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Laughter as a medical provider's resource: Negotiating informed choice in prenatal genetic counselling¹

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Abstract

This paper aims to challenge the perception that in medical encounters laughter is an interactional resource primarily employed by patients. Drawing on 34 video-recorded prenatal genetic counseling (PGC) sessions collected in a Hong Kong hospital, and combining quantitative and qualitative methods, we illustrate that laughter is in fact frequently employed by the medical providers in our data. The particular focus of the paper is on the ways in which laughter initiated by the medical providers assists interlocutors in negotiating informed choice, a crucial aspect of PGC sessions.

Findings indicate that laughter initiated by the medical providers performs at least two PGC-specific functions: it assists the medical providers in “laughing off” and overcoming patients’ resistance, and it helps them in dealing with patients’ direct questions. Laughter is thus an important resource for the medical providers in pursuing the institutional goals of the interaction, namely negotiating informed choice with their patients.

Key words: laughter, medical interactions, prenatal genetic counseling, informed choice, conversation analysis, quantitative analysis

Running head: laughter as medical providers’ resource

1. Introduction²

This study explores some of the functions that laughter may perform in the medical context, or more specifically, in prenatal genetic counseling (henceforth, PGC). Our particular focus is on laughter as a resource for the medical provider. Previous research on laughter in medical encounters observed that patients tend to laugh more often than medical providers, and that patients’ laughter is normally not reciprocated by medical providers (West, 1984; Haakana, 2001). West (1984), for example, found that invitations to laugh were routinely declined by both doctors and patients. However, doctors’ declination to join patient-initiated laughter occurred more frequently than patients’ declinations to join doctor-initiated laughter. These observations indicate that in medical settings laughter contributes to and reinforces the asymmetry of interlocutors’ relationship. Similar findings are reported by Haakana (2001), who observed that most laughter was initiated by the patient, and in most cases the doctors did not join in. However, the absence of reciprocation of laughter by doctors should not be perceived as a declination to join in laughter. Haakana refers to the earlier work by Jefferson (1984) and notes that in particular when dealing with delicate issues, “by not laughing the doctors seem to be doing the

proper thing” (Haakana, 2001: 196), as laughter in the medical context is employed “for purposes other than amusement” (ibid. p. 196).

However, in contrast to these findings, our data provides a very different picture: in the PGC sessions that we recorded in a Hong Kong hospital, the medical providers laughed more than the patients³. In addition, most instances of medical providers’ laughter were reciprocated by patients. This paper thus aims to challenge the perception that laughter is an interactional resource primarily employed by patients in all medical settings. We aim to achieve this by exploring some of the versatile interactional functions that laughter may perform when used by medical providers by drawing on authentic discourse data recorded during PGC sessions. Our particular focus is on how interlocutors in these PGC sessions negotiate informed choice. More specifically, we look at the ways in which laughter that is initiated by the medical provider constitutes a crucial aspect in the process of negotiating informed choice with the patient: it assists the medical providers in “laughing off” and overcoming patients’ resistance, and it helps them in dealing with direct questions (so-called “famous-infamous” questions) by the patients.

Although there is a substantial body of research on laughter as an interactional phenomenon (e.g. Jefferson, 1979; 1984; 1985; Jefferson et. al., 1987; Glenn, 1989; 1991/1992; 1995; 2003; Hopper & Glenn, 1994), there are only a few discourse and conversation analytic studies on laughter in medical contexts (e.g. West, 1984; Haakana, 2001; 2002). Most of the research on laughter in medical encounters was conducted in medicine and psychology, where the multiple functions of laughter are generally evaluated positively, and the phenomenon of laughter is not typically differentiated from humor.

Some of these positive functions of laughter are facilitating patients’ recounting of sensitive topics, and assisting them in going through painful experiences, as well as generally helping patients with their rehabilitation (for an overview see Schmitt, 1990). In an early study on the use of humor by patients and medical providers in an obstetrics-gynecological ward in an American hospital, Emerson (1963; 1969 as cited in Mallett & A’Hern, 1996), for example, demonstrated that the use of humor and laughter enables the participants to talk about sensitive or delicate topics. Similar findings were observed by Mallet and A’Hearn (1996: 548), who also found that humor and laughter help patients get through painful experiences and “avoid conflict with those whose actions were causing [their] distress”, i.e. the medical providers. Ragan’s (1990) study on laughter in gynecological exam interactions further illustrates the value of laughter for coping with potentially embarrassing situations. In this study, patients and medical providers employ laughter and verbal play during “most precarious” (Ragan, 1990: 82) moments in attempts to build rapport and to preserve face in mutually face-threatening situations.

Conversation analytic studies note that laughter is different from humor and is often employed by interlocutors to perform other functions than amusement (Haakana, 2001:189). It is precisely this ability of laughter to do more “‘serious’ business” (Edwards, 2005) that makes it a very useful interactional resource (Glenn, 2003) in the medical context. Conversation analytic studies indicate that since medical encounters often involve embarrassing or sensitive moments or discomfort on the part of the patient, laughter (especially when it is shared between interlocutors) may ease this tension and create alignment between participants (Haakana, 2001).

The next section introduces the data on which this study is based. We then provide a simple quantitative analysis of our data which forms the background for a more detailed qualitative analysis of laughter as medical providers' resource. The paper ends with a discussion of the findings with a specific focus on laughter as medical providers' resource when negotiating informed choice.

2. Data and medical background

The data for this study are part of an on-going larger interactional study of PGC in Hong Kong, in which we have been collaborating with medical colleagues from a Prenatal Diagnostics and Counseling Department in a Hong Kong hospital since 2006. In this paper we focus on 34 PGS sessions, which vary in length from nine to twenty-two minutes. The total recording time is seven hours. The duration and the number of the selected consultations were determined by our aim to compare our data with a previous study of laughter in a medical context conducted by Haakana (2002).

All consultations were videotaped and transcribed using the transcription conventions developed by Gail Jefferson (Heritage and Atkinson, 1984: ix-xvi; Glenn, 2003: xi-xii). The occurrences of laughter were transcribed on a particle-by-particle basis (see Jefferson, 1985 for the advantages of this method). In transcribing the laughter sequences, we also noted the sequential positioning of laughter and laughter initiation and completion points. Using video-recordings rather than audio-recordings allowed us to also note the occurrences of participants' visual actions (such as smiles) which are relevant to the analysis of laughing practices.

The PGC sessions we look at in this paper are dyadic, and they occurred between four Chinese doctors and nurses (whose mother tongue is Cantonese) and Filipina patients (whose mother tongue is Tagalog). The consultations were conducted in English, which functioned as a lingua franca for all interlocutors. The patients in our data are pregnant and of advanced age. Due to their advanced maternal age (i.e. over 35 years) they have been referred to the clinic in order to explore the options of conducting medical tests to find out about the babies' health. The prenatal care in the Hong Kong clinic where we collected our data routinely includes an offer of testing for Down Syndrome. During the PGC session, the patients are offered three choices, namely 1) direct or invasive tests such as amniocentesis or CVS, which involve inserting a needle into the uterus or placenta, 2) indirect or non-invasive tests such as sonographic measurement of the fetus's neck and a blood test, and 3) a no test option. The final decision on which tests (if any) to conduct lies with the patient. Nevertheless, it is the medical provider's responsibility to ensure the patient receives sufficient information in order to make an informed choice.

Informed choice is generally understood as providing the patient with sufficient and good quality information on the available testing options, so that she can make an autonomous choice (Marteau and Dormandy, 2001; Browner et al, 2003; Bekker et al, 2004; Dormandy et al, 2006). Negotiation of informed choice is a complex interactional activity and involves: 1) discussion of the patient's personal risks of carrying a baby with disorders based on her age and medical history; 2) explanation of the options for PGC testing; 3) facilitation of the patient's choice of whether to pursue the PGC testing; and 4) assessment of the patient's understanding of

provided information and discussion of any questions a patient may have (Bernhardt et al., 2005). Considerations of risk involved with particular tests, a risk of having a baby with genetic disorders, as well as moral and ethical implications involved in the possibility of positive screening results and a potential termination of pregnancy all add to the complexity of this interactional activity.

3. Methodology

In our analysis we employ conversation analytic techniques to demonstrate that medical provider-initiated laughter occurs in organized ways at certain stages of the PGC sessions. We have chosen CA as a methodology because it is concerned with “*the interactional accomplishment of particular social activities*” (Drew and Heritage, 1992: 17, original emphasis). These activities are comprised of sequentially organized social actions, which are described by CA researchers with regards to their context, social organization and any alternative means by which these actions (and activities) can be realized (Drew and Heritage, 1992:17; for a more detailed description of CA: see, for example, Atkinson and Heritage, 1984: 1-15; Drew and Heritage, 1992: 16-19; Glenn, 2003: 35-42).

There is a small but growing number of researchers who apply conversation analysis to the study of genetic counseling sessions (see, for example, Pilnick, 2002; Lehtinen, 2005, 2007; Lehtinen & Kääriäinen, 2005). While previous studies of PGC dealt with various outcomes of PGC sessions, such as patient satisfaction or a change in patients’ decisions, more recent research emphasizes the importance of studies that focus specifically on the “interior of practice” (Biesecker and Peters, 2001: 192), i.e. that provide in-depth analyses of the *processes involved in* PGC. As Pilnick and Dingwall (2001: 103) note:

Whilst outcome studies provide useful information on, for example, client satisfaction, in order to disseminate “good” or “successful” genetic practice, it is necessary to identify the component parts of the *process* which result in this satisfaction and the factors which influence them.

We address this issue by exploring the processes involved in PGC with a particular focus on negotiating informed choice. This focus on the process makes CA an ideal methodological tool for the analysis of our interactional data. However, our analysis is also ethnographically informed, drawing on diverse information about participants’ ethnic and socio-economic backgrounds. Prior to and after the PGC consultations, a member of the research team conducted interviews with the patients and the medical providers in order to obtain further useful information. These ethnographic data were used to support our analysis of the interactional data.

4. Medical providers' laughter

4.1 Quantitative analysis

Most instances of laughter in our data occurred during two specific stages in the PGC session, namely the so-called educational and decision-making stages. Although the content and duration of each PGC session in the data set vary depending on the patient's family and medical history, all PGC sessions display certain similarities in terms of the stages of the session:

- 1) Opening of a session
- 2) Taking the medical and family history of a patient
- 3) Educational stage in which the medical provider explains the nature of Down Syndrome, the screening and testing options that are available to the patients in the hospital and the risks associated with the tests
- 4) Decision-making stage in which the patient makes an informed choice regarding genetic testing
- 5) Closing of the session

The frequent usage of laughter in the third and fourth stages may be attributed to the fact that this is where highly sensitive and potentially disturbing information is delivered to the patients, and informed choice is negotiated. In the subsequent sections we provide a simple quantitative analysis of the data before we discuss the functions of medical providers' laughter in the PGC sessions in more detail. In our analysis we follow the previous work of Haakana (1999; 2002) (who built his study on West's work (1984)). In particular, we aim to extend and enunciate Haakana's claims about the distribution of laughter in medical interactions beyond primary care encounters. We focus on medical provider's laughter as our initial observations indicated its prevalence in our data. However, we also provide the figures of patient laughter in the data to enable a comparison with Haakana's studies (1999; 2002) and to illustrate the distribution of laughter within our data set. In line with Schegloff (1993), the main aim of our quantitative analysis is to support and inform the subsequent qualitative analysis, which will be the primary focus. Combining both, quantitative and qualitative analyses, we believe, renders a more accurate understanding of the interactional nuances and also informs our subsequent qualitative investigations (see also Holmes and Schnurr 2005). As Holmes and Meyerhoff (2003: 13) argue, there is clearly "a place for quantitatively oriented studies, at least as a background for understanding the [...] significance of particular linguistic choices at specific points in an interaction." In our study, we consider a quantitative analysis essential as it supports our observations of remarkable differences between the data in our study as compared to previous studies of laughter in medical settings.

We closely follow Haakana (2002: 208) in our quantitative work (for the discussion analytical problems associated with quantitative approaches to interactional data see for example Haakana (2002) and Schegloff (1993)). In line with this research, we maintain that quantitative studies are not an alternative to qualitative analysis. Rather, as Haakana (2002: 227) notes, quantitative studies supplement the analysis of "single cases, and then, of collection of cases" to provide a fuller picture of an interactional phenomenon. Similar to Haakana (2002: 213-214), we were

interested in the general interactional uses of laughter, therefore we counted “every occurrence of laughter that was not preceded by laughter in the previous turn” (Haakana, 2002: 213), regardless of the position of laughter within the turn (i.e. regardless of whether it occurred in the turn-final position, within the turn or as a responsive laugh). This approach allowed us to see patterns of reciprocation: in particular, how often laughter in the speaker’s turn was reciprocated by the recipient. Also, following Haakana, we counted a smiling/smiley voice as responses because these phenomena are linked to laughter and are often seen as minimal or “milder” versions of laughter (see Haakana, 2002; Fridja, 1996 cited in Haakana, 2002). The number of analyzed consultations was determined by the total recording time of 7 hours which was equivalent to the duration of recordings in Haakana’s data set for comparison purposes. Table 1 gives an overview of the data in Haakana’s study and in the present study:

Table 1 here

Table 2 recalls the distribution of laughter in Haakana’s study (2002) and Table 3 summarizes the statistical information of the use of laughter in our study.

Table 2 here

Table 3 here

We first compare the statistical patterns in the two data sets and then discuss the factors that contribute to the differences in the occurrences of laughter. The quantitative analysis of our data is particularly noteworthy when compared to the earlier studies of laughter in medical encounters by Haakana (1999; 2002). In contrast to Haakana who reported that the patients in his data laugh more frequently than the doctors, our findings indicate a larger number of occurrences of medical providers’ laughter. Overall, in the 34 PGC sessions, we recorded 112 instances of medical providers’ laughter versus 89 instances of patients’ laughter. Also striking is the sharp decrease in the amount of patient laughter: 251 occurrences in Haakana’s data as compared to 89 occurrences in our data. Similar to Haakana, these numbers refer to the first occurrence of laughter within the sequence, or, in other words, to those cases where the previous turn in a sequence did not contain any laughter.

Also notable is the increase in the reciprocation of laughter for both patients and the medical providers in the present study: 61 percent of patient laughter and 64 percent of medical provider laughter were reciprocated (in comparison to 10 and 29 percent respectively in Haakana’s study). In regard to the medical providers, this indicates that apart from the absolute increase in laughter, there is also an increase in the frequency with which they reciprocate patient’s laughter as compared to Haakana’s study. Another difference between Haakana’s study and the present study lies in the figures for non-reciprocation: 18 percent of patient laughter and 24 percent of medical providers’ laughter were non-reciprocated. The pattern that emerges from these figures is thus in striking contrast to those reported in previous studies as in our data the medical providers laugh more and, moreover, they reciprocate patients’ laughter more often (than receive reciprocation themselves).

To a certain extent, these remarkable differences in the use of laughter may be explained by the different types of medical consultations in which they were observed. While Haakana's studies dealt with primary care visits, our study involves genetic counseling visits within the framework of routine antenatal care. The distinguishing attribute of acute primary care visits is the presence of an acute problem or reason for the patient's visit which requires immediate doctor's attention and possible treatment or further investigation (Heritage and Maynard, 2006:14). In the prenatal genetic counseling context, on the other hand, pregnant women do not have a medical condition for which they are seeking medical care; they are referred for PGC due to the higher risk of having a child with genetic disorders associated with advanced maternal age. As a consequence, acute primary care visits and PGC sessions differ with regards to the participants' agendas (see Heritage and Maynard, 2006: 14 for more details on acute primary care visits). Interactionally these differences are realized through who talks more during the consultation. In the primary care visits patients need to present their symptoms to the medical providers and by doing so they often engage in sensitive talk, or bring up topics "that cannot be addressed directly or explicitly [...] without endangering the interactional harmony of the encounter by threatening the listener's face (and therefore also the speaker's own face)" (Linell & Bredmar, 1996: 347-348). A genetic counseling session, by contrast, is inherently an information-providing encounter, in which the medical providers do most talking while presenting information regarding prenatal diagnosis to the patients. Regardless of whether the diagnosis has been established, much of the provided information is risk information and deals with sensitive topics (Sarangi & Clarke, 2002). Since in the genetic counseling setting it is the medical providers who do most of the talking, it is perhaps not surprising that they employ laughter as an interactional resource more frequently in dealing with sensitive issues.

However, despite these difference there are also a considerable number of similarities between the two settings which, we believe, justify a comparison of our data sets: in both medical contexts there are typically two participants (i.e., a medical provider and a patient), and there is an asymmetrical power relationship in that one interactant takes on the role of the knowledgeable professional, and the other is the lay person. The fact that all PGC visits are scheduled in a hospital and may be conducted by the same doctors who would run regular antenatal clinics, also adds to the perception of PGC activities as medical. Thus, following Sarangi (2000), PGC can be characterized as a "hybrid" medical encounter situated in-between and resembling both primary care encounters and counseling or other psychotherapeutic encounters.

In the qualitative analysis in the next section we explore in more detail the various interactional functions that medical providers' laughter may perform in the two stages of PGC sessions, namely the educational and decision-making stages. Our particular focus is on how the laughter assists the medical providers in negotiation informed choice.

4.2 Qualitative analysis

The medical providers in our data routinely employ laughter in performing two activities: when trying to overcome the patient's resistance (26 instances), and when dealing with direct questions (31 instances) from the patients. In these two cases the medical providers' laughter occurs in response to the patient's turn to "laugh off" (Sacks, 1992 as cited in Haakana, 1999; Haakana, 1999) or to minimize the seriousness of the undesired (in the eyes of the medical provider)

implications of the patient's turn. Haakana analyzes two contexts when doctors "laughed off" in response to the patients' actions: in particular, they "laughed off" in response to the patients' complaints about the medical institution and doctors, and also in response to displays of affect (Haakana, 1999). Haakana notes that in such cases doctors typically laugh alone, and their laughter "mark[s] the patient's action as laughable" and not serious (Haakana, 1999: 268). He also notes that, in addition to claiming that the patient's actions are not very serious, laughter also carries a sequential and structural meaning: by laughing, the doctors initiate a move to the next agenda item. The contrast with Haakana's findings (1999) that we observed in our data is that "laughing off" is often reciprocated by the patient in the data, which indicates that participants may display their awareness of their different stances. The two particular contexts when the medical providers' "laughed off" the patients' actions include laughing to overcome the patients' resistance and in response to the patients' direct questions.

In the analysis to follow we look at these two contexts in more detail. In these cases, we argue, the medical providers' laughter helps them achieve the aim of the PGC sessions: to ensure that the patient has (what the medical providers consider to be) the necessary information to be able to make an (in the medical providers' eyes) autonomous informed choice. "Laughing off" patient resistance to genetic diagnosis or specific tests enables the medical provider to continue with the information delivery to ensure that the patient has sufficient information to make an informed choice. By "laughing off" patients' direct questions the medical providers ensure that they maintain their non-directive stance and the patients make their own choice regarding genetic diagnosis.

4.2.1. Medical providers' laughter to "laugh off" patients' resistance

Since the main medical agenda of the PGC sessions is the patient's informed choice, it is of crucial importance for the medical providers to deliver to the patient the information that (according to the medical providers' understanding) is necessary for the patient to make an informed choice about which tests, if any, to perform. The medical providers employ a number of turn construction units to outline and explain the various testing options. However, patients may preempt the information delivery process by refusing to undergo any tests at the first mention. Only very few studies have focused on the issue of why patients choose not to have prenatal genetic counseling (see, for example, Rapp, 1999; Halliday et al, 2001), yet in our data there is abundant evidence of patients who at least initially resisted undergoing prenatal diagnosis.

We refer to these instances (where the patients appear to refuse prenatal diagnosis at the first mention of tests) as patient resistance following Glenn who notes that "structurally, resistance means acting to discontinue the activity proposed or in progress" (2003: 141). While the refusal to undergo prenatal diagnosis may constitute a patient's (more or less) informed choice, to the medical provider this kind of direct refusal presents several dilemmas. On the one hand, a patient's refusal makes further explanation unnecessary, but at the same time the medical providers see their agendas as helping the patient make an informed choice, or, in other words, letting the patient hear and consider all the benefits, drawbacks, and implications of available tests, and make her choice based on that information. On the other hand, continuing with the information delivery disregarding the patient's initial choice goes against the medical providers'

professional ethos of non-directiveness which postulates avoiding imposition of the medical providers' values, judgment and opinions on the patient (see also Kessler 1997; 2001; Weil 2003; Weil et al, 2006). In this precarious situation, one of the resources that the medical provider's in our data employ to prevent the consultation from becoming deadlocked is to "laugh off" the patient's refusal, as the examples below illustrate.

Example 1⁴

(MP - medical provider, P - Patient)

- 1 MP: Um:: (0.3) ((writing)) So, now it's up to you
2 whether you want to have test or not. So the first
3 choice, the first option, is no test. Because some
4 people doesn't want any test.
5 P: No. ((Shakes her head)) I don't want.
6 MP: → You do(h)n't wan(h)t(h), ok. Uh- or, I give you
7 more information first, alright? Um: because,
8 some people may continue with the pregnancy
9 even if the baby is Down syndrome. So they do
10 not want to know beforehand, [so =
11 P: [Mm
12 = they prefer not to have any test. And it is one of
13 your options. .h And the second option is the
14 amniocentesis. ((MP continues to provide
15 information about amniocentesis))

Example 1 occurs at the very beginning of the educational stage in negotiating informed choice. The medical provider starts her explanation of testing options by stating that it is the patient's choice whether to pursue prenatal genetic testing or not (lines 1-4). In the data there is no strict order that the medical providers follow in presenting the testing options to the patients. Incidentally in this example, the patient's refusal of prenatal tests at the first mention is somewhat prompted by the medical provider who foregrounds the "no test" option by presenting it to the patient as "the first choice" and the "first option" (lines 2 and 3). Although the medical provider is being non-directive in delivering the information about a "no test" option, as is for example reflected in her referral to '*some people*' (lines 3-4), the patient takes up this option (line 5) and states that she does not want to have any test. It has been reported in the research literature on genetic counseling that patients tend to more readily relate to personalized information rather than the information presented to them in more general terms (see, for example, Rentmeester, 2001). The medical provider, then, acknowledges the patient's decision by repeating the words "don't want" and "ok" and embeds laughter particles into her utterance (line 6).

Laughter in this example carries a complex meaning: it displays the medical provider's perspective, namely, her disagreement with the patient's choice. As Glenn notes, laughter in the recipient's turn may indicate "reluctance, rather than affiliation with what the laughable⁵ is doing" (Glenn, 2003: 49). In these cases, laughter "offers a response somewhere between outright rejection and outright co-implication in potentially problematic talk." (Glenn, 2003: 49).

The “problematic” aspect of the patient’s talk is her refusal to have tests before she has received any information about genetic testing. By “laughing off” the seriousness of the implications of the patient’s turn, the medical provider also initiates a move forward in the agenda: receiving more information first. By continuing the information delivery (line 6 onwards) the medical provider ensures that the patient’s choice is eventually an informed one, i.e. it is made *after* the necessary information has been provided.

The next example is another instance where the medical provider employs laughter in responding to the patient’s resistance, in particular, resistance towards receiving more information about a specific invasive test, namely amniocentesis.

Example 2

(MP– medical provider; P - patient)

- 1 P: I want to continue (pregnancy).
2 MP: You want to continue. Mm, or, would you like to have
3 more information on amniocentesis?
4 P: ((shakes her head throughout the utterance)) No (it’s
5 not- it’s not) [(necessary)].
6 MP: → [You d(h)on’t] wa(h)nt [hah >hah hah
7 → hah< hah]
8 P: → [heh heh huh huh
9 → huh] I’m s(h)o(h)-
10 MP: → Yo(h)u don’t w(h)ant.
11 P: → I don’t wa(h)nt t(h)o.
12 MP: Ok, now. Uh, in fact, this screening test can- uh
13 estimate your risk again. If it is high:, then, we will
14 advise you to go for amniocentesis.
15 P: Mm hmm.
16 MP: If the risk is low? Then we will not arrange further
17 testing. Detection rate is eighty-six percent. So you
18 would prefer not to know of any amniocentesis=
19 P: =No.

This example illustrates how the medical provider’s laughter functions as a means to respond and perhaps even attempt to overcome the patient’s resistance, and how it allows the medical provider to proceed with the information delivery. In this example, the patient states that she would like to continue her pregnancy (line 1). In our data it is typical for Filipina patients to opt out of genetic diagnosis due to a large number of Roman Catholics among them, and their opposition towards termination of pregnancy. These patients choose to continue their pregnancy regardless of the child’s prenatal genetic diagnosis. Here the medical provider acknowledges the patient’s decision but still inquires whether the patient would like to receive more information about amniocentesis (lines 2-3). The patient refuses the information (line 4), which is further strengthened by shaking her head throughout the utterance; and reiterates her refusal several times later on in the interaction (lines 11 and 19). Despite the patient’s repeated refusals to receive more information on amniocentesis, the medical provider makes a number of attempts

to continue with the information delivery. First, her formulations (or candidate understandings) (Kurhila, 2006) of the patient's decision not to hear more about amniocentesis (lines 6, 10) contain embedded laughter particles throughout and are followed by the medical provider's hearty laughter, indicating that the medical provider does not agree with the patient's choice (Glenn, 2003). The patient then reciprocates the medical provider's laughter (lines 8-9, 11) and tries to provide what looks like an account of her decision in line 9, '*I'm s(h)o(h)-*', thereby signalling her awareness of the precarious situation (Emerson, 1963; 1969 as cited in Mallett & A'Hern, 1996; Ragan, 1990; Mallett & A'Hern, 1996): the patient has formulated her decision not to receive more information, and the medical provider "laughs it off" and appears to want to deliver more information. After the patient repeats her decision (line 11) the medical provider brings up amniocentesis once again as the procedure that the patient will be advised to consider if the results of the screening test are positive (i.e. the patient's risk of having a baby with Down Syndrome is high). This seems like a potentially face-threatening act; however, the patient does not object to it directly and only utters a continuer '*Mm hmm*' (line 15) allowing the medical provider to go on with the explanation in what circumstances the patient will not be advised to pursue amniocentesis (lines 16-17).

Although the patient does not change her mind and stays with her initial decision, the medical provider has nevertheless succeeded in providing at least some information: by bringing up the screening test and the possibility of obtaining positive test results, the medical provider invited a reconsideration of the patient's rejection to receive more information on amniocentesis. So at least from the medical provider's perspective, negotiating informed choice, or more specifically, ensuring that the patient is in a better position to make an informed choice (from the medical provider's perspective) has been successfully achieved. Laughter thus helps the medical provider to overcome interactional difficulties arising from the patient's refusal to receive any information on amniocentesis which clearly disrupts the information delivery, which in turn makes it interactionally more difficult for the medical provider to pursue her agenda of informed choice.

In the data that we have collected, there are a number of instances like Example 2 where the medical provider does not accept the patient's initial decision without at least providing some (as she thinks necessary) information about the various testing options.

Sometimes when faced with the patient's resistance, the medical provider may even explicitly ask the patient whether she would consider changing her mind, as in Example 3. This example occurred at the very end of the information-delivery stage of the consultation. Throughout the session the patient has expressed her firm decision not to undergo any test due to religious reasons, and the medical provider challenged this decision on several occasions. Although the medical provider managed to deliver the information to the patient about the nature of invasive and non-invasive tests, the patient still stayed with her initial decision. At this point in the interaction, the medical provider resorted to asking the patient a direct question whether she would change her mind regarding the decision not to take any tests.

Example 3

(MP - medical provider; P - patient)

- 1 MP: Ok? So, em:, amniocentesis is accurate but may
2 cause miscarriage. For screening test, it is safe, but
3 the: uh detection rate is about (fifty six-) eh eh
4 detection rate is about seven[ty percent.
5 P: [seventy] percent
6 MP: ((smiling through the utterance)) Or, you can adopt a
7 third choice, that is no test.
8 P: Yes.
9 MP: Yeah, that's what you want?
10 P: That's what we want.

((14 lines are omitted in which the medical provider makes arrangements with the patient to have an ultrasound at eighteen weeks of gestation))

- 11 MP: → Ok? (0.4) So you- you will not change your mind?
12 → Ah [huh huh huh huh
13 P: → [°N(h)o(h)o°(.)
14 MP: Anyway, you'll continue with the pregnancy? =
15 P: = Yes. =
16 N: = Right. °I see. ° So, you will em: (ultra sound)
17 P: Ultra sound (.)
18 ((Nurse is writing something down))

Example 3 begins with the medical provider summarizing the testing options to the patient (lines 1-4, 6-7). When the medical provider mentions a “no test” option (lines 6-7), the patient utters ‘yes’. The medical provider offers her candidate understanding (Kurhilla, 2006) of the patient’s answer (line 9), ‘*yeah, that's what you want?*’ And the patient confirms that this is what she opts for (line 10). Although the patient’s decision is very clear, the medical provider still challenges it. In the extract displayed here, for example, the medical provider formulates the patient’s refusal by asking an explicit question ‘*so you- you will not change your mind?*’ (line 11). Like in the previous examples, the medical provider’s utterance-final laughter signals her disaffiliation with the patient’s decision. The laughter here may further signal the problematicity of asking the patient whether she would change her mind, a direct question that challenges the patient’s choice and goes against the professional ethos of non-directiveness. The laughter is reciprocated by the patient who confirms that she is not going to change her mind, and the patient’s utterance contains embedded laughter particles (line 13). Similar to Example 2 laughter by both participants may signal their awareness of their misaligned agendas. The medical provider offers another formulation of the patient’s decision (line 14), and only after receiving yet another confirmation from the patient (line 15), she moves on to the next agenda item, i.e. making arrangements for the patient to take an ultrasound. In this example the medical provider employs a number of techniques to make the patient re-consider her decision not to undergo genetic

diagnosis, including reformulations of the patient's decision, and "laughing it off", both of which express her disaffiliation with the decision and invite its reconsideration by the patient.

Our analysis of interactions in Examples 1 and 3 also suggests that a no-test option seems to be the least preferred options by the medical providers. This observation has also been supported by follow up interviews with some of the medical providers involved in the consultations who said that they prefer if the patient opts for at least a screening test, as this option is not harmful to the baby or the patient.

In the next section we look at another function of laughter, namely laughter as a way of dealing with patients' direct questions.

4.2.2 Medical providers' laughter as a means of "laughing off" patients' "famous-infamous questions"

In genetic counseling contexts questions in which the patient seeks explicit advice from the medical provider on a future course of action are referred to as "famous-infamous questions" (Sarangi & Clarke, 2002). These questions are "famous" in the sense that they are frequent phenomena in the genetic counseling setting. For example, in our data around 30% of the patients indicated in the pre-consultation interviews that they would like to receive advice from the medical providers, and direct questions for advice occurred in 33% of the video recorded data. Such frequent occurrence of questions requesting advice may at least partially be attributed to the fact that the majority of non-native speakers in our data (around 90%) are Filipina patients who are employed as domestic helpers. Most of these patients lack familial support in making a potentially life-changing decision, and that is why, as indicated in the pre-consultation interviews, they expect the medical providers to direct them in their decisions. These questions requesting advice are "infamous" in a sense that the medical providers typically understand their responsibilities as *not* giving the patients any direct advice regarding genetic testing but rather aim to assist them in making "their own" decision. Thus the questions with which patients seek explicit advice from the medical provider present the medical provider with a precarious situation in which they have to decide how to assist the patient in making a decision while still maintaining a non-directive approach to counseling at the same time.

More recent research, however, questions the general applicability of non-directiveness to all genetic counseling contexts. Pilnick (2002: 346), for example, notes that counselors who fail to answer patients' direct questions may not necessarily "uphold [...] the principle of client autonomy, if the client's autonomous choice is to delegate the decision". Nevertheless, such a situation poses a potentially difficult moment in the interaction for the medical providers in our data who, as confirmed in the follow-up interviews, typically avoid giving direct advice to the patients.

In these precarious situations, where the medical providers are confronted with a direct question from the patient, they draw on a number of resources to avoid addressing the question directly. Sometimes, the medical providers respond in a nondirective way and provide information about patient's choices in general terms (e.g. they may employ generic nouns such as "some people",

“some women”) or re-direct the question to the patient (e.g. “It is entirely up to you...”). In our data it is also typical for the medical providers to respond to these questions with laughter as a way of “laughing off” the patient’s question. In these instances, then, laughter displays the medical provider’s reluctance and even resistance (Glenn, 2003) to address direct questions. Examples 4 and 5 are good illustrations of the various functions that laughter performs in these situations.

Example 4 is extended to demonstrate that the patient is facing difficulties in deciding whether she needs to pursue genetic diagnosis.

Example 4

(MP - medical provider, P - patient)

- 1 MP: Ok that’s fine. Now, so today we invite you to come to
2 see if you want to have a test for Down Syndrome.
3 And, after you’ve watched the video, uhm, do you
4 have any idea of Down Syndrome?
5 P: What— what’s the— Down Syndrome?
6 MP: You don’t know what it is,
7 P: → >Mm hm< It i— Do you think I need to (do it)?
8 MP: → Ok, now, it’s up to you.[Some people doesn’t—]
9 P: → [<I wa:nt to know>]
10 [↑huh].
11 MP: → [Some] people prefer to know whether the baby’s
12 Down Syndrome beforehand, so they go for tests. But
13 some people [doesn’t want to know].

((20 lines are omitted in which the medical provider talks about the non-hereditary nature of Down Syndrome and the patient’s personal risks related to her age))

- 14 P: → Mm(.)°Would you- would you do that?°
15 MP: → Hmm? (.) [hgh hnh hh h]
16 P: → [(smiles)] I(hh) am- hah I’m v(h)ery
17 → sc(h)are .hh
18 MP: You’re very (scared).
19 P: Yeah.
20 MP: Ok.
21 P: °I’m scared°.
22 MP: Most of the time it is ok. Because, your- chance of
23 having a Down syndrome baby is only one out of two
24 hundred. That means, two hundred women, at age
25 thirty-eight, only one will have a baby with Down
26 Syndrome. And for the rest, bear normal babies. Ok?
27 P: Mm hmm.
28 MP: Uh, only the risk is a little bit hi:gher when compared
29 with young women. Alright?

30 P: ((nods)) Ok.

This extract is taken from the beginning of the consultation where the medical provider inquires about whether the patient has watched a video on Down Syndrome (that all patients are required to watch prior to the counseling session), and whether she knows what Down Syndrome is. After the medical provider has established that the patient does not know what this technical term refers to (line 6), the patient asks a direct question to the medical provider: *'do you think I need to do it?'* (line 7). In replying, the medical provider avoids giving any direct advice to the patient. She explicitly states that it is up to the patient to make the decision: *'it's up to you'* (line 8). The medical provider's answer is characterized by the use of generic terms (e.g. *'some people'* (lines 8 and 13), and the use of the distancing and rather excluding pronoun *'they'* (line 12). She thus seems to emphasize the importance of the patient's role in the decision making process.

However, as the interaction proceeds it becomes clear that the medical provider's reply was not satisfactory for the patient. In line 14 the patient addresses another "famous-infamous" question to the medical provider. Although there is a lot to say about this example, we concentrate here on the use of laughter as a response to the question from the patient. First, we would like to note the difference in the two instances of the patient's questions: the first question occurs at the very beginning of the consultation, while the second question occurs in the seventh minute of the interaction when the medical provider has already explained to the patient that she is at a higher risk of having a baby with Down Syndrome. It may thus be suggested that this information should have convinced the patient of the necessity to consider genetic screening. In addition, the formulations of the questions in the first and the second instances are also different. In the first question the patient is asking about the necessity to undergo genetic diagnosis, whereas in the second instance she addresses a hypothetical question to the medical provider *'would you- would you (do) that?'* thus placing the medical provider in the hypothetical situation of making the decision. This hypothetical question seems to be somewhat unexpected by the medical provider which is evident from her use of the repair initiator *'hmm'* with a rising intonation which allows her to avoid providing an answer to the patient's question (Sack, 1992: 6). The medical provider then pauses and initiates a hearty laugh (line 15). While the medical provider laughs, the patient smiles (line 16). The patient's smile may signal that she is also aware that what she is asking the medical provider to do (namely make the decision for her) is relatively direct and imposing. The patient then provides an account for her questions: she is very scared (lines 16-17). The medical provider picks up this idea of being scared and builds further information delivery on that.

Focusing on the interactional occurrence of laughter, we observe that it occurs in the place where the medical provider's answer to the patient's question would normally occur. Laughing at this point in the interaction and more specifically at this point in the utterance allows the medical provider to "laugh off" the seriousness of the implications of the patient's direct question and to avoid answering it explicitly. In other words, if the medical provider would not laugh or provide any other kind of response at this point in the interaction, the *absence* of an answer to the patient's question would be very obvious and marked. Thus laughter is one of the available interactional resources available to the medical providers that allow them to work through an interactionally challenging moment and, perhaps more importantly, to maintain the non-directive stance in the consultation (which would have been threatened if the patient's question was addressed directly). By laughing at this moment, the medical provider also signals a move to the

next agenda item (Haakana, 1999). And by reciprocating laughter in the form of a smile, a ‘minimal acknowledgement of laughter’ (Haakana, 2002: 222), and using embedded laugh particles in her utterance, the patient expresses her awareness of the imposition of her question.

The next example provides another instance of laughter as a means of “laughing off” a patient’s direct question. It occurs after the medical provider has finished the delivery of information and the patient has decided to have a routine ultrasound and to discuss with her husband any further testing options.

Example 5

(MP – medical provider, P - patient)

- 1 MP: ((smiles)) is that too much information for you today?
2 (6.0) Or we will have an ultrasound first, and then
3 you dis- you discuss with your husband, and you call
4 me back what test you want. Or if you have any
5 problem I can explain to you again. Is there any part
6 you don’t- you are not very sure?
7 P: °Twelve weeks°, °seventeen weeks° (reading from
8 the file)
9 MP: Yeah.
10 P: → Ok, you, you, you, what is your suggestion? Maybe
11 → just the first o[ne?
12 MP: → [ghh gheh .h, ok, um, nah, different
13 people have diff- different opinion, all right? Um, the
14 first thing you, you need to, to do is to think whether
15 you want to have test or not.
16 P: Yea:h.
17 MP: Some people doesn’t want to know (.) beforehand.
18 They want to continue the pregnancy until term and
19 they don’t want to
20 P: Oh:..
21 MP: Know it beforehand.

Like in example 4, the medical provider answers the patient’s direct question by producing laughter (line 12). After having ensured the patient that if she requires some more information about any aspect of the information, the medical provider would be happy to provide this (lines 5-6), and after reading out loud some of the information provided in the leaflet (line 7), the patient addresses a direct question to the medical provider inquiring about which test the medical provider would recommend: ‘*Ok, you, you, you, what is your suggestion? Maybe just the first one?*’ (lines 10-11). The end of the patient’s utterance overlaps with the onset of the medical provider’s laughter. This instance of laughter is a sign of the medical provider’s reluctance or resistance to answer this question directly. Her reluctance is also reflected in her use of the hesitation marker ‘*um*’ (line12), the discourse marker ‘*ok*’ (line12), and the Cantonese particle ‘*nah*’ (line12) which may roughly be translated as ‘*well*’ or ‘*ok*’ here. And by laughing and employing several hedges the medical provider successfully delays her answers and allows the

patient to project it as dispreferred. When she finally does reply, her response to the patient is non-directive, which is shown, for example, in her use of several generic noun phrases, such as ‘*different people*’ (lines 12-13), ‘*different opinion*’ (line 13), ‘*some people*’ (line 17) and the pronoun ‘*they*’ (line 18). In “laughing off” the patient’s question, the medical provider accomplishes not making the decision for the patient while at the same time keeping the conversation going.

The medical provider’s laughter in examples 4 and 5 thus helps her in overcoming interactional difficulties presented by the patient’s explicit request for advice and thereby ensuring that the patient is ultimately the person who makes a choice. In Example 5 we also see the sequential and structural use of laughter: the medical provider “laughs off” the patient’s question which disrupts the medical provider’s agenda of the information delivery, and by doing so she brings the conversation back to the information delivery.

5. Discussion and conclusion

It was the aim of this paper to challenge the perception that in medical encounters laughter is an interactional device typically employed by the patients. We have explored some of the versatile functions of laughter by medical providers by combining qualitative and quantitative methods. A quantitative analysis of 34 PGC sessions recorded in a public hospital in Hong Kong has shown that in our data the medical providers draw on laughter and reciprocate patients’ laughter more frequently than the patients. These observations are in contrast to earlier studies (e.g. West, 1984; Haakana, 1999; 2002) that argue that medical providers use and reciprocate laughter considerably less frequently than patients, and that, as a consequence, the laughter contributes to and reinforces the asymmetry inherent to the relationship between medical providers and patients.

Our quantitative investigations provided the backdrop for a qualitative in-depth analysis of representative instances of laughter by the medical providers in the PGC sessions. The examples have shown that the medical providers’ laughter performs diverse interactional functions. The medical providers in our data routinely employed laughter when performing two PGC-specific activities: when responding to and trying to overcome the patient’s resistance, and when dealing with advice-seeking questions from the patients. In these cases, the medical providers’ laughter occurred in the responsive turn and it allowed them to “laugh off” (Haakana, 1999) or to minimize the seriousness of the implications of the patient’s turn.

In particular, laughter frequently occurred after the patient had indicated her resistance towards receiving any more information. However, delivering medical and other information is a necessary and crucial aspect of informed choice: only *after* the patient has received all the information about testing options and risk assessment is she in a position to make an *informed* choice. And as the medical providers said in the follow-up interviews, it is their responsibility to ensure the patient has sufficient information to consider the advantages as well as risks and implications of the various testing options. By drawing on laughter in these interactionally challenging moments, in particular when the patients have indicated their refusal to receive any more information, the medical providers attempt to “laugh off” the patients’ resistance and to continue with the crucial information delivery. In particular, the laughter in these situations functions as a way to express the medical provider’s misalignment with the patient’s choice, and

enables the medical provider to initiate a move to information delivery in cases where the patient has explicitly refused to know more. Thus laughter in these instances performs complex interactional functions: it displays the medical providers' stance towards the patient's resistance, and it also downplays the seriousness of the patient's turn. Moreover, it also performs several structural and sequential functions as it marks the initiation of the move to the next agenda item by the medical provider (Haakana, 1999). Ultimately, laughter enables the medical provider to pursue her institutional goals, that is, to continue the information delivery and ensure that the patients' choice is actually an informed one (i.e. is based on the patients' careful assessment of the various factors).

Laughter by the medical providers in our data is also employed as a way to deal with patients' "famous-infamous", or advice-seeking questions. These instances in which patients directly ask the medical providers what they would do and which test they would recommend, are interactionally challenging as they put the medical providers in a difficult situation: the medical providers explicitly understand their role as *not* providing any direct advice about which tests to perform, rather they aim at assisting the patients (mostly through information delivery) in making their own choice. Laughter becomes a valuable interactional resource in these situations, as it may be used by the medical provider to "laugh off" the patient's question and express her reluctance and even resistance to directly addressing it.

We have also observed in the data that when the medical providers employ laughter to resist or "laugh off" the implications of the patient's turn, their laughter is often reciprocated by the patient. This observation poses an analytic dilemma: previous studies (Jefferson, 1984; 2004; Haakana 1999; Glenn, 2003) have indicated that if one party is resisting an activity through laughter, other parties do not generally treat it as an invitation to laugh, however in our data the patients are often laughing along with the medical providers. Although the question of why this may be the case is complex (and in itself warrants a separate investigation), a number of reasons can be put forward. In particular, in order to provide a full account of why medical providers' laughter is reciprocated by patients one has to take into account the specific context of PGC, participant roles (or footings) as well as participants' sociocultural backgrounds. For the examples analyzed in this paper we maintain that by reciprocating the medical providers' laughter, interlocutors signal their awareness of the precarious situation where the medical providers' and the patients' agendas misalign.

Based on these diverse functions of medical providers' laughter we would argue that laughter is indeed an important interactional resource that performs a wide range of functions in medical contexts, and that enables the medical provider to pursue the institutional goals of the interaction: the negotiation of informed choice in PGC sessions.

We would like to conclude by drawing the attention to the socio-cultural context in which the PGC sessions took place. As mentioned earlier, the medical providers and patients who participated in our study are non-native speakers of English who used English as a lingua franca for communication in the PGC sessions. Thus, one possible explanation for the higher counts of medical providers' laughter in our dataset as compared to previous studies (Haakana 1999; 2002) could be the fact that the medical providers did not use English as their mother language. In other words, when delivering complex medical information, non-native interlocutors may particularly

strongly rely on laughter as a strategy to offset challenges arising from the usage of a language other than their native one (see also Kurhilla, 2006 for the discussion of the role of laughter in non-native interactions). Our data, however, provides very little evidence to make any solid conclusions about the correlation between the language proficiency of the participants and the occurrences of laughter. But what we could assert is that medical providers routinely draw on laughter as a resource to perform the various conversational and interpersonal functions outlined above. Laughter in our data thus seems more clearly motivated by the direct contextual aims of the PGC session, rather than serving as a coping mechanism to overcome the lack of alternative ways of expressing and communicating those aims. This observation is in line with previous research on laughter in L2 contexts which also suggest that the use of laughter in L2 encounters is often motivated by the socio-cultural and situational context, as well as the institutional and interactional power of participants rather than their non-native command of the language (Adelswärd & Öberg, 1998).

However, there is clearly a need for further research to focus on laughter in encounters between non-native speakers. Such investigations, we believe, would contribute to a better understanding of the versatility of laughter – not only in medical, but also in other social and professional encounters.

Notes

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³ While pregnant women are often referred to in the literature as “women” or “clients”, we use the term “patient” in line with the practices at the hospital where the data were collected. Similarly, we use the term “Down Syndrome” as opposed to “Down’s Syndrome” in line with the practices at that hospital.

⁴ In all data extracts the names of the participants and other identifiers have been removed.

⁵ Glenn (2003:49) notes that he uses the term laughable “retroactively” to describe any referent that draws or has the potential to draw laughter.

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Appendix

Table 1. Overview of data in Haakana's study and in the present study (Zayts & Schnurr)

	Haakana	Zayts & Schnurr
Number of consultations	60	34
Overall duration of recordings	7 hours	7 hours
Duration of each consultation	Not mentioned	9 - 22 minutes

Table 2. Distribution of laughter and its responses (Haakana, 2002: 213)

	Occurrences of Laughter			
	Patients		Doctors	
Laughter	26	10%	17	29%
Smiling/smiling voice	49	20%	16	27%
No reciprocation (i.e. no laughter/smiling)	176	70%	26	44%
Responses	N=251	100%	N=59	100%

Table 3. Distribution of laughter and its responses in the present study

	Occurrences of Laughter			
	Patients		Medical Professionals	
Laughter	54	61%	72	64%
Smiling/smiling voice	19	21%	13	12%
No reciprocation (i.e. no laughter/smiling)	16	18%	27	24%
Responses	N=89	100%	N=112	100%