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Collaborative decision-making in return-to-work negotiations

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ABSTRACT

This study addresses the ways in which shared decision-making in multi-party return-to-work (RTW) negotiations is constructed as a collaborative practice. The research data are video-recorded Finnish RTW negotiations (n = 14), in which the physician, employer and employee make highly sensitive decisions concerning the employee's return to work after a long sick leave. We show how the participants used turn design, gazes and gestures as resources in both treating their co-participants as eligible to participate in decision-making and claiming the deontic rights for themselves. We also present a deviant case in which a negotiator included only one participant in the decision-making in their initial proposal, which was treated as accountable by the co-participants.

1. Introduction

Shared decision-making has become essential in clinical practice (Charles et al., 1997; Land et al., 2017; Stevenson et al., 2000). Shared decision-making refers to a collaborative process in which both health care professionals and patients participate in building a consensus about the preferred treatment, sharing information and working together to reach a mutual agreement about the best course of action (Charles et al., 1997; Coulter and Collins, 2011). Previous studies on shared decision-making in clinical settings have primarily investigated dyadic encounters between individual patients and individual clinicians (Ijäs-Kallio et al., 2012; Koenig, 2011; Landmark et al., 2015; Stevenson et al., 2000; Stivers, 2005). It has been shown, for example, how, in these dyadic encounters, different shared decision-making practices create collaboration between physicians and patients (Land et al., 2017). The focus has usually been on how or to what extent patients are engaged in decision-making concerning their own health and treatment options (Ijäs-Kallio et al., 2012; Koenig, 2011; Landmark et al., 2015; Peräkylä, 2002; Stivers, 2005; Toerien et al., 2013).

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In multi-party health care encounters—that is, encounters where three or more people make decisions related to health—shared decision-making has received less attention. Earlier studies found that in a clinical rehabilitation context, patients commonly take part in multi-party decision-making by resisting the proposed rehabilitation goals (Barnard et al., 2010) or by providing initiatives to participate when professionals misalign with each other regarding the formulation of rehabilitation (Keel and Schoeb, 2017). Furthermore, it has been shown that in multidisciplinary meetings at the Department of Emergency Medicine, the decision-making process is usually formulated to invite confirmation and make the decision shared (Seuren et al., 2019). As early studies recommended, more research is needed on the balance and distribution of authority in multi-party meetings (Seing et al., 2012) and the effects of the wider professional context on the enactment of decision-making (Jensen and Sarangi, 2018; Pilnick and Zayts, 2016).

In this study, we analyse decision-making in a multi-party setting where shared decision-making is an explicit institutional goal: return-to-work (RTW) negotiations. The key participants in this study are an employee returning to work after a long sick leave, the employer, the physician, and other relevant representatives of occupational health. We describe the ways in which participants in RTW negotiations make decisions concerning an employee's return to work. Through a turn-by-turn conversation analysis, we demonstrate how health care professionals, employers and employees orient to shared decision-making during RTW negotiations. We show how they use turn design, gaze and gesture as resources in both treating their co-participants as eligible participants in decision-making and claiming rights for themselves.

1.1. Return-to-work negotiation

In Finland, RTW negotiations are meetings that are organised as part of rehabilitation services in occupational health care after an employee has been on a long sick leave. Providing occupational health care services to support work ability is a statutory duty of Finnish employers. These services are provided by the employer or by a contracted service provider. The costs are covered by employers, who receive partial compensation by the Social Insurance Institution of Finland and through tax-based deductions from the employee's salary. The legislation that regulates the occupational health care services states unequivocally that health care professionals must be professionally independent of both the employee and the employer (The Law of Occupational Health Care Services, 2001b, §5). Thus, the service provider can be regarded as a neutral party.

In RTW negotiations, the participants identify potential work modifications to facilitate the employee's return to work according to the employee's actual work ability. These modifications might involve cutting working hours, reducing the workload and finding ergonomic solutions. In addition, the participants must decide on the need for joint follow-up meetings concerning the employee's return-to-work.

The employee's possibility to return to work after a long sick leave must be planned, at the latest, when the employee has received sickness benefits for 90 days in a period of two years to secure the continuation of benefits received from the Social Insurance Institution of Finland. RTW negotiations are part of the mandatory occupational health care services that organisations provide for their employees. The participants always include a physician (who usually chairs the meetings), an employee and an employer. In addition, other service providers in health and rehabilitation services (e.g. physiotherapists) or human resource management (e.g. human relations [HR] specialists) may be present. The official aim of the RTW negotiation from the perspective of occupational health care is to achieve a decision that satisfies both the employee and the employer. According to instructions and recommendations from the Finnish Medical Association (Eskola, 2010) and the Finnish Institute of Occupational Health, 2018 (Reho et al., 2018), the perspectives of both the employee and the employer need to be heard. This requirement is in line with the spirit of the Law of Occupational Health Care Services, which states that the employer, employee and occupational health care act in co-operation (2001a, §1).

The situation is delicate, as the stakes in finding a satisfactory solution are high for both the employee and the employer, and several perspectives need to be considered when making decisions (Lappalainen et al., 2018; Liira et al., 2012). For example, a decision about cutting working hours could affect the employer and the employee in different ways: for the employer, it could mean having to retain a substitute to work the remaining hours; for the employee, it may enable coping with work but also cause significant financial change. In addition, physicians need to balance their roles as neutral chairpersons and as medical experts, which is another delicate dimension that must be managed in the course of decision-making.

In multi-party RTW negotiations, the negotiation occurs on two levels. The first level of decision-making concerns the participants' interests regarding the possibilities and responsibilities related to workplace adjustments and rehabilitation efforts, which results in a delicate situation. The second level involves the negotiation of who is eligible to participate in the decision-making, which is the focus of this study.

1.2. Conversation analytic approach to shared decision-making in multi-party settings

Using conversation analysis (CA), in this study, we examine the ways in which the negotiating parties orient to shared decision-making during RTW negotiations. We focus on the participants' practices in managing speaker selection, establishing interactional associations and distributing deontic rights in a multi-party setting.

Previous studies have shown that speakers can either select a particular next speaker (Lerner, 1996; Sacks et al., 1974), or the selection can be ambiguous (Stivers, 2001). It has been shown that the person reference 'you' may be an efficient means of speaker selection in multi-party interactions (Lerner, 1996; Sacks et al., 1974). However, the use of 'you' or 'we' does not automatically resolve who is being referred to, as the use of these words alone does not distinguish a recipient addressed by the speaker's co-participants (Lerner, 1993). Therefore, researchers and participants in multi-party settings also need to consider embodied actions (e.g. gaze direction, posture and gesture) (see Tiitinen and Ruusuvuori, 2012; Goodwin, 1979; Mondada, 2016; Rossano, 2012; Weiss, 2018). For example, gaze can be used in a multi-party setting as a way of applying pressure on the addressed respondent when they are not taking the turn (Stivers and Rossano, 2010) or as a means of negotiating appropriate self-selection following an ambiguous speaker selection (Stivers, 2001). Thus, the analysis must focus on both the vocal and embodied resources that are visibly mobilised by the participants to fully understand the multimodal and systematic practices in speaker selection (Mondada, 2016).

Participants can make references to various multi-person social units (Kangasharju, 1996). Kangasharju (1996) stated that this kind of interactional collective, or, more specifically, association, was previously described as common in multi-party meetings. Lerner (1993) argued that participants can make conjoined participation relevant in relatively enduring associations (e.g. couples and colleagues). Moreover, occasion-specific and momentary associations can become relevant units of participation, especially in speaker-selection practices. In this study, we focus on the latter type of association.

The practices involved in establishing an association are usually 'speaking to an association' and 'speaking or acting together as an association' in allocating turns and selecting the next speaker (Lerner, 1993). Previous studies have shown that participants can establish and address their co-participants or themselves as an association by using the person reference 'you' (and pluralised references such as 'you guys') or the collective person reference 'we' (Kangasharju, 1996; Lerner, 1993; Lerner and Kitzinger, 2007). Associations may also be based on the orientation toward shared accountability for the action, such as answering a question addressed to more than one participant (Djordjilovic, 2012; Lerner, 1993).

Another aspect that affects participation in decision-making is the distribution of deontic rights among the interactants (Heritage, 2013; Stevanovic and Peräkylä, 2014; Svennevig and Djordjilovic, 2015). Previous studies on decision-making in dyadic situations have found that participants orient to one another's deontic rights in deciding upon future actions (Stevanovic and Peräkylä, 2012). Deontic rights concern individuals' authoritative right to determine their, or someone else's, future actions, and they can be claimed in variable degrees of necessity in determining what 'ought to be' (Stevanovic, 2013).

During decision-making, participants may design their turns in ways that produce the more-or-less symmetrical distribution of deontic rights. Previous studies have shown, for example, that turns that are linguistically designed as declarative statements suggest stronger deontic rights to the initiating participant than interrogatives do (e.g. Stevanovic, 2018; Toerien et al., 2013). The right to participate in decision-making presupposes the right to take part in the discussion in which the decisions are made. Controlling the participatory rights of a conversation can thus also be understood in terms of deontic rights; that is, as a question of who has the right to decide which speakers are relevant, such as respondents who have a primary right to accept or reject a suggestion. It was shown in early studies that turn allocation based on gaze is a powerful tool for controlling the relevancy of primary respondents in multi-party interactions (Tiitinen and Ruusuvuori, 2012; Goodwin, 1981). Through these dynamics, speaker-selection practices also affect participants' possibilities and rights to participate in decision-making and thus to decide upon the question at hand.

In the current study, we examine the ways in which these deontic rights—the right to participate in decision-making and the right to control the speaker selection in this process—are distributed in multi-party RTW negotiations.

2. Data and the analytical process

The data collected in the study consisted of 14 video-recorded RTW negotiations, each of which was between 25 and 60 min in duration (altogether 540 min or 9 h). The data were collected between 2015 and 2017 in a joint research project by the Tampere University and the Finnish Institute of Occupational Health. The analysis was based on video recordings and transcriptions that were made according to CA conventions (Jefferson, 2004). The excerpts are presented mostly with two-line transcriptions. The first line represents the original one in Finnish, and the second is an intelligible translation into English. Where it is relevant to the analysis, we provide an additional line in the middle showing the original word order. In the transcriptions, we applied Rossano's convention[1] (2012) to represent eye gazes (see the transcription key in the Appendix). We anonymised the transcriptions by modifying or deleting potentially identifying information, such as names,

[1] We refer to gazes from the physician's perspective during the proposals and from the employee's and supervisor's perspectives after the proposals.

locations and workplaces. We also anonymised all the figures that are part of the transcriptions. We received a statement of acceptance from the ethical board of the Finnish Institute of Occupational Health, 2018 .

The analysis included four steps. During the first step, the first author watched the video-recorded RTW negotiations several times and made preliminary observations about the data from the perspective of decision-making. The author observed that the physicians made the majority of the decision-making initiations in the data, which was in line with their institutional role as chair of negotiation. In the second step, we made a collection of these physician-initiated decision-making sequences to understand profoundly how the physician and the co-participants in the RTW negotiations orient to one another's deontic rights. The physicians' initiations were made by recommendation actions (Stivers et al., 2018); that is, by proposing, offering and suggesting. Because the type of action affords different responses with regard to deontic rights, in our analysis, we focused on the physicians' turn design as well as their gaze and gesture during initial actions.

We observed that in many cases, the physicians mitigated their claims to deontic rights by offering that the proposed future action would be assessed by the other negotiating parties. The findings of the preliminary analyses suggested that the phenomenon of mitigating one's claims to deontic rights would be relevant in understanding the potential of shared decision-making in RTW negotiations. Thus, during the third step, we focused on cases in which this type of mitigation by the physicians occurred. In further analyses, we observed that the other participants also mitigated their claims to deontic rights and reinforced the orientation to shared decision-making. Our final collection of data on locating and analysing shared decision-making practices thus included all cases in which the physician distributed deontic rights in making a proposal or in which the other participants distributed deontic rights after the physician's proposal ($n = 20$) in addition to deviant cases ($n = 4$). The fourth step included a systematic analysis of all these cases.

3. Analysis and findings

In the analysis, we found that the participants oriented to shared decision-making in the following ways: First, the physicians provided for the distribution of deontic rights among the negotiators when they initiated the decision-making sequence. Their key resources were turn designs that mitigated their own deontic rights and the persona references ‘we’ or ‘you’ (plural). Second, the physicians utilised gaze and gesture to allocate two of the other participants as entitled to take the next turn. Third, the other negotiators left space for another to respond, or they allocated the turn to other participants by a gaze before producing their own response, which occurred after the physicians initiating turns during the transition relevance place (TRP). Fourth, in responding to the physicians' initiating turns, the negotiators treated the decision-making as contingent on the other negotiating parties who had not yet answered.

This pattern was observed in most of the cases included in our data ($n = 20$). Four cases deviated from the pattern. In these cases, the physician addressed a turn to only one participant (i.e. the supervisor, employee or a health professional). However, our analysis showed that even in these cases, the participants oriented to decision-making as shared among the participants, as the participants whom the turn to accept or refuse the physician's proposal was allocated offered the turn to other participants to answer.

We illustrate these key findings using three excerpts from three RTW negotiations. We present the excerpts in two parts. The first part (labelled ‘a’) shows the physician's proposal; the second part (labelled ‘b’) illustrates how the other participants received the proposal.

3.1. Negotiating parties treating co-participants as eligible to decide and claiming the deontic right for themselves

In Excerpt 1, the physician uses turn design and gaze direction to address both the employee and the supervisor as an association of recipients and the addressed recipients use gaze as a tool (Goodwin, 1981) to negotiate the deontic rights between them. Excerpt 2, is a similar case, in which the physician also uses gesture to construct sharedness. After the physician's proposal, the negotiating parties treat the decision to be made as explicitly contingent on the co-participants' responses and points of view.

Excerpt 1a

Before the conversation shown in Excerpt 1a, the negotiating parties decided that the employee would return to work through a work trial, which allows an employee to work with the current employer for a defined period while retaining employment with her pre-injury employer. They also decided that the work trial would run for three months. At the beginning of Excerpt 1a, the physician proposes a joint follow-up meeting during the work trial. The seating arrangement is presented in Fig. 1.

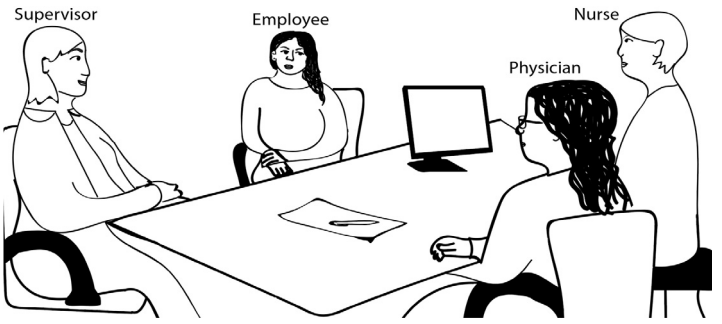


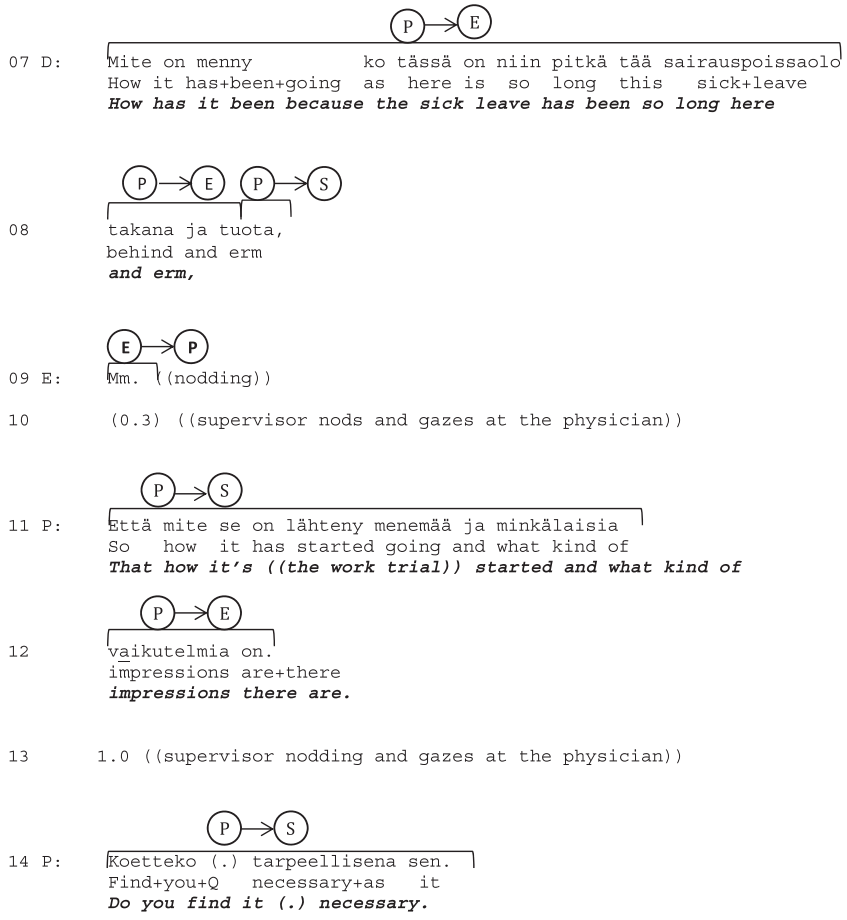
Fig. 1. Seating arrangement of participants (P = physician, E = employee, S = supervisor). The occupational health nurse is taking the minutes.

```
                                  (P→E)
01: P:  ┌Tässähä          pittää varmaa sitte tuota nii ni oisko se┐
        Here+as-you-know 0 should probably then erm     so be+would it
        Here one should probably erm so would it  be

                                  (P→S)
        ┌──────────────────────────────────────────────────────┐
02      ↑hyvä siellä           tuota .hh iha jo työkokkeilun (.)
        good there             erm      right already work+trial
        good there erm .hh already during the work trial (.)

                                  (P→E)
        ┌──────────────────────────────────────────────────────────┐
03      kuluessa vaikka siellä keskivaiheilla (.) jossakin    niin tuota
        during for+example there in+the+middle    somewhere   like  erm
        for example in the middle (.) somewhere erm,

                (P→S)                                (P→E)
        ┌──────────────────┐                 ┌──────────────────┐
04      [nii ni    puolivälin paikkeilla (.) [niin tuota  (.) sopia että
        so like    middle term around        like erm         agree
        so around the middle term       (.) like erm    (.) agree that

                                  (P→S)
        ┌──────────────────────────────────────────────────────┐
05      piettäs niinkö semmonen      seurantapalveri ihan että,
        have+would like the+kind+of  follow-up+meeting  just that
        we would have the kind of follow-up meeting just for that,

06      (0.5) ((E and S are nodding simultaneously, gazing at the physician))
```

The physician's proposal begins in line 1. There are possible TRPs in lines 6, 9–10 and 13, where the recipients respond minimally with nods and “Mm” (line 9) but do not take a turn to display commitment to the proposal (see Stevanovic, 2012). In line 14, the physician then asks the polar question, ‘Do you find it necessary’? In building her proposal, the physician uses turn design and gaze to treat both the employee and the supervisor as the addressed recipients and as the parties of the association who share the accountability for (or right to) the next action (Lerner, 1993), which in this case is the answer.

In this excerpt, the physician's turn design is oriented to shared decision-making in four ways. First, the physician uses the conditional construction in asking about the necessity of the follow-up meeting (line 1: ‘Would it be good’). This construction conveys the symmetrical distribution of deontic rights between the negotiating parties because the realisation of the proposed follow-up meeting is presented as contingent on the employee and the supervisor (see Curl and Drew, 2008; Stevanovic, 2018, p. 10). Second, the physician uses a plural verb (line 5: *piettäis*, translated as ‘we would have’), in referring to all participants as being in control of the proposed action. Third, in asking for an opinion concerning the necessity for the follow-upg, the physician uses pluralised person references to address both the employee and the supervisor as eligible to decide, thus suggesting an association (line 14: ‘Do you[2] [plural] find it necessary’?). Fourth,

[2] Unlike in English, in Finnish, the pronoun ‘you’ is a different word in the second person singular than it is in the second person plural. For example, 2sg. = *sinä*/you, 2pl. = *te*/you.



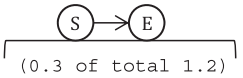
throughout her lengthy turn, the physician frames the proposal with deontic caution by utilising the word *varmaan*/ ('probably', line 1) and the hesitancy markers *tuota* (*niin ni)/erm so like* (lines 1, 3–4, 8) as well as accounting for the proposal (lines 7–8).

In addition to these features of turn design, the physician's gaze behaviour also indicates that both the other negotiating participants are eligible to respond: she gazes alternately at both the employee and the supervisor during her proposal (Lerner, 2003). At the first TRP, she gazes at the supervisor (line 5) although she first gazed briefly at the employee (end of line 4). It is noteworthy that during the silence between turns in line 6, both the employee and supervisor nod, indicating their interpretation of being treated as eligible recipients of the turn. As the physician continues her proposal in lines 7 and 8, her gaze is divided between the employee and the supervisor in the possible turn transition. She gazes first at the employee (line 7) and then at the supervisor (line 8), which shows her orientation to the employee's and the supervisor's shared right to respond, thus treating them both as eligible to decide on the suggested future action. At the syntactic and semantic TRP, when she says 'sick leave' and 'behind', she gazes at the employee. She then immediately gazes at the supervisor in the intonational TRP, saying 'and erm'.

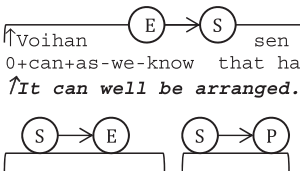
Furthermore, the physician does not treat the recipients' silent nods (lines 6, 10, and 13) or the employee's neutral continuer particle 'Mm' (line 9) as adequate ways to receive the proposal. She adds an increment (lines 7–8) and reformulates her question (line 14), making a response to her proposal relevant. Thus, the physician orients to the necessity of the employee and the supervisor to provide their articulate views concerning the proposal.

Excerpt 1b (continues directly from 1a)

15 (Total of pause 1.2)



16 E: ↑Voihan sen pittää.
0+can+as-we-know that have.
↑It can well be arranged.



17 S: ↑Mm hyvähän se on.=
good+as-we-know it is.
↑Mm it would be good yes.=

18 P: =Joo,
=Yes,

As in Excerpt 1a, at the end of her question in line 14, the physician gazes at the supervisor, which the latter could have treated as allocating the next turn to her and answered on her own behalf or that of the association (Lerner, 1993). However, in line 15, instead of responding, the supervisor turns her gaze from the physician to the employee, thus passing the role of the first answerer to the employee (see also Weiss, 2018), who reciprocates the supervisor's gaze. By passing the turn to the employee through a gaze, the supervisor also treats the employee as having the primary deontic right to decide on the issue at hand (Stevanovic and Peräkylä, 2012). This silent negotiation of speakership shows how the participants orient to decision-making as contingent on one another's points of view. The employee and the supervisor treat the projected next turn as a possible place for simultaneous talk, and they forestall that outcome by producing the shared opportunity to participate, in which they both could respond by expressing their individual points of view (Lerner, 1993), as the analysis will show.

In line 16, the employee answers the physician's question by saying, 'It can well be arranged' (line 16). Two elements in the turn design of the answer highlight the continuing orientation to shared decision-making. First, the employee uses the zero-person construction, in which the verb is inflected as the third-person singular, but the subject of the clause is unspecified. The construction can be translated variously as 'you', 'one' or 'anyone' in English. Finnish speakers usually use a zero-person construction when they express a generic argument, in which the zero person is an indexical site with which to identify (Couper-Kuhlen and Etelämäki, 2015; Laitinen, 1995).

Following the proposal, the zero-person construction conveys that the employee is treating the follow-up meeting as an acceptable but generic option, which leaves the 'assessment floor' open to the supervisor. Second, the employee uses the clitic *-han* (line 16: *voihan*, translated here as 'well') with the modal verb, which also indicates that the decision is not ready and established but still open for assessment by the supervisor.

In addition to these turn design features, the employee leaves the floor open before the supervisor has responded by utilising her gaze direction: during her answer, she looks at the supervisor instead of the physician, who originally posed the question. Hence, the employee confirms their association as eligible decision-makers orienting to a mutual decision. She also mobilises the association of the decision-makers by allocating the next speaking turn to the supervisor in using her gaze direction. The employee's turn design and gaze behaviour could be interpreted as continuing the orientation to distributed deontic rights so that the supervisor can also steer the on-going decision-making. In line 17, the supervisor agrees with the employee's response by positively evaluating the physician's proposal. She first gazes at the employee, but in completing her turn, she gazes at the physician. In this way, the supervisor addresses her turn to both the employee and the physician and orients to their mutual

decision.

Excerpt 1 illustrates our observation that in the RTW negotiations, the physicians (who usually start the decision-making sequences with their proposals) orient to shared decision-making by treating the supervisor and employee as an association with the shared deontic right to respond to the proposal, which is achieved with the help of turn design and turn allocation through gazes. The supervisor and employee share this orientation by mitigating their own right to take the turn, offering it to the other participant, thus distributing the decision-making rights among themselves.

Turn design and gaze behaviour are the main resources used in allocating speaking turns and distributing deontic rights when participants are engaged in building shared decision-making in RTW negotiations. Following the proposal, the negotiating parties used gesture in addition to turn design and gaze direction to show their orientation to distributed deontic rights, which is shown in the second excerpt.

Excerpt 2a

In this case, the negotiating parties have decided that the employee will return to work on part-time sick leave. Hence, the employee will work partially during her rehabilitation process, which will take 90 days. The physician makes a new proposal concerning the follow-up meeting in the middle of the part-time sick leave. The seating arrangement is presented in Fig. 2.

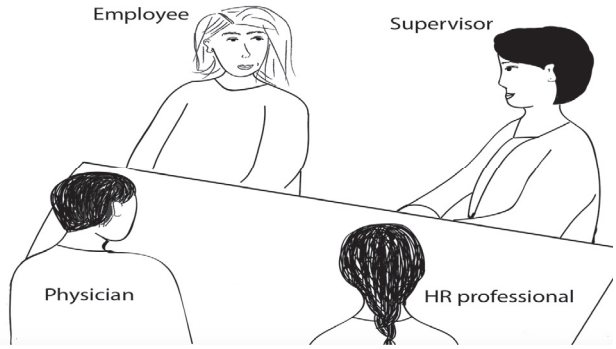


Fig. 2. Seating arrangement of the participants

P→▤

01 P: Sitte vaa se kysymys et pide- tarvitseeko meidän pitää tämän aikana

Then only that question that shall- do we need to have during this

P→▤ P→S

02 niinku väliseuranta palaveria,

like a follow up meeting,

03 (0.2) ((E and S gaze at the P and remain in listening position))

P→E

04 P: Eli tota,

So um,

E→P

05 E: ↑Mm mm.=

06 P: =Kokoontua täällä jos me haetaan tätä (.) kokonai- eöh (.) koko ajaksi
Get together here if we apply for this (.) ful- eöh (.) for full time

07 ja sitte toisaalta hh voitte vähä säätää niitä prosentteja itsekin, (.)
and on the other hand you can adjust those percents by yourselves

08 P siinä välissä, (.) monesti kokoonnutaan niinku (.) parin kuukauden
in the middle, (.) often [we] ***gather like (.) after a couple of months***

09 kuluttua keskustelemaan .h miten on mennyt.=
to discuss .h how it has been going.=

10 =Sitte jos on hyvä yhteys esimiehen ja alaisen välillä
=If there is a good connection between the supervisor and the employee

11 niin se ei ole aivan välttämätöntä.[.hhh
then it is not totally obligatory. [.hhh

Fig. 3. P Gazes at minutes

Fig. 4. P leans backwards, gazes at E

12 [((HR nods))

13 E: Mm.

As in Excerpt 1a, the physician treats all negotiating participants as eligible to make the decision (see also Stivers et al., 2018); he does this in three ways. First, he speaks to the association of the recipients by utilising the collective person reference 'we' in his initiative turn (lines 1–2). He uses the pluralised recipient indicator 'you' in explaining that the employee and the supervisor can adjust the percentage of the part-time sick leave themselves (line 7).

Second, even though it is obvious that the physician treats the follow up meeting not necessary, he still overtly leaves the decision to the employee and the supervisor by posing the question to them and allocating them as recipients by gaze. His own view is observable in line 1 where he self-corrects the turn preference from a more positive formulation of 'shall we have a meeting' into 'do we need to have a meeting', and in the way he gives grounds for the meeting not being necessary (lines 6–11). Hence, he distributes deontic rights and leaves the decision to the employee and the supervisor.

Third, and as an important comparison to Excerpt 1, the physician utilises a hand gesture. Toward the end of his turn (line 11), the physician starts to lean backwards when he produces the word 'obligatory', and he gazes at the employee at the end of his turn (see Figs. 3 and 4). Hence, the physician creates a physical distance between himself and the employee and supervisor,

who are on the opposite side of the table, which helps indicate the closure of the turn and the opening of the response turn (Li, 2014).

During the physician's initial turn, we begin to see that the other participants also treat decision-making as shared. In line 2, the physician finishes his utterance with a continuing intonation. Thus, although he then gazes at the supervisor, the latter treats the physician's turn as not yet finished (line 3). The physician then expands his proposal, shifting his gaze from the supervisor to the employee (line 4). By nodding and producing minimal responses, the employee orients to show her interpretation that she has been treated as an eligible recipient of the turn (line 5).

Excerpt 2b (continues directly from 2a)

14 (total length of pause 2.5)

(0.1 of total 2.5)

Fig. 5. P gazes at E.

(1.2 of total 2.5)

Fig 6. P gazes at S, smiles and gestures.

(1.3 of total 2.5)

Fig. 7. S starts smiling.

(1.4 of total 2.5)

Fig. 8. E starts smiling.

15 E: [£Mm£.= ((nods))

16 P: [£Voitteh,£ =
£You can,£=

17 S: =Mitä oot mieltä?
=What do you think?

18 P: £Niih.£
£Yeah.£

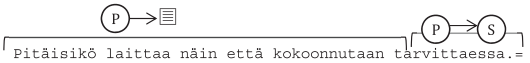
Fig. 9. P starts to lean toward the table and gazes at E.

19 S: Heh.=

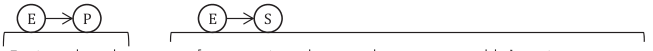
20 E: =No mä mo- mu- eh- no ku mä mietin et mit- mitä
Well I- mo- mu- eh- well I am thinking that wha- what

21 siinä sitte niinku?
then there like?

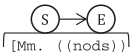
((21 lines omitted concerning the employee's information seeking))



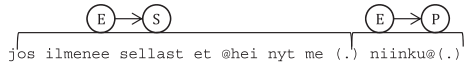
44 P: Pitäisikö laittaa näin että kokoonnutaan tarvittaessa.=
Should [one] write that [we'll] gather if necessary.=



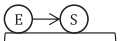
45 E: =Just meinasin [sanoa et voi- se ois varmaan niinku et
=I was just going to [say that ca- it would probably be like that



46 S: [Mm. ((nods))

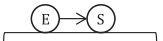


47 E: jos ilmenee sellast et @hei nyt me (.) niinku@(.)
if there appears that kind of @hey now we (.) like@

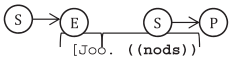


48 E: täs tarvitaa,=
here need [it],=

49 S: =Joo.
Yes. ((nods))



50 E: Jotain [semmosta,
Something like that,



51 S: [Joo. **((nods))**
Yes.

As in Excerpt 1b, the physician makes visible the distribution of deontic rights by shifting his gaze between the employee (Fig. 5) and the supervisor (Fig. 6). After leaning backwards (Excerpt 2a), his gesture of a spread hand continues to establish that the decision is contingent on the association of the co-participants, who are sitting on the opposite side of the table (Fig. 6). After the physician's gesture of a spread hand, the supervisor smiles and gazes at the employee (Fig. 7), who smiles back and gazes at the supervisor (Fig. 8). With their reciprocal facial expressions, the parties may be seen to negotiate which one is going to take the next speaking turn and give an opinion concerning the follow up -meeting (Excerpt 1a: lines 9–10), that is, they orient to responding as an association (see Fig. 9).

The orientation to shared deontic rights concerning the decision is further observable in the rest of the excerpt, particularly in the supervisor's direct question, 'What do you think', which is directed to the employee through gaze (line 17). The physician joins the supervisor's turn allocation to the employee by continuing the question, saying *Niih*/'Yeah', leaning toward the table and gazing at the employee (line 18).

We also see that the employee treats the decision-making as shared. This happens after the physician's new proposal, when he continues to orient to the distribution of deontic rights among the participants by using an interrogative with a conditional expression ('should') and an inclusive person reference (translated here as 'one' and 'we'). However, the physician gazes at the supervisor (line 44), selecting her as the next speaker. At this point, the employee self-selects. She agrees with the physician's second proposal and expresses an independent commitment to it, as she claims that she was just thinking the same thing (line 45). In her self-selection, she orients to her right to take part in the decision-making as an eligible participant. Moreover, in her following turn design and gaze toward the supervisor, she treats the decision-making as shared: she formulates her point as conditional ('it would probably be like', 'if we like here need it'), uses the collective person reference 'we', gazes at the supervisor in referring to the need for a control meeting in the future (lines 47–48) and addresses her turn to the supervisor by gazing at her at the TRP (line 48).

Like the employee, the supervisor orients to decision-making as shared. To show her agreement with both the employee's answer and the physician's proposal, the supervisor gazes at the employee during the first response particle (line 49: *Joo*/'Yes'), and with the second particle, she shifts her gaze to the physician at the TRP (line 51: Joo/'Yes'). Thus, as in Excerpt 1b, all participants concerned in the decision are treated as addressed recipients when the decision-making is closed.

In our analysis of the first two excerpts, we demonstrated how shared decision-making was achieved by the collaborative orientation to the deontic rights distributed among the negotiating parties. The orientation was observable (i) when the physician made the proposal, (ii) in the transition relevance places following the proposal, and (iii) in receiving the physician's proposal. With the turn design elements in the proposal and response (i.e. the use of the collective person reference 'we' and pluralised recipient indicator 'you') and the negotiation of speaker selection through gaze and gesture, the participants treated all members of the established association as eligible to participate in decision-making.

3.2. Deviant case: dyadic-oriented proposal recast as a shared decision

There were four cases in which the physicians addressed their proposals to only one negotiating party and thus did not orient to decision-making as shared with everyone whom the proposed action concerned. In these cases, in responding to the proposal, the addressed recipient distributed deontic rights to the negotiator who was not addressed. Hence, they recast the original dyadic-oriented activity as shared. An example is provided in Excerpt 3.

In Excerpt 3a, the physician makes a proposal concerning the employee's appointment with the physiotherapist, orienting to the decision as concerning only the physiotherapist and herself. Excerpt 3b shows how the physiotherapist then orients to distributing deontic rights to the employee, thus recasting the relevance of making the decision as an association. Fig. 10 shows the placement of the participants.

Excerpt 3a

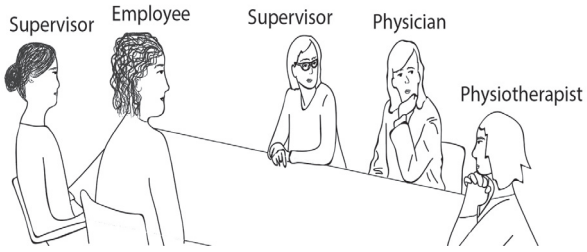


Figure 10. Seating arrangement of the participants.

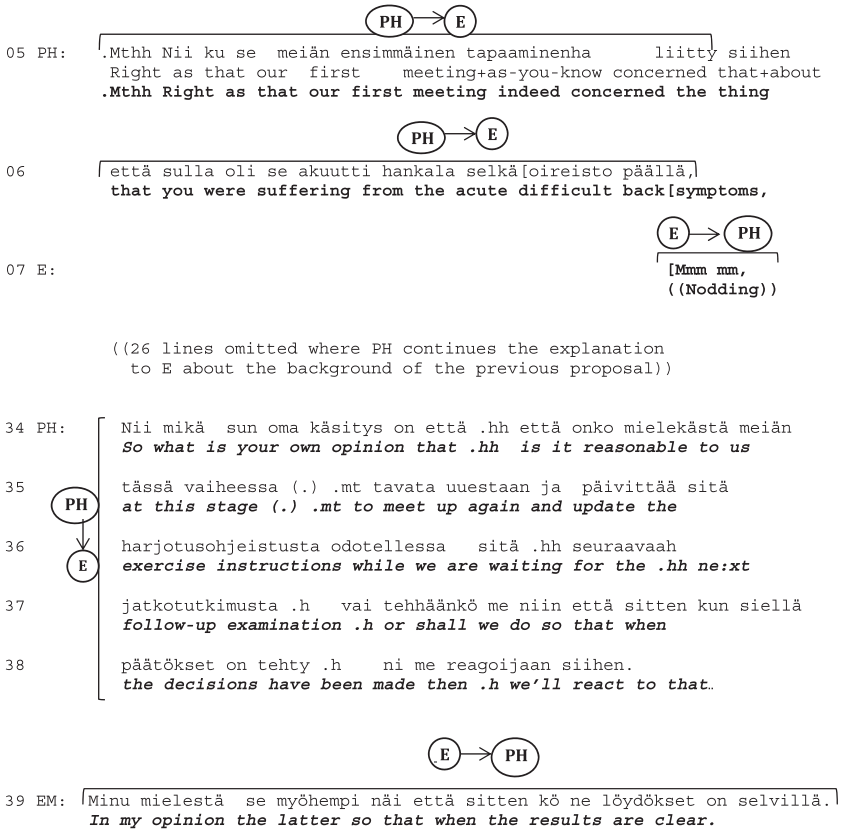
The negotiating parties decided that the employee will return to work by using part-time sick leave for three months, which means that the employee will be working partially during her rehabilitation process. The physician makes a proposal that the employee could visit the physiotherapist before the part-time sick leave begins.

```
01 P:    Se- sää oot siellä   helmikuun loppua oli ko tapasitte
            That- you were it was the end of February when you [plural] met
02       että  sillon siinä vähän oli kyllä
            so then there was a little bit of [pain] indeed
03    P     et tietysti   sitäki   voi  aatella että   käykö   sitte  vielä
          ↓ so of course that+too  0+can think  that visit+Q then   also
      PH  so of course one can also consider whether ((she)) would meet you
            ((physiotherapist))
04       sitä ennen sulla tai,
            before that
```

In making the proposal (lines 1–4), the physician treats only the physiotherapist as eligible to participate in the decision-making. First, the physician uses the second person singular form and gazes only at the physiotherapist when she proposes a meeting with the employee and the physiotherapist at the TRP. Second, she refers to the employee as the object of their discussion by using the construction, 'whether [she] would meet you before that' (line 3).

Excerpt 3b shows how the physiotherapist treats the physician's turn allocation to her exclusively as implicitly deviant by not responding to the physician. The physiotherapist recasts the decision-making as shared with the employee, whom the proposed appointment also concerns.

Excerpt 3b (continues directly from 3a)



Although the physician's proposal makes an acceptance or rejection relevant as the next relevant action, the physiotherapist does neither. Instead, she uses the response particle, *Niin*/Right, thus claiming her alignment with the physician's action (Sorjonen, 2001, pp. 167–171), but she continues by explaining the purpose of the proposal to the employee (starting at line 5). She also shifts her gaze from the physician to the employee at the TRP. Hence, she orients to the employee's deontic rights to participate in making the decision. The employee receives the information by minimal responses ('mm-m', 'mm') and by nodding and gazing at the physiotherapist (line 7).

Having explained the purpose of their meeting, the physiotherapist directly asks the employee's opinion concerning the proposal and uses several practices to include the employee as a recipient (line 34). First, she reformulates the physician's earlier proposal in two options. Second, she depicts the employee's eligibility as a decision-maker (lines 34–38) by using the collective person reference 'we' in referring to the proposed action (lines 37–38). Third, she gazes at the employee in proposing the two options. By leaving the physician's question un-answered and addressing the employee instead, the physiotherapist makes clear that she is unable to respond to the physician without the employee's opinion.

The physician's choice of addressing the physiotherapist specifically without including the employee as a recipient may be understandable because the proposed encounter was contingent on the physiotherapist's expert opinion. Earlier studies have suggested that allocating a turn by gazing at a particular interactant entails specific epistemic expectations related to what the person has the moral responsibility to know (Markaki and Mondada, 2012; Raymond and Heritage, 2006; Stivers et al., 2011) or is assumed to know (Ford, 2008).

As demonstrated in Excerpt 3 and other deviant cases, in the present context, even when the decision-making was initially treated as dyadic (perhaps because it required a specific opinion), it was recast as shared in the subsequent talk turns.

4. Discussion

4.1. Summary of findings

The findings of this study showed how in multi-party RTW negotiations, decision-making is oriented to as shared by distributing deontic rights jointly through turn design, gaze behaviour and gesture. We showed where and how within the

decision-making sequence, the negotiating parties treat their co-participants as eligible to participate in decision-making and claim the rights to make the decision as an interactional association.

In the present study, our focus was on the decision-making sequences initiated by the physician. The orientation to shared decision-making begins with the physician's proposal. In our data, he physician treats the decision to be made contingent on the recipients' assessment and agreement, which are achieved by alternately gazing at the negotiating parties concerned in the decision and using a collective reference and pluralised recipient indicator to address their shared right to take the next speaking turn and make the decision as an association. After the proposal, all negotiating parties concerned in the decision continue the shared decision-making process by monitoring the turn allocation. The negotiating parties pass their speaking turns to another addressed speaker by using gaze, (Excerpt 1), turn design (Excerpt 2) and/or gesture (Excerpt 2) so that the decision-making can continue smoothly after the silence between turns (Sacks et al., 1974). When the other negotiating parties produce their responses to the proposal, they first gaze at their co-participants and then at the physician (Excerpts 1 and 2).

We also presented a deviant case in which the physician included only one participant in the decision-making in their initial proposal, which was treated as accountable by the co-participants (Excerpt 3). In the turns following the proposal, the co-participants bypassed the right to accept or reject the proposal, gave an explanation concerning the proposal, and recast the decision-making activity as being shared by using the same verbal and nonverbal resources as in the first two excerpts.

4.2. Implications for research on decision-making

Our study contributes to the CA field of decision-making. The findings of this study are in line with earlier interactional evidence showing how rights and responsibilities to participate are negotiated in the interactional process of shared decision-making (Landmark et al., 2015; Pilnick, 2008; Stevanovic and Peräkylä, 2012). Our findings also expand the previous understanding of the significant role of medical experts in medical consultations. For example, previous studies have shown that medical experts may step back from their involvement in decision-making (Pilnick and Zayts, 2016). Furthermore, it has been demonstrated that medical experts determine whether the patient's experience is relevant as a basis for making a decision (Landmark et al., 2015). These previous studies have focused on dyadic settings, and thus our study presents a new context by analysing multi-party negotiations, which are at the interface between the medical consultation and the workplace meeting.

Our findings showed that in a multi-party setting in which shared decision-making is an official stated goal (Finnish Institute of Occupational Health, 2018), not only the physicians during their proposals but also the other participants with their responses distribute deontic rights so that participation is offered to all parties concerned in the proposed future action. Although medical experts usually initiate decision-making in our data, they are not solely responsible for achieving shared decision-making. The orientation to hear different experiences and points of view can be constructed reciprocally between all the negotiating parties.

4.3. Implications for conversation analytic research on speaker selection

Earlier CA studies (Auer, 2017; Tiitinen and Ruusuvuori, 2012; Weiss, 2018) on gaze, turn-taking organisation and speakership have shown that when the first speaker addresses more than one co-participant simultaneously, the speaker who has been gazed at during the TRP usually takes the next speaking turn. We have shown that other participants may pass their speakership to another participant after the proposal by means of their turn design and gazes. The reason is not a lack of knowledge, as previous studies have shown (Auer, 2017; Weiss, 2018) but the 'lack of the right to decide alone' when a participant is part of the established momentary decision-making association.

In our study, the practice of establishing an association (see also Lerner, 1993) are clearly observable when the physicians are speaking to an association during the proposal and when the negotiating parties collaboratively construct the orientation to shared decision-making. The negotiating parties not only secure their own speakership (see Ford and Stickle, 2012) but also orient to the possibility of the other participants taking the next turn and thus to distributing deontic rights within the association. This orientation of all participants in RTW negotiations may be explained by the delicate nature of the negotiation — a meeting in which highly consequential decisions are made concerning the future of the employees and the HR choices of the organisation in question. The negotiation of deontic rights through gaze direction has been shown to affect each participant's possibilities to decide how the course of the RTW decision-making will proceed (see also Ruusuvuori, 2001, 2000). In our data, this was done by the silent collaborative negotiation of speakership through mutual gaze (Stivers, 2001), which made it possible for both the employee and the supervisor to give their opinion, thus steering the on-going decision-making without disturbing the flow of the conversation (cf. Kaukomaa et al., 2013).

Paananen and Majlesi (2018) suggest that in health care settings in general, relationship building is essential due to the highly sensitive nature of the topics involved. We propose that shared decision-making as an association in the context of RTW negotiations could be considered an interactional process in managing the delicacy related to differing interests, opinions and possibilities to steer the interaction. Consequently, this study illustrates a micro-level collaborative practice of distributing decision-making rights, which may be applicable in other contexts aiming at shared decision-making.

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Appendix. Gaze direction in transcriptions. Adapted from Rossano's (2012) convention for transcribing eye gaze.

Symbol	Meaning
	Physiotherapist turns toward the employee.

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