in his now seminal work, has argued that nondirectiveness is an *active* relationship between the healthcare provider and the client evoked and developed in the counseling session. The healthcare provider should appeal to the client's "competence and ability for self-direction" (Kessler 1997: 169).

Another difficulty that healthcare professionals have been reported to face is related to the question of how nondirectiveness is actually enacted in practice. For example, counselors have been shown to conflate nondirectiveness with indirect language (e.g., Benkendorf et al. 2001: 199). These may lead to undesirable outcomes, such as impeding clients' understanding (Benkendorf et al. 2001; see also Zayts and Kang 2009). For example, when counselors use generic nouns, such as "some people" or "most people", clients may face difficulties in inferring which utterances apply to them or, indeed, they may assume that "what most people do" is what they should also do (Benkendorf et al. 2001; Pilnick 2002). On the other hand, studies have shown that the use of

indirect language does not prevent professionals from directing their clients towards particular decisions through, for example, particular structuring of information and foregrounding the tests of their preference (Zayts et al. 2013). Therefore, nondirectiveness and directiveness have to be understood in a broader sense as a stance that professionals take towards information-giving and genetic screening and testing. It is this broader understanding of nondirectiveness that we apply to the analysis of our data.

4 Data and Methodology

The data for this study comes from a larger study of PS conducted at one prenatal hospital in Hong Kong in 2006–2012. The corpus includes 120 video-recorded consultations between healthcare providers and pregnant women. Five healthcare providers (4 obstetricians and 1 obstetric nurse) participated in the study. All the healthcare providers were Hong Kong Chinese. The women recruited for the larger study originated from more than 20 countries around the world, in South Asia, North and South America and Europe.

PS in Hong Kong is part of prenatal services provided to all pregnant women. The tests that are offered to pregnant women include: 1) screening tests (blood test and nuchal measurement); and 2) diagnostic tests (CVS or amniocentesis).[2] Women may also opt out of testing if they wish. While screening tests are safe to the fetus, they do not have a 100 % detection rate. Diagnostic tests offer a higher detection rate (nearly 100 %) but pose a potential risk of miscarriage. Typically, pregnant women are offered diagnostic testing if their screening results indicate a high risk (1 in 250 or below) of having a Down syndrome baby. Noteworthy is the fact that there are very few Board-certified genetic counselors in Hong Kong, and the role of genetic counselors is taken up by obstetricians and midwives. Some of them may have received additional training in counseling. This situation may have implications that are relevant to our focus on relational work in these encounters. First, the pregnant women may have met the healthcare providers in the hospital previously during their routine prenatal visits and may have established some kind of rapport or trust with them. Second, when PS services are provided by the same medical personnel as routine prenatal services, the women may conflate the two, and the

2 CVS is a procedure in which a needle is inserted into the placenta under the ultrasound guidance and a small amount of chorionic villi (placental tissue) is aspirated for chromosomal study. Amniocentesis involves inserting a needle into the mother's uterus to withdraw 20 ml of amniotic fluid.

medical agenda (that is, taking the test) may take precedence over the psychosocial or counseling agenda of these encounters (i.e., facilitating women's informed decision-making) (see Zayts et al. 2013 for further discussion).

The primary data for this study comprise 24 consultations (with an overall recording time of more than 8 hours) where participants are Cantonese[3]-speaking pregnant women and their husbands (referred to as HP, W and H accordingly in the transcripts). In our study, the recruitment of Cantonese-speaking women started later than that of English-speaking women; therefore, the corpus contains a smaller number of consultations involving Cantonese-speaking clients. However, Cantonese-speaking clients comprise the majority at the hospital where the study is set. Table 1 provides simple statistics for clients who received PS services in 2007–2009:[4]

	Chinese	Non-Chinese	Total number
Total number of clients ±35 years old seen at the hospital	(the breakdown by nationality is not available)		10487
Clients who consented to PS	2602	2323	4925
Clients who were screened positive	262	37	299
Clients who opted for further diagnostic testing (after being screened positive)	131	11	142

Table 1: Clients who received PS services in 2007–2009.

Table 1 indicates that out of 10487 women who received PS services, 2602 Chinese and 2323 non-Chinese women 35 years old or older consented to PS (4925 of women in total). Among those women who consented to PS, 262 Chinese and 37 non-Chinese women received a positive screening result (299 of women in total). 131 Chinese women and 11 non-Chinese women (142 women in total) have consented to further diagnostic testing.

The secondary data for the study comprise interviews with recruited women that a research team member conducted prior to and after the consultations. In the interviews the researchers collected the demographic information about the participants and their feedback on the consultations. We also interviewed the

3 Cantonese is one of the two official languages (along with English) spoken in Hong Kong.

4 During the writing of this paper, the screening program in Hong Kong underwent a reform: before July 2010 only women ≥ 35 years old at delivery were offered prenatal screening. The statistics, therefore, only includes women of this age group. From July 2010, the number of women undergoing screening at the hospital has increased; however, the statistics are not available.

healthcare providers and obtained information about their background and professional training, and the medical agenda of the PS consultations. We selectively draw on the interview data, in particular in our analysis of the participants' expectations of these encounters. In addition, we have studied the institutional guidelines and regulations that apply to the provision of PS services. While these guidelines contain detailed flowcharts of the activities of PS (e.g., medical history taking; provision of information about tests), the interviews with the healthcare providers have revealed that the providers have flexibility in how they choose to present the information to their clients. In other words, the healthcare providers are not legally or institutionally obliged to adhere to a strict protocol in these encounters on the understanding that they strive to ensure that the clients are fully informed about possible screening and testing options before they make a decision.

Following a standard Ethics Committee approval by the lead author's institution and the hospital where the study was set, the data were video-recorded and transcribed using simplified transcription conventions traditionally used in conversation analytic studies (see Atkinson and Heritage 1984: ix–xvi for details). The analysis of the extracts in this paper is accompanied by the English translations first done by a bilingual research assistant and then verified by a bilingual research team member.

We employ the framework of relational work (Locher and Watts 2005); relational work represents a continuum of verbal behavior ranging from negatively marked non-politic/inappropriate impolite to negatively marked non-politic/inappropriate overpolite. Politic/appropriate behavior is either unmarked or positively marked, depending on whether it is perceived as non-polite or polite, respectively. In contrast to Brown and Levinson's Politeness Theory (1987 [1978]), the framework of relational work thus provides further insights into the realm of politic or appropriate behavior by distinguishing between non-polite and polite behaviors. It is thus particularly useful for investigations of appropriate, unmarked behavior that normally goes unnoticed in an encounter. Following Locher and Watts' claim that it is possible to "specify the 'appropriateness' of an interaction under analysis before [...] salient behavior can be identified" (Locher and Watts 2005: 17), we use the framework of relational work here to explain why certain behaviors are constructed as appropriate and politic by interlocutors although they may be perceived as marked and inappropriate from an outsider's perspective.

Locher and Watts (2005: 17) further argue (borrowing Bourdieu's term "habitus") that the "appropriateness is determined by the frame or the habitus of the participants [...] within which face is attributed to each participant by the others in accordance with the lines taken in interaction". In other words, partic-

ipants' habitus depends to a large extent on the specific structures and expectations of what normally constitutes appropriate and normal behavior in a specific context. To define the "habitus" or normal practice and expectations of the participants in the PS encounters in our data we first examine relevant contextual information derived from the interviews with the participants and intensive participant observations conducted at the research site. These supplementary data enabled us to specify the "social frames, social norms and social expectations" (Locher and Watts 2005: 16) that the participants orient to in the PS consultations. They enabled us to define what behaviors are considered to be "appropriate" and "politic" by the participants. We then examined the interactional data to explore how these "politic" behaviors are discursively enacted and negotiated amongst participants.

5 Prenatal screening in Hong Kong

The interviews with the pregnant women have revealed a high expectation (in 50 % of the data) of being led in the decision-making (for a more extended discussion, see Zayts et al. 2013). The women commented on the professional knowledge and experience of the healthcare providers, and perceived them as being in a position to help "solve [their] problems" (interview data with one of the participants) and to give advice. The healthcare providers, in turn, expressed a strong orientation towards advising the patients to take a test. While they all acknowledged that women had the right to make their own decisions, including refusing testing, they also described taking screening tests as the option that is "in the best interests" of their clients. The fact that the PS consultations are conducted on the premises of a prenatal hospital by the same healthcare professionals who are involved in the provision of routine prenatal care may also impact the healthcare providers' predisposition towards taking tests; and the women's orientation towards the healthcare providers' advice. Therefore, these supplementary interview data point to the participants' orientation towards a more directive approach by the healthcare providers. In what follows we look at how the healthcare providers' directive stance is discursively constructed as "appropriate" and "politic" by participants in all three stages of the PS, including information-giving, advice management and decision-making (Sarangi 2000). We provide a representative example and discuss each stage in turn.

5.1 Information-giving stage

At this stage the healthcare providers inform the pregnant women and their husbands about available tests, their benefits and drawbacks; as well as costs and timing when they can be performed. The information-giving stage is preceded by the client watching a 15-minute video about Down syndrome. According to the interviews with the healthcare providers, the video exposes the clients to the information for the first time; and the purpose of the face-to-face information delivery is to ensure that the information is fully understood. It is not uncommon for the clients to arrive in the clinic having already decided what tests they would like to pursue, in particular in cases when clients are familiar with PS services from their previous pregnancies. We have noted a tendency in Chinese clients (in 74 % of cases) to opt for amniocentesis due to the high detection rate of this method. Due to the risk of miscarriage that the method poses, however, the healthcare providers in *all* cases in the corpus make sure that they introduce the benefits of having screening tests first, as Example 1 illustrates.

(1) Example (HP: healthcare professional; H: husband; W: woman)
Context: This is the woman's third pregnancy. Before the consultation she has decided to take an amniocentesis as she took the test in her previous pregnancies.

1. HP: 咁另外抽胎水個日呢，我哋就會同你詳細咁睇超聲波。.h咁或者你對篩查冇咩興趣，但係講一講比你聽啦。篩查呢個(.)作用呢，其實就係再重新計過你個唐氏綜合症既機會有幾大。咁初步嚟睇你年紀嗰度呢，就話你一百分之一機會呀嗎，咁就咁睇年紀一樣嘢。.h咁其實如果我哋睇多幾樣野個準確性會高啲，八十個percent既，.h就睇年紀啦吓，詼同埋睇bb呢個既頸嗰陣時既厚度，加埋你血液個度，計埋一條數再係–用電腦分析計到條數出嚟呢就睇你有唐氏綜合症既機會係大定係細。假如驗出嚟既機會大呢,就叫你做羊水。
   On the day you do the amniocentesis, we'll look at the ultrasound in detail. .h Maybe you're not interested in the screening test, but I'll tell you about it. The purpose of the screening test is (.) to re-calculate the chance of Down syndrome. Initially by looking at your age, you have a chance of one in one hundred, that is by only looking at your age. .h If we look at more things, the accuracy will be higher, eighty percent then. .h Considering the age, er and the baby's nuchal thickness together with the blood, (.) the result is calculated. Using the computer to analyze the calculation to see whether the chance of Down syndrome is large or small. .h If the chance is tested to be high, we will ask you <for amniocentesis>.
2. H: 唔唔。
   Um um.

3. HP: 吓。驗出嚟既機會細呢就唔做其他檢[驗。
Right, if the chance is tested to be low then we won't do other tes[ts
4. H: [唔唔。
[Um um.
5. HP: 吓。.h 咁個準確性係八十六個percent。好處呢就係安全。你對-
有冇興趣做嗰個 篩查呀 .hhhhh
.h The accuracy is eighty-six percent. The advantage is that it's safe. Are you interested in (.) doing the screening hhhhh
6. H: [.hhh
[.hhh
7. W: [.hhh
[.hhh

The healthcare provider's awareness of the woman's preference to take an amniocentesis test becomes apparent at the beginning of the extract, when she states, "Maybe you are not interested in the screening test, but I will tell you about it" (turn 1). She takes a directive stance by affirmatively stating that she will tell the patient about the screening test regardless of the woman's preference. The directiveness is also evidenced by how the healthcare provider frames the conditions under which amniocentesis will be offered, namely if the screening test results place the woman in a high-risk group. These conditions are medical, and by saying that "we will ask you for amniocentesis" ("we" here referring to healthcare providers as hospital representatives), the healthcare provider thereby excludes the woman and her husband from the decision-making. The healthcare provider is also directive in stating that if the screening test results are normal, then no further tests will be performed (turn 3). The healthcare provider sums up her presentation of the screening test by stating its benefits, the accuracy rate and the safety, and she addresses a direct question to the couple about whether they are interested in taking the screening test (turn 5). The question is adjoined by laughter particles that may signal here the healthcare provider's awareness of her proposition being different from the couple's initial choice (Glenn 2003; see also Zayts and Schnurr 2011). And while the healthcare provider is being directive in the extract, the woman and her husband are not actively involved in the interaction: their verbal participation is limited to minimal acknowledgements (turns 2 and 4), and overlapping laughter in response to the healthcare provider's laughter (turns 6 and 7). While minimal responses and laughter may convey a range of meanings here (including resistance to the action being proposed [Glenn 2003; see also Zayts and Schnurr 2011]), what is important is that the couple is *not actively* opposing the healthcare provider's talking about and suggesting the screening tests. Therefore, the directiveness of the healthcare provider's discourse could be inter-

preted to a certain extent as being co-constructed by the participants as appropriate politic behavior in this interaction. And although it could be argued that in this example, participants seem to conform to cultural stereotypes that would suggest that Chinese people tend to respect and conform to the hierarchical relationship between healthcare providers and clients in an institutional setting (Yu 2003; Gao and Ting-Toomey 1998), we would argue that such an interpretation is too simplistic and does not take into account dynamic enactments of culture. Moreover, such an overgeneralization is challenged by those instances in our data where the couples do not follow the healthcare providers' advice.

The next extract is taken from the advice management phase of the consultation. It presents an example where the woman is eliciting advice from the healthcare provider. Instances of advice elicitations create favorable grounds for suggesting a specific course of action to the clients: by eliciting advice the clients construct themselves as lacking some knowledge or expertise, which at the same time constructs the healthcare providers as being in a more knowledgeable and expert position. Perhaps it is not surprising, therefore, that instances of advice elicitations enable the healthcare providers to take a more directive stance.

5.2 Advice management

In the data instances of advice-giving may occur at different stages of a consultation. They can be either elicited by clients or initiated by healthcare professionals. In a genetic counseling setting, any information presented by the healthcare providers may potentially be taken as advice by the clients (Sarangi 2000). What does and does not constitute advice, therefore, is difficult to distinguish. Pilnick (1999) maintains that advice contains a normative dimension, because it posits a certain possible or preferable course of action. While in previous research on advice-giving in counseling contexts professionals have been reported to be at pains to evade it and to employ a range of discursive strategies to avoid being directive (see, for example, Silverman 1997; Pilnick 1999), this is not the case in our data, where the healthcare professionals may frame a course of future actions for the clients, as Example 2 illustrates.

(2) Example (HP: healthcare professional; H: husband; W: woman)
Context: This is the woman's first pregnancy. The husband, who is also present at the consultation, has a younger brother with Down syndrome; he is not sure, however, whether the condition is due to an additional chromosome. If the brother has an additional chromosome, then the condi-

tion is not hereditary in which case there would be no need to perform any additional tests on the husband or the baby.

1. W: 係咪要差唔多3個月，宜家要開始做・啦，度頸皮呀?係啦，喺人話呢好似話要3個零月開始就要[(.)做嘛。唔可以太大。
   Is it around 3 months, I need to start doing it now, measuring the nuchal skin? Yes, people said like starting from the 3rd month we need
2. HP: [(.)to do it. It is not too large.
   [係，即如果係:想知・ [呢，
   [yes. If you want to know [then,
3. W: [諗諗.
   [Huh huh.
4. HP: 噉: 諗就可以有一個，即唔哂抽bb組織嗰度既[方法既。
   So er we can have a, that's a way of not extracting the baby's tissue.
5. W: [諗 諗諗
   [Huh huh huh
6. HP: 噉就係綜合度頸皮啦，同埋譬如你今日驗血，
   To combine the measurement of the nuchal skin, and for example if you do the blood test today,
7. W: 唔: 唔:。
   Um: hm:.
8. HP: 噉然之後呢就可以睇，都有9成準既，
   And then we can see, it is 90% accurate.
9. W: 啊:
   Oh:
10. HP: 即睇bb有呢個唐氏個機會會係高一或低囉。
    That's to see whether the baby's chance of Down syndrome is high- or low.
11. W: 唔: 唔:。
    Um: hm:.
12. HP: 吓。
    Huh.
13. W: 唔唔。
    Um hm.
14. HP: 噉可以做咗呢度先啦，噉我哋就可以 in the meantime 再安排你下一次再返嚟照超聲波，
    So we can do this first, we can in the meantime further arrange for you to do ultrasound when you come back next time,
15. W: 啊，好呀[好呀。
    Oh, sure [sure.
16. HP: 即- 即係嗰個就唔關唐氏綜合症[事既
    That-that's it is not related to Down syndrome.
17. W: 啊。
    Oh.
18. HP: 即睇結構個度。
    That's to see the structure.
19. W: 好呀好呀。
    Sure, sure.

20. HP: 噉呢段時間我哋就問一問兒科醫生，(0.5) 諗細佬
During this period of time we will ask the pediatrician, (0.5) er about whether your brother
21. W: 唔。
Um.
22. HP: 係47條染色體呀，一或係46條染色體
Has 47 chromosomes, or 46 chromosomes
23. W: [º啊::º.
[ºOh:º.
24. HP: 如果佢係47，我哋唔需要進一步做其他野囉。
If he has 47, we don't need to do anything further.
25. W: 啊:
Oh:
26. HP: 吓，如果係: h唔::
Huh. If it's: h um::
27. W: 46就[要。雙數要。
46 then [we'll have to. For an even number we'll.
28. HP: [46・呢，我哋驗咗先生先，
[46, we need to test the husband first,
29. W: 啊。
Oh.
30. HP: 如果先生染色體無事既話，噉就唔需[要:
If the husband's chromosomes are fine, then there's no [need:
31. W: [啊::
[oh::
32. HP: 進一步囉。
To see further.
33. W: 明啦明啦。
I understand I understand.
34. HP: 得唔得呀?
Is that okay?
35. W: 啊，okay。
Oh okay.

The woman's question whether the nuchal measurement is performed around the third month of gestation comes after the healthcare provider has delivered the information about the screening tests to the couple (turn 1). The healthcare provider first confirms this information and then states that the test can be arranged if the woman "want[s] to know" (turn 2), thereby constructing the woman as the main decision-maker. She also provides information about the safety of the test, namely that it does not involve extracting the baby's tissue (turn 4).

From turn 6 onwards, the healthcare provider's discourse becomes increasingly directive as she starts to outline the possible course of action to the couple. Building on the woman's question about the nuchal test, the healthcare

provider starts talking about an integrated test that combines the nuchal measurement and the blood test to achieve a higher detection rate (of 90 %). She mitigates her suggestions to take a blood test on the day of the consultations by presenting it to the couple as an example (turn 6) that will allow seeing whether a chance of having a Down syndrome baby is high or low. From turn 14 onwards, the healthcare provider presents the couple with a detailed course of action in a "list format", assuming they have agreed to the integrated test: the woman can take an integrated test, and have an ultrasound to check the baby's structural development (that is not related to Down syndrome) (turns 14 and 16). At the same time a pediatrician will be contacted to check whether the condition of the husband's brother is chromosome-related (turns 20–22). If the brother is confirmed to have 47 chromosomes, then no further tests will be performed (turn 24); if he has 46 chromosomes, then the husband will be tested further (turns 26 and 28); if the husband's test results are fine, then no further tests will be performed (turns 30 and 32). By using "we" in the suggested course of action the healthcare provider actively constructs herself as a co-decision-maker.

The directiveness of the healthcare provider's discourse is co-constructed by the couple who issue minimal acknowledgements when the healthcare provider starts talking about the integrated test, and then express their affiliation with her proposed plan of action more explicitly through lexical means, "oh sure sure" (turn 15), "sure, sure" (turn 19), "okay" (turn 35) and turn co-completion and co-construction (turns 26, 27 and 28). The couple's minimal responses and their compliance with the proposed course of actions may in part be accounted for by a highly sensitive and potentially emotionally charged situation such as PS. The clients' minimal participation is, however, typical of our data, as is the fact that the healthcare providers generally take on a more directive stance on that basis of lack of/minimal responses and/or uptake of information from the clients (for a more extended discussion see Zayts and Pilnick 2013). This extract therefore demonstrates that while the healthcare provider takes a very directive stance by outlining a specific course of action to the couple, this directiveness is considered to be "appropriate" and "politic" by the couple who do not question or resist the proposed course of action but instead signal their agreement (for a detailed discussion of advice-management instances when advice is elicited by clients see Zayts and Schnurr 2012).

The next extract is taken from the decision-making stage and demonstrates a misalignment of the healthcare provider's and the client's agenda regarding the tests: while the couple would like to pursue amniocentesis to get definitive results, the healthcare provider does not consider it a "worthy" option unless indicated by a positive screening test report. The example is particularly inter-

esting as it contains explicitly "salient verbal behavior" (Locher and Watts 2005: 16–17) of the couple opposing the healthcare providers' suggestions. It thus nicely illustrates how notions of "appropriate" and "politic" behavior are dynamically constructed and negotiated among participants.

5.3 Decision-making stage

At this stage the clients make a decision whether they would like to pursue screening or testing for Down syndrome.

(3) Example[5]

Context: The extract occurs after the healthcare provider has introduced the screening test to the couple. Before the consultation the couple has stated their decision to take an amniocentesis.

1. HP: 係喇。 咁::你有無改變主意呢?
   Right. So: have you changed your mind?
2. (1.5)
3. W: 即係就如果個-呢個咁既s即係呢個篩查啦[吓:
   That is if I- this s that is this screening test,
4. HP: [唔。
   Hm.
5. W: 如果係個:嗰個um (TSK)成數低呢:
   If it is the er (TSK) possibility is low
6. HP: 唔。
   Hm.
7. W: 咁我都可以做羊水嫁嗎:
   I can also do amniocentesis, right?
8. HP: Er通常我哋係安排一個檢驗:
   Er usually we arrange one testing.
9. H: .hhhhhh ((laughs))
   .hhhhhh ((laughs))
10. W: [一個一係羊水一係呢個
    One. Either do this or the other one?
11. HP: 係呀
    Yes.
12. H: .hhhhh hehehe
13. HP: 因為既然個報告都話係正常,其實就真係都係唔建議你.hh唔建議你做:胎水囉.因為始終譬如你做出嚟個機會率係好細既話,因為[做胎水係有一個
    Because since the report is normal, actually we really do not recommend you .hh to recommend you to have amniocentesis. Because all along for example if your possibility is very low, because [amniocentesis (has a)

5 Part of the example is also analyzed in Zayts et al. (2013).

14. W: [好細都有機會有呀媽:
[very small means there is still a chance of having it.
15. H: 唔咪,[胎-唔咪
No the [fetus no
16. HP: [你又講得啱呀:但係嗰個對比你小產既機會就係:個小產機會大過你er唐氏綜合症既機會呢,°(我就覺得)唔值得做囉°。
[you are right, but for example when that compared to your miscarriage chance is: the chance of miscarriage is greater than your er chance of having Down syndrome, °(I feel that) it isn't worth doing it°.
17. H: 唔唔。
hm hm.
18. W: °咁點呀°?
So what should we do?
19. H: 唔?羊水.
Eh? Amniocentesis. ((pointing to the paper))
20. W: 吓?
Eh?
21. W: 羊水. 抽羊水.
Amniocentesis. Do the amniocentesis.
22. W: 有機會無嫁.
But it would carry a risk of miscarriage.
23. H: 唔?一次過做呀嗎:
Um. Because it gets done at one time.
24. W: 吓?
Eh?
25. H: 一次過做呀嗎:
Because it takes one time to complete:
26. W: 有機會[無嫁wor.
But it carries a risk of [miscarriage.
27. H: [既然-既然你頭咁講啦,你-即係你做完之後,你可能最後又擔心剩返嗰可能10零個percent都有機會有既話呢,吓,我就覺得就直頭唔好做依個喇,無謂即係攪兩次喇第一樣野,同埋你就算做咗你-你都擔心嗰10幾個percent嗎:
[Since- since you said just now, you- that is after doing it, you may still worry about the remaining ten odd percent chance of having Down syndrome, I feel it's better not to do this one, no need to test twice for the same thing. And even though you have done it, you're worried about the ten odd percent right?
28. W: 唔唔.
Um um.
29. H: 咁意義唔太大。
So it doesn't make much sense.
30. W: °唔: 咁[做羊水啦:°
°Um: Then [do the amniocentesis.°
31. HP: [°你點睇呢.°
[°What do you think.°
32. W: [.hhh ((P laughs))
[.hhh ((P laughs))

33. HP: [.hhh ((laughs))
[.hhh ((laughs))
34. H: This one, [of course.
This one, [of course.
35. HP: [你好似,太太好似有d想做篩查係咪呀?
[You seem- Mrs. seems to like to have the screening test, is that right?
36. W: 我做羊水啦,其實一開始$都係諗住$做羊水嫁啦:
I'll do amniocentesis then. Actually at the beginning I $thought of $ amniocentesis anyway.
37. HP: 你嚟之前,頭先你同我講過你想做羊水。=
Before you came, previously you told me that you'd like to have the amniocentesis.=
38. H: =係呀.
=Yes.
39. HP: 咁啦: 因為依家依家到 um 做羊水都有段時[間啦。
How about this: because from now-now till the time for amniocentesis there is still [time.
40. H: [唔。
[hm.
41. HP: 咁你返去諗吓囉,如果真係想改既咁你咪話返比[我哋聽囉。
So you'll go home and think about it. If you really want to change, then you can [tell us.
42. H: [Okay。
[Okay.
43. HP: 你都仲有幾日時間。
you still have time.
44. H: 唔唔
Um um.
45. HP: 唔唔
Um um.

In this example the healthcare provider takes a very directive stance: she explicitly asks the couple if they have changed their mind about taking the amniocentesis (turn 1). Following the woman's question whether an amniocentesis may be performed after the screening test, she unambiguously tells the couple that usually only one test is arranged, thereby encouraging the couple to make a choice (turns 8 and 11). She also frames the account of why amniocentesis should not be taken as a "recommendation" from the healthcare professionals (turn 13), and explicitly expresses her own preference by saying "(I feel that) it is not worth doing it" (turn 16). The couple then proceeds to the decision-making regarding what they should do (turns 18–30) (for an extended discussion of this part of the example see Zayts et al. 2013), confirming their initial choice to pursue amniocentesis.

This discussion is marked by what Locher and Watts (2005: 16–17) describe as "salient verbal behavior" as the couple openly contests the healthcare provider's "recommendation" to take a screening test. It is important to note, though, that this couple presents the only exception in the Chinese corpus and no other examples of open contestations have been found. Based on the argument that the screening test report is not entirely accurate, the husband affirmatively conveys the couple's decision to take amniocentesis to the healthcare provider (turn 34).

The healthcare provider, however, does not accept this decision at a face value and picks up on the woman's uncertainty regarding amniocentesis due to the risk of miscarriage, "You seem- Mrs. seems to like to have the screening test is that right?" (turn 35). By highlighting the woman's perspective (which she also favors) the healthcare provider, therefore, attempts to impact the couple's decision. When the woman explains that before the consultation she had planned to take an amniocentesis (turn 36), the healthcare provider employs another strategy that impacts the couple's future actions: she suggests that they should take some time to think over their choices (turns 39, 41 and 43). And while prior to this point in the interaction the couple has been very affirmative in pursuing their choice of an amniocentesis test and resisting the healthcare provider's suggestion about doing a screening test first, they do not object to this proposed course of action. Rather, the husband issues a minimal acknowledgement (turn 44) and the woman does not say anything.

The directiveness of the healthcare provider's discourse in this example is thus mainly constructed through her active engagement with the couple's decision-making by promoting the screening test option, aligning herself with the woman's uncertainties about amniocentesis and deferring the couple's decision until they think it over. It is important to note, however, that it seems that the couple are resisting the test that the healthcare provider is promoting rather than the directiveness of her actions, which is evidenced, for example, by their final agreement to think over their choice. Thus, like in the previous examples, the directiveness of the healthcare provider's discourse is constructed as "appropriate" and "politic"; although the couple do not necessarily agree with her suggestions they do not contest or question her (directive) way of conduct.

6 Discussion and Conclusions

This paper has started from the premise that in Chinese genetic counseling contexts healthcare providers tend to be directive while clients expect to be told what they need to do. This general claim is supported by a large body of litera-

ture on social interaction in Chinese institutional contexts and was also reflected to some extent in our data of prenatal screening in Hong Kong. In particular, studies have reported a tendency in Chinese institutional contexts to respect and uphold asymmetrical power relations and to transfer decision-making responsibilities to those in more powerful positions. In the context of PS of Chinese patients in a Hong Kong hospital we also found some of these tendencies enacted; particularly with regards to clients' expectations of receiving advice on which testing option (if any) to pursue. One of our participants nicely summarized this general expectation when she described to us how she arrived at her choice of which test to perform: "she [i.e., the medical provider] said 'take the test' and I took the test".

As we have argued throughout, however, such an approach which focuses exclusively on how participants display and enact what appears to be culturally influenced norms and expectations clearly runs the risk of over-generalizing the potential impact of *culture* and often neglects what is actually going on at the micro-level of an interaction. And although in some of our examples the patients followed the healthcare professionals' advice (and thus perhaps conformed to cultural stereotypes) in other examples they did not. We would thus argue that interlocutors' behavior is not a matter of adhering to or challenging cultural stereotypes but of negotiating meaning and, more specifically, what kinds of behaviors constitute appropriate and politic behavior in a specific (here: institutional) context. In doing so participants of course also take into consideration the specific norms and constraints that characterize a particular situational context (e.g., financial considerations; or participants' institutional roles). But rather than viewing the relationship between these constraints and a particular interaction as linear and fixed, we argue that it is dynamically enacted and co-constructed among participants throughout an interaction.

In our analyses we have tried to combine these two approaches by considering the norms of the wider sociocultural and the institutional contexts in which the PS sessions took place while also conducting a detailed analysis of how interlocutors construct and negotiate meaning (in particular, what behaviors they consider to be "politic" in this specific context) throughout their interactions.

We have suggested that the framework of relational work (as proposed by Locher and Watts 2005) provides a very useful interpretative approach to combining these two levels of analysis. More specifically, as our analyses of the healthcare providers' directiveness in the various stages of the PS sessions have shown, this framework enables researchers to explore how meaning is created and negotiated on the micro-level of an interaction while at the same time acknowledging the potential impact of the sociocultural and the institutional

contexts on the macro-level (as reflected, for example, in clients' expectations prior to the PS; or the healthcare providers' understanding of their role in these encounters). All these levels seem crucial for an understanding of how notions of politic behavior are negotiated among participants, for example as they co-construct meaning and arrive at decisions.

More specifically, by examining three representative examples from three main stages of PS, we have shown that the healthcare providers' directiveness is constructed as "politic" behavior by participants. This directiveness was evident, for example, i) in the healthcare provider's decision to deliver the information about the screening tests despite the couple's decision not to take the test (Extract 1); ii) in her outlining to the couple the future course of action (Extract 2); and iii) in the healthcare provider's suggestion to delay the couple's decision to pursue the test that she does not favor until they "think about it" (Extract 3). As we have shown, this directiveness is discursively co-constructed between the healthcare providers and the couples, who mostly align with the healthcare providers' actions by limiting their verbal contribution to minimal acknowledgements or by actively agreeing with the proposed course of action. This co-construction, in turn, takes place in the specific institutional context of the interaction and as such interlocutors are likely to orient to ulterior motivations behind both ostensive directiveness and compliance (as, for example, motivated by financial concerns and interlocutors' roles). This process of negotiation of what constitutes politic behavior is particularly obvious in those (albeit rare) instances where interlocutors have different agendas and where they do not agree about which decisions to make.

We hope that our research has illustrated some of the benefits of employing the framework of relational work to analyses of interactions in specific sociocultural contexts. Although we have looked at only one specific cultural context we would like to encourage future research to apply this framework to others; particularly to intercultural and crosscultural settings. We believe that relational work has a lot to offer in these contexts as it enables the researchers to move away from (often stereotypical) assumptions about the possible impact of culture on participants' behavior towards more in-depth analyses of specific social encounters without making *a priori* assumptions about the role of culture in what is considered to be "politic" and "appropriate" behavior. Our analysis has highlighted the importance of considering relational work not only within the specific sociocultural and institutional frameworks of reference in which an interaction takes place, but also of giving due consideration to issues of interlocutors' sensitivity and affectivity which are likely to be of particular relevance in healthcare settings; especially in the PS context that we have looked at.

Since relational work builds on more recently developed, dynamic and co-constructed notions of culture, it clearly has a lot to offer to an area of inquiry which too often builds on essentialist assumptions about culture and the ways it supposedly influences participants' behavior.

Bionotes

Olga Zayts is Assistant Professor at the School of English, University of Hong Kong. Her research focuses on professional communication in multicultural and multilingual contexts, in particular in healthcare and business settings. She has published widely on various communication issues in genetic counseling and prenatal screening contexts; (cultural) identity; and (im)politeness.

Stephanie Schnurr is Associate Professor at the Center for Applied Linguistics, University of Warwick. Her main research interests are professional discourse and medical communication. Stephanie has published widely on workplace discourse with a particular focus on leadership performance and gender, cultural identity, the multiple functions and strategic uses of humour, and (im)politeness.

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