Negotiating treatment preferences: Physicians' formulations of patients' stance

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Abstract

Eliciting patients' values and treatment preferences is an essential element in models of shared decision making, yet few studies have investigated the interactional realizations of how physicians do this in authentic encounters. Drawing on video-recorded encounters from Norwegian secondary care, the present study uses the fine-grained empirical methodology of conversation analysis (CA) to identify one conversational practice physicians use, namely, *formulations of patients' stance*, in which physicians summarize or paraphrase their understanding of the patient's stance towards treatment. The purpose of this study is twofold: (1) to explore what objectives formulations of patients' stance achieve while negotiating treatment and (2) to discuss these objectives in relation to core requirements in shared decision making.

Our analysis demonstrates that formulating the patient's stance is a practice physicians use in order to elicit, check, and establish patients' attitudes towards treatment. This practice is in line with general recommendations for making shared decisions, such as exploring and checking patients' preferences and values. However, the formulations may function as a device for doing more than merely checking and establishing common ground and bringing up patients' preferences and views: Accompanied by deprecating expressions, they work to delegitimize the patients' stances and indirectly convey the physicians' opposing stance. Once established, these positions can be used as a basis for challenging and potentially

24 altering the patient's attitude towards the decision, thereby making it more congruent with the
25 physician's view. Therefore, in addition to bringing up patients' views towards treatment, we
26 argue that physicians may use formulations of patients' stance as a resource for directing the
27 patient towards decisions that are congruent with the physician's stance in situations with
28 potential disagreement, whilst (ostensibly) avoiding a more authoritarian or paternalistic
29 approach.

30

31 **Keywords:** Norway; physician-patient communication; shared decision making;
32 conversation analysis; formulations; patient preferences; patient involvement; secondary care

Introduction

Seeking and discussing ‘patient values and preferences’ is characterized as an ‘essential element’ in Makoul and Clayman’s (2006) influential model of shared decision making (SDM), which they based on an extensive literature review of studies defining shared decision making. However, in spite of its prominence, fine-grained empirical studies of how physicians actually elicit and deal with patients’ perspectives in authentic interactions are remarkably scarce (Clarke et al., 2004; Da Silva, 2012; de Haes, 2006). Conversation analytic studies on medical decision making have mainly focused on how treatment recommendations or options are presented and jointly negotiated, and its implications for patient involvement in decisions (e.g. Collins et al., 2005; Costello & Roberts, 2001; Quirk et al., 2012; Stivers, 2006; Toerien et al., 2011; Toerien et al., 2013), while health communication studies have focused on developing tools for measuring and guiding communication behaviors associated with shared decision making and patient involvement (e.g. Clayman et al., 2012; Elwyn et al., 2013; Krupat et al., 2006). Using actual physician-patient encounters as data and the methodology of conversation analysis (CA), we have identified one conversational practice physicians recurrently use to bring this essential element into the process of decision making, namely, *formulations of the patient’s stance*. In such formulations, the physicians summarize or paraphrase their understanding of the patient’s preference or views towards treatment. The influence these formulations have on the interaction is the topic of this paper.

Formulations of patients’ stance and core SDM concepts

The present study draws on a body of prior research on the practice of ‘formulating’, first described by Garfinkel and Sacks (1970) and further developed by Heritage and Watson (1979; 1980). A formulation “involves summarizing, glossing or developing the gist of an informant’s earlier statements” (Heritage, 1985, 100). For the purpose of investigating talk about ‘patient values and preferences’, we have selected physician formulations of the

patient's stance or preference related to treatment. Although formulations have been described as summaries of immediately preceding talk (Antaki, 2008; Heritage & Watson, 1980), we have included formulations of patients' stances expressed in previous encounters (e.g., made available through charts or referrals), since continuity of care across encounters is the nature of medicine.

In addition to seeking patient values and preferences, the ability to 'check and clarify understanding' has been defined as another essential element in shared decision making (Makoul & Clayman, 2006). Moreover, it is a central communication skill in medical curricula (e.g. Frankel & Stein, 1999; Silverman et al., 2005). As formulations are paraphrases of others' talk, they involve "an assertion of a *specific understanding* of some segment of talk and works to solicit a confirmation of that understanding by another" (orig. emphasis) (Heritage & Watson, 1980, 260). By inviting confirmation, physician formulations may serve the function of checking and clarifying shared understanding of the patient's perspective. Furthermore, as the patient's perspective is within his or her knowledge domain, the physicians' formulations of this stance may provide an opportunity for the patient to elaborate, allowing further exploration of their view (Deppermann & Spranz-Fogasy, 2011; Hayano, 2013; Weiste & Peräkylä, 2013). On the surface, therefore, formulating a patient's stance appears to fulfill two core SDM elements: 1) eliciting patients' preferences and views and 2) checking and clarifying understanding.

The purpose of this study is twofold: 1) to explore what objectives formulations of patients' stance achieve while negotiating treatment and 2) to discuss these objectives in relation to two essential elements of SDM: eliciting patients' perspectives and securing shared understanding.

Formulations in non-medical institutional settings

Formulations “allow the current speaker to select some parts of the prior speaker’s words, ignore others, add spin, and present the package in a form that projects agreement [which] makes them a powerful discursive tool” (Antaki et al., 2007, 168-169). Previous studies have shown how formulations are used for strategic purposes in various institutional contexts. In therapeutic settings, therapists’ formulations achieve other objectives than neutral summarizing or ‘active listening’, serving central therapeutic projects (e.g. Antaki, 2008; Antaki et al., 2005; Hutchby, 2005; Weiste & Peräkylä, 2013). In news interviews, interviewers’ formulations invite the interviewee to commit to stronger and more newsworthy versions of own previous statements, as well as prompting elaboration and proposing directions for subsequent talk (Heritage, 1985). Interviewers’ formulations manage to maintain, on the surface, a neutral stance, by appearing to merely summarize what the other has said. In radio call-in programs, the radio host can ‘construct’ controversy by formulating tendentious or absurd versions of the callers’ previous talk as an initial step for challenging or defeating the callers’ position (Drew, 2003; Hutchby, 1996). Similarly, ‘exaggerating formulations’ found in cognitive psychotherapy transform the client’s descriptions in order to challenge dysfunctional thoughts (Weiste & Peräkylä, 2013).

Formulations in medical settings

To some extent, these findings contrast with the few studies that have been conducted on formulations in medical settings. Formulations in general practice consultations were found to foster mutuality, not exert power (Gafaranga & Britten, 2004). Formulations during history-taking were found to display empathic understanding, shifting to psychological aspects of the illness, a shift regularly resisted by patients (Deppermann & Spranz-Fogasy, 2011). However, in a health appraisal interview, Beach and Dixon (2001) found conflicting functions. Here, formulations both attend to the patient’s emotions, soliciting elaborated disclosure of adverse experiences in a non-judgmental way, while also disattending and

closing down other topics brought up by the patient. Based on this single case study, the authors suggest further research should investigate what detrimental impacts and problematic consequences formulations might reveal across a broader set of medical encounters. The present study contributes to this by showing that formulations of patients' stance may delegitimize that stance as a way of challenging and potentially altering the patient's position towards a decision more congruent with the physician's view.

Data and method

Our data set consists of 380 video-recordings of actual encounters in a university hospital in Norway, collected in 2007-08 as part of a randomized controlled trial investigating the effect of communication skills training (see Fosslı Jensen et al., 2011), and available through broad consent. The research was approved by the Regional Ethics Committee for Medical Research in Southeast Norway. The data represents a wide range of non-psychiatric specialties, increasing the scope for detecting communicative practices with applicability beyond a particular medical setting. Physicians were randomly selected for participation, and 69% accepted; patients were recruited consecutively, and 94% accepted (Fosslı Jensen et al., 2011; Gulbrandsen & Jensen, 2010). A subset of 140 video-recordings was included inductively in order to identify decision making sequences where physicians elicited patients' views and preferences. Starting broadly, we identified some disciplines where characteristics of SDM seemed to be more prevalent. We proceeded to include encounters from these disciplines strategically to maximize efficiency, as going through 380 could not be done. In the 140 encounters, we first identified decision making sequences where decisions were presented as 'to be made', i.e. with potential of co-decision (Collins et al., 2005). The further analysis sought to identify instances of what we initially described as physicians' treatment questions, understood as inquiries seeking to reveal the patient's stance towards treatment. This broad category resembles what Reuber et al. (2015) recently has described as 'patient view

elicitors'. In 17 of the 140 encounters, physicians explicitly oriented to patients' preferences and views through various forms of treatment questions. These encounters form the primary data for this study and were distributed on the branches of gynecology/obstetrics (6), gastroenterology (4), orthopedics (2), infectious disease (2), oncology (1), urology (1) and anesthesia (1). In 14 encounters, the discussion was focused on choosing invasive procedures, such as surgery (12) or biopsy (2). In the remaining 3 medications, additional tests or watchful waiting (Elwyn et al., 2000) were the options of discussion. In other encounters, patients' preferences were not elicited explicitly, but could be oriented to indirectly through e.g. physicians seeking acceptance to treatment recommendations (see e.g. Koenig, 2011; Stivers, 2006).

As described above, the encounters were part of a trial investigating the effect of communication skills training, but the 17 encounters distribute evenly in regard to whether the physician had received training or not. To 'explore patients' perspectives' was part of the training, but specific strategies were not taught. The fact that physicians seeking patients' views and preferences did not occur more often is reflected as well in a low performance score of patient involvement in decision making in the data set as a whole (Gulbrandsen et al., 2014). When checking the 17 encounters for rating of patient involvement in decision making given by expert observers and patients (Fossli Jensen et al., 2010; Fossli Jensen et al., 2011), the selected encounters scored significantly better on patient involvement compared to the 363 not selected consultations. Thus, the selected cases may illustrate current 'best performance' of involving patients in authentic consultations. Although patients' perspectives are not framed as problematic or illegitimate in all these encounters, open-ended treatment questions exploring patients' perspectives more openly are rare; in most cases treatment questions seem to address potential opposing treatment preferences. The following analysis

builds on a comparison of all instances of formulations of patients' stance. We have selected the clearest cases to illustrate core features and variation in trajectories involving such formulations.

Conversation analysis (CA) (see e.g. Sidnell & Stivers, 2013), a systematic methodology for studying recordings of real interactions, is used to analyze the selected video-recordings. Repeated inspection of recordings together with detailed transcripts based on the transcription system developed by Jefferson (2004) (see Appendix), enable fine-grained analysis of the participants' observable conduct with an aim to identify interactional practices and how they affect sequential trajectories that follow (Drew et al., 2001). Analysis of utterances and actions is based on the interpretation of them by the co-participant, as displayed in his or her response in the next turn (the so-called 'next turn proof procedure') (Hutchby & Wooffitt, 2008).

Findings

We identified formulations of patients' stance to be a practice physicians use in order to elicit, check, and establish patients' stances towards treatment. As we will show, the formulations function as more than neutral summaries in that they in subtle ways assess the legitimacy of the patients' treatment preference. Patients' stances framed as less than fully legitimate work to elicit a rationale for the preference that in turn can be challenged or attempted altered, as illustrated in trajectory (a) in Table 1. In one case only, indicated with dashed arrows in trajectory (b), the patient's stance is framed as legitimate and given implicit support by the physician. This case differs in several respects, both regarding turn design features of the formulation and the physician's subsequent actions. Thus, in addition to merely bringing up and making patients' perspectives relevant, the physicians' formulations of patients' stance

may function as a device for assessing the legitimacy of patient stances and for negotiating other treatment options. We have not found any cases in our data where treatment options are presented as completely equipoised.

Patient's previous talk (either immediately before or referenced from e.g. charts or referrals from previous encounters)	(a) physician's formulation of patient's stance as less than fully legitimate	Rationale of stance is pursued, challenged and/or attempted changed
	(b) physician's formulation of patient's stance as legitimate	Consolidate decision-implicative agreement

Table 1. Trajectories in formulations of patients' stance

We have given priority to examples of trajectory (a) as they are prominent in our data. The analysis focuses on design features of the formulations as well as subsequent actions by the physician.

Formulating patient's stance as less than fully legitimate

In the following case, the physician opens the encounter by reviewing the referral from the patient's primary care physician: the patient, a 48 year old woman, has been referred due to a strong bleeding disturbance. And in lines 1-6 the physician continues to summarize talk from the previous encounter:

(1) Uterus (gynecology) (00:46-01:07)

1 D: .hh og så har han ((clears throat)) snakket med deg om e:

.hh and then he has talked to you about e:

2 (0.3) .h e: hormonespira:l?

(0.3) .h e: hormonal co:il?

3 P: ((micro head nod))

200 4 D: .hh men du vil (.) ((lateral head shake)) ikke prøve det?
201 .hh but you don't (.) want to try that?

202 5 P: ne:i? ((lateral head shake))
203 no:?

204 6 D: du vil gjerne fjerne livmoren.
205 you would like to remove the uterus.

206 7 P: °mm,° ((small head nods))

207 8 D: .hh får jeg lov å spørre hvorfor?
208 .hh may I ask why?

209 9 P: .h fordi jeg er e: ve:ldig s:liten og lei av å være et
210 .h because I am e: ve:ry sick and tired of being a

211 10 (.) menstruelt menneske? .h[h] det har vært pla:gsomt
212 (.) menstrual person? .h[h] it has been bo:thersome

213 11 D: [°m°] ((small nod))

214 12 P: fra jeg var fjorten år? ((narrative follows))
215 since I was fourteen years old?

216 The summary is constructed as a series of declaratives about the patient's wishes and
217 experiences. Such statements about matters about which the interlocutor has the primary
218 epistemic authority ('statements about B-events') are recurrently treated as requests for
219 confirmation (Heritage, 2012), and indeed the patient provides such confirmations at lines 3,
220 5, and 7. The declaratives thus contribute to establishing common ground and continuity from
221 a previous encounter by getting first hand from the patient what is only reported second hand
222 by another physician. Furthermore, it introduces talk about treatment by mentioning a
223 specific treatment (hormonal coil) proposed by the referring physician (lines 1-2). The target
224 lines are the two formulations of the patient's stance in lines 4 and 6. In line 4 the physician

225 first formulates that the patient does not want to “try that”. The adversative conjunction “but”
226 marks the patient’s stance as somewhat problematic by contrasting it with the referring
227 physician’s proposal, while highlighting her stance as *active*; that is, she has actively turned
228 down a treatment recommendation (“you don’t want to”). The subsequent formulation (line 6)
229 articulates what the patient *does* want: “you would like to remove the uterus”.

230 The physician’s formulations manage to check his understanding of previous events and
231 establish common ground. However, the formulations perform additional actions: First, they
232 get the patient’s stance ‘on the record’ (Heritage, 1985) as an active wish, thus framing the
233 patient as a responsible agent. Second, the patient’s stance is conveyed in opposition to the
234 referring physician’s proposal. Furthermore, after the patient has confirmed the formulations
235 (lines 5, 7), the physician inquires about her reason for this wish: “may I ask why?” (line 8).
236 Such why-interrogatives treat the accountable event and responsible agent as not in accord
237 with common sense, conveying a challenging stance (Bolden & Robinson, 2011). Besides
238 framing the patient’s stance as not in accord with another medical professional, the physician
239 prefaces the interrogative with a request for permission (“may I”), which frames the question
240 as delicate (Schegloff, 1980). The patient responds with a long narrative built to justify her
241 wish for radical treatment by highlighting her endurance (lines 10, 12), referring to herself as
242 a “menstrual person” (line 10), indicating that this is a dominant feature of her identity, and
243 pointing to major negative effects on her everyday life (data not shown).

244 Extract (2) does not contain additional formulations of the patient’s stance, but illustrates how
245 the physician builds on the positions established by his previous formulations, further
246 challenging and negotiating the patient’s position. The extract begins with the end of the
247 patient’s long response, initiated in line 10 in the previous extract (29 lines of transcript is
248 omitted).

249 **(2) Uterus (gynecology)** (02:07-02:49)

250 42 P: og så er jeg blitt åttogførti å:r

251 and then I have become forty eight years o:ld

252 43 og tenker atte:: HH[hh]h

253 and think tha::t HH[hh]h

254 44 D: [mm,]

255 45 (0.5)

256 46 D: .hhh

257 .hhh

258 47 P: jeg tre:nger i[kke] livmora mer,

259 I don't nee:d [the] uterus anymore,

260 48 D: [ing-]

261 [no-]

262 49 D: nei inge- HeHe .hh ingen tviler på det du sier?

263 no no- HeHe .hh no one questions what you're saying?

264 50 vi e- man (.) kan forstå hvor plaget du er av den?

265 we e- one (.) can understand how bothered you are by it?

266 51 .h men poenget mitt er at hvis (0.4) man kan finne

267 .h but my point is that if (0.4) one can find

268 52 a:ndre metoder? som kan hjelpe deg at du blir kvitt

269 o:ther methods? that can he:lp you get rid of

270 53 blødningsforstyrrelsene dine? .h uten å fjerne livmor?

271 your bleeding disturbances? .h without removing uterus?

272 54 (0.3) Vi:l du gjøre det?

273 (0.3) do you Wa:nt to do that?

274 55 (1.5)

275 56 P: ne:i, ((lateral head shake))

276 no: ,

277 57 D: jeg bare tenker på hvorfor skal man s:kyte

278 I'm just thinking why should one shoo:t

279 58 på en flue med kano(h)n?

280 a fly with a canno(h)n?

281 59 P: .hh e ↱asså jeg tenker sånn okey?

282 .hh e (well) I think like this okay?

283 ((cross arms animated))

284 60 n- da må jeg ha noen V:eldig konkrete: og Gode alternativer?

285 n- then I must have some V:ery concrete and Good alternatives?

286 61 D: °m° ((short nod))

287 62 P: .hh fordi at jeg o:rker ikke å ha mensen lenger?

288 .hh because I can't sta:nd having periods any longer?

289 63 D: nei. skjønner. ((nods))

290 no. I see.

291 In lines 49-50, the physician first acknowledges her bothersome situation, before he indicates

292 his opposing position (“but my point is”, line 51). He follows with a rhetorical inquiry about

293 her willingness to try “other methods” if they are available and if they would resolve her

294 problem effectively (lines 51-54). By providing a potential solution, the inquiry is framed as a

295 reasonable proposal designed to achieve acceptance. Rejections of proposals are dispreferred

296 actions that usually generate accounts that explain or excuse the non-compliance (Pomerantz,

297 1984). The patient’s minimal rejection in line 56 is therefore noticeable as openly

298 disaffiliative or uncooperative. This negative stance may be considered as oriented to by the

299 physician in that he upgrades his challenge in lines 57-58: “why should one shoot a fly with a
300 cannon”. This rhetorical question characterizes her position as in conflict with the common
301 sense expressed in the idiomatic expression, thus further weakening the legitimacy of her
302 position. The patient subsequently modifies her stance by opening up for considering “very
303 concrete and good alternatives” (line 60). However, the preparatory gesture of crossing her
304 arms (line 59), emphatic stress on “Very” and “Good”, and her subsequent account in line 62
305 all serve to maintain her oppositional stance.

306

307 In (1) and (2) the physician’s formulations contribute to establishing the patient as a
308 responsible agent with an active wish in opposition to a proposed treatment recommendation.

309 In the subsequent talk, this is used as a basis for pursuing an account and challenging the
310 patient’s position. This delegitimizes the patient’s position by constructing it as diverging
311 from common sense, and in (2) the physician succeeds in opening up an opportunity for
312 negotiating other treatment options. Throughout, the patient works to justify her position, and
313 in the remainder of the encounter the negotiation continues, eventually ending up with a less
314 invasive procedure recommended by the physician, deferring the option of surgery.

315

316 In the next case, with a different gynecologist, it is the physician who promotes surgery,
317 although the 75-year-old patient has expressed that the vaginal coil she has had as a remedy
318 for six months has not been bothersome, and she has had only minimal symptoms of
319 incontinence. The patient restates her lack of symptoms in line 1:

320

321 **(3) Incontinence (gynecology) (02:55-03:20)**

322 1 P: nei? [merka'ke det da,]

323 no? [didn't feel that then,]

324 2 D: [nei. nei.]
325 [no. no.]

326 3 D: **men e: så du er fornø:yd med den**
327 **but e: so you are satisfi:ed with that**

328 4 **ringen du har hatt i seks månter.**
329 **coil you have had for six months.**

330 5 P: ja, ((nods)) jeg syns det, at den [har vært] grei,
331 yeah, I think so, that it [has been] okay,

332 6 D: [.hhh]

333 7 D: men ska:l en ung sprek dame
334 but shou:ld a young healthy woman

335 8 som deg gå: med en sånn e::: pessar inni skjeden?
336 like you u:se such e::: pessary in the vagina?

337 9 P: jeg vet ikke?
338 I don't know?

339 10 D: [du har jo takket nei til operasj-]
340 [you have said no to operati-]

341 11 P: [jeg har- jeg har en venninne som] ble operert? og der har
342 [I have- I have a friend who] got surgery? and there it has

343 12 det jo etter et år sigi ned igjen?
344 after a year descended again?

345 13 D: .hh er det de:rfor du takket nei til operasjon?=
346 .hh is that why: you said no to surgery?=
347 14 P: =ne::i, det va'ke no snakk om jeg kunne ve:lge her da:?
348 =no::, there wasn't any talk about me having a choice the:n?
349 ((turn continues))

350 The physician initiates his response to the patient's description with an adversative
 351 conjunction "but", indicating from the outset that there is something problematic with
 352 the patient's talk, and possibly starting a challenge right away, before he continues to
 353 formulate the gist of the patient's stance, with the inference marker "so": "so you are
 354 satisfied with that coil you have had for six months" (lines 3-4). Note that at this point,
 355 the patient had not expressed any stance, nor had she used the word "satisfied." The
 356 physician transforms her symptom description ("didn't feel that") to a stance of being
 357 "satisfied" with the coil (Antaki, 2008). After the patient's confirmation in line 5, the
 358 physician moves on with a kind of polar question that Heinemann (2008) has
 359 described as challenges that are unanswerable: "but should a young healthy woman
 360 like you use such a pessary in the vagina?" (lines 7-8). The reduced legitimacy of this
 361 option and the physician's opposing stance is reinforced by the Norwegian "en snn"
 362 (lit. "a such"), a modal determiner marking psychological distance to the object
 363 referred to (Johannessen, 2012) and the turn initial "but". The question either invites
 364 the patient to defend her stance (going against the physician's opinion) or to affiliate
 365 with the physician's position (giving up her own stance). The patient resists the
 366 question by neither confirming nor disconfirming ("I don't know", line 9). In response,
 367 the physician pursues an account in line 10 with a stronger and revised version of her
 368 stance from being satisfied with the coil to having actively turned down surgery,
 369 indicating stronger agency on her behalf. Simultaneously, in overlapping talk
 370 (indicated with square brackets), the patient provides a delayed account; referring to
 371 her friend's negative experience with surgery (lines 11-12). However, unlike the
 372 patient in (1) and (2), the patient here, in line 14, resists the physician's framing of her
 373 stance as an active decision.

374 In extract (3), the physician works to elicit and establish, in his own terms, the patient's
375 stance towards treatment, before challenging it and pursuing an account based on her ascribed
376 agency. In the further talk, not shown here (but see Landmark et al., 2014), the physician
377 introduces and advocates surgery as a viable option.

378

379 The following extracts (4) and (5) are from an obstetric consultation during which the
380 treatment in question is whether or not to perform a cervix measurement. Unlike the two
381 previous encounters, the physician here grants the patient's wish, but the analysis shows how
382 he formulates her stance as a resource for eliciting the patient's rationale and challenging her
383 expectations for the future prenatal follow-up plan. The woman had had a problematic first
384 pregnancy due to cervical incompetence: she almost went into labor in week 21. Now she is
385 21 weeks pregnant with her second child. In the previous talk, she described the first
386 pregnancy, and in line 1, the physician responds empathically to her description:

387

388 **(4) Cervix (obstetrics) (02:47-03:40)**

389 1 D: men det var godt at det har gått bra da:

390 but it's good that it went well

391 2 P: j[a.hh]

392 y[ea.h]

393 3 D: [ikke] sant på tross av alt det der.=men du har litt tak nå:?

394 [right] in spite of all that.=but you have some cramping no:w?

395 4 (.)

396 5 P: .h[hh ()]

397 6 D: [.h og så er] du redd.=

398 [.h and you] are scared.=

399 7 P: =ja. ikke akkurat nå: nå har jeg'ke tak,
400 =yes. not right no:w right now I don't have any cramps,
401 ((14 lines omitted, P elaborates on condition and they establish that P is
402 21 weeks pregnant))

403 22 D: [s:]å da: tenkte du at det er greit å ha
404 [s:]o the:n you thought that it is okay to have
405 23 en ekstra undersøkelse?
406 an extra examination?

407 24 (0.7)

408 25 P: ja: jeg fikk henvist det fra jordmor, og jeg syns det er
409 ye:s the midwife referred me, and I think it is
410
411 26 veldig greit, fordi jeg fikk akkurat samma oppfølging
412 quite good, because I had just the same follow-up
413
414 27 der borte? [.hh o:g og] og hele tiden (på en måte)
415 over there? [.hh a:nd and] and the whole time (sort of)
416

417 28 D: [((nods))]
418

419 29 P: passe på at'n ikke gå- den går vertfall under da.
420 make sure that it doesn't go- it at least doesn't go belo:w.
421

422 30 (0.5)
423

424 31 [((D leans forward))]

425

426 32 P: [e::] en- at'n ikke blir enda mindre enn (.) to komma

427 [e::] en- that it won't get even smaller than (.) two point

428

429 33 fire, av det den var der borte?=
430 four, of what it was over there?=
431

432 34 D: =livmorhalsen,
433 =the cervix,
434

435

436 35 P: livmor[halsen ja.]
437 the cer[vix yes.]

438

439

440

441

442 After the physician's empathic acknowledgement (line 1), he formulates her condition by

443 referring to a physical symptom ("some cramping now") and an emotional state ("scared")

444 (lines 3, 6). In line 7, the patient gives a turn-initial agreement, but disconfirms any cramping

445 right now. In the following (the 14 lines omitted), she continues to elaborate on her physical

446 condition, while ignoring the reference to her emotional condition (Deppermann & Spranz-

447 Fogasy, 2011). After this elaboration, the physician formulates the patient's stance as a wish

448 for "an extra examination" (lines 22-23). Similarly to the formulations in (3) the patient's talk

449 is transformed to a candidate conclusion (indicated by "so") about what she wants, inferred

450 from her symptom description, and perhaps from notes in the referral, whereas constructing it

as something she merely "thought" mitigates the strength of her wish expression.

Nevertheless, the adjective "extra" foregrounds the extraordinary status of the option, turning

it into an accountable action. Together with rising intonation, this invites the patient to agree

and to explicate her rationale for wanting the examination. After a delay indicating a

dispreferred response (line 24), the patient indeed provides a multi-unit account where she

451 subtly rejects two presuppositions in the formulation (lines 25-29): first, she rejects full
 452 agency by distributing part of the responsibility to the midwife, who is a legitimate and
 453 medically authoritative third party (Gill, 1998); second, she indirectly counters the
 454 extraordinary status of the option by pointing out that she received the same follow-up during
 455 her last pregnancy at a different hospital (i.e. yet another legitimate medical authority). The
 456 final part of her account states a medical objective, namely to monitor a previous experienced
 457 high risk factor for preterm birth (cervical incompetence). In addition to providing a relevant
 458 motivation for the option, she portrays herself as medically knowledgeable by referring to a
 459 technical measurement level (lines 32-33), thus strengthening her epistemic authority. In sum,
 460 the formulation subtly indicates the patient's wish as "out of ordinary", seeking out the
 461 patient's underlying reasons.

462

463 Extract (5) follows immediately after (4) and shows the physician's subsequent actions:

464

465 **(5) Cervix (obstetrics), (4) continued (03:40-04:20)**

466 35 P: livmor[halsen ja.]

467 the cer[vix yes.]

468 36 D: [riktig.] okey. så det er e: ja. jeg skjønne.

469 [right.] okay. so it is e: yes. I understand.

470 37 .hh okey. (0.8) ((hand palms meet)) det kan vi:

471 .hh okay. (0.8) we: can

472 38 da vet jeg hva du ↑vi:l, e hva du forventer av ↑meg, .h

473 then I know what you ↑wa:nt, e what you expect from ↑me, .h

474 39 o:g du er enogtyve uker og med den forhistorie

475 a:nd you are twenty-one weeks and with that prehistory

476 40 så vi:l du ath .h vi må:ler livmorhalsen selvom
 477 you wa:nt to have the cervix me:asured even though
 478 41 det er (.) fortsatt veldig tidlig?
 479 it is (.) still very early?
 480 42 P: mm, ((nods))
 481 43 D: .hh men at vi gjø:r det slik at vi har en utgangs↑punkt?
 482 .hh but that we do: it so that we have a starting ↑point?
 483 44 P: mm, ((nods))
 484 45 D: for å kunne sammenligne? (0.7) O:m (0.4) situasjonen
 485 to be able to compare? (0.7) I:f (0.4) the situation
 486 46 skulle tilsi det.
 487 should indicate it.
 488 47 P: mm,
 489 48 D: ikkesant? det er det du tenker,
 490 right? that is what you think,
 491 49 (0.4)
 492 50 P: ja,
 493 yes,
 494 51 D: ja. .hh (.) >okey. jeg skal gjø:r ↑det,< .h (.) Me:n jeg
 495 yes. .hh (.)>okay. I will do ↑it,< .h (.) Bu:t I
 496 52 har lyst til å understreke en ting for deg,
 497 want to emphasize one thing to you,
 498 ((D continues, on that it is normal to be scared, and one should avoid too
 499 many examinations))

500 Although the patient has just distributed the responsibility to two other medical authorities,
501 the physician continues to portray the patient as the responsible agent in his claims of
502 understanding: “then I know what *you want*, e what *you expect* from me (line 38, italics
503 added). In sequential terms this response is remarkable in that it holds back a decision on the
504 question by merely providing a receipt of information about her wishes, and it is heard as
505 building up to something else than a straightforward acceptance. Subsequently, in lines 39-41,
506 he again formulates the patient’s stance as an active wish (“you want to”) more specifically,
507 by incorporating her pregnancy status (“twenty-one weeks”), rationale (“that prehistory”),
508 and stated objective of the examination (“have the cervix measured”). By tailoring it to her
509 previous talk, the formulation shows that he has heard and understood the patient’s account.
510 However, the physician’s version also introduces a new counterargument in turn-final
511 position: “even though it is still very early”, emphasizing “even though”, which delegitimizes
512 the option by portraying it as extraordinary at this point. The formulation thus incorporates
513 the physician’s perspective, in which he questions the necessity of the examination, while
514 seemingly speaking from the patient’s point of view.

515 After additional increments, still receiving only minimal responses (lines 43-47), the
516 physician explicitly pursues a stronger confirmation of her stance (line 48) which is produced
517 after a slight delay (lines 49-50). Following this, the physician finally takes a position on the
518 treatment question. He formats it as a granting of a request: “>okey. I will do it,<” thus once
519 again displaying his opposing stance by presenting it as a concession to her wishes rather
520 than a decision based on a common agreement. And also the following expansion of the
521 response constitutes a disclaimer about the necessity of the examination. It starts with a
522 preannouncement of an admonition: “but I want to emphasize one thing to you”. The marked
523 “Bu:t” stresses the opposing stance, underlining his reluctant position. In the subsequent long
524 turn (not shown here), the physician acknowledges that it is normal to be afraid in her

525 situation, while emphasizing that one should avoid too many examinations that might
526 increase anxiety.

527 Getting the patient's stance and agency 'on the record' allows the physician to slightly
528 challenge the patient's expectations for future follow-ups. Through the formulations of the
529 patient's stance in (4) and (5), and the subsequent reluctant granting and admonition, he
530 builds a case for normalizing or diminishing the patient's presented problem, possibly with
531 the intention of reassuring her that there is nothing to worry about and preventing excessive
532 future follow-ups. However, as the analysis shows, there is a substantial risk of
533 delegitimizing the patient's stance in the process.

534 In the extracts we have seen so far (1)-(5), the physicians formulate the patients' stances as
535 active treatment wishes, framing the patients as responsible agents. Accompanied by
536 deprecating expressions, they work to delegitimize the patients' stances and indirectly convey
537 the physicians' opposing stance. These established positions are then used as a basis for
538 challenging and/or renegotiating the patients' stance, treating them as accountable. The final
539 case we will consider differs from this trajectory, suggesting that formulations of patients'
540 stance may also achieve other objectives.

541 *Formulating patient's stance as legitimate*

542 Extract (6) is drawn from orthopedics, where surgery may have a particularly privileged
543 status relative to other treatment options, affecting both parties' expectations of surgery as a
544 potential treatment option (Hudak et al., 2011). Extract (6) is the only case in our data in
545 which a formulation of the patient's stance is found without any signs of conflicting treatment
546 preferences. Instead, the physician formulates the patient's stance as legitimate, thereby
547 consolidating their congruent positions.

548 The male patient has had a meniscus injury for ten years that has gradually worsened. During
 549 the three minutes before the extract starts, the patient provided a vivid description of physical
 550 restraints on work and everyday life, with long and painful periods every time the knee cap
 551 slips out. During this narrative, the physician complimented the patient for being “extremely
 552 patient” (data not shown), after which the patient replied that his spouse, a health care worker,
 553 had expressed lack of patience on this matter. The physician refers to this previous talk in the
 554 formulation of the patient’s stance in lines 3-4:

555 **(6) Knee (orthopedics) (03:12-03:24)**

556 ((P narrative about physical restraints on work and everyday life caused by
 557 the knee))

558 1 D: ja,
 559 yes,

560 2 P: .hh [men-]
 561 .hh [but-]

562 3 D: [så nå] er'e egentlig ikke bare samboeren som er
 563 [so now] it's not only your spouse that is

564 4 lei detta?=du er [litt lei det sjøl og?]
 565 tired of this?=you are [a bit tired yourself as well?]

566 5 P: [(er Møkka lei)]
 567 [(am Fed up]

568 6 P: ja jeg e:r så møkka lei det?=for[det] at (jeg) må
 569 yes I a:m so fed up of it? =be[cause] (I) have to

570 7 D: [ja,]
 571 [yeah,]

572 8 P: (så) ta så hensyn te det?
573 (so) take it into consideration so much?

574 9 D: ja,
575 yeah,

576 10 P: men så e're ikke no problem å gå da? [jeg] kan lø:pe
577 but then it isn't any problem to walk? [I] can ru:n

578 11 D: [nei,] ((nods))
579 [no,]

580 12 og spille fotball med dattra mi men .h[h]
581 and play football with my daughter but .h[h]

582 13 D: [m]m, ((nods))

583 14 P: det jeg merker
584 what I do feel ((turn continues before D initiates physical
585 examination a few seconds later))

586 The physician's formulation of the patient's stance (lines 3-4) offers his version of the
587 patient's previous talk (initiated with "so"), by adding the emotionally loaded word "tired,"
588 which the patient had not used (Weiste & Peräkylä, 2013). Unlike the previous cases, this
589 stance is not framed as a wish for a specific treatment option, and thus ascribes less agency to
590 the patient. Instead it orients to the patient's *motivation* for active treatment, based on his
591 experience of the problem. The orthopedic setting and the patient's history might be enough
592 to invoke the underlying options of surgery vs. watchful waiting at this point (Hudak et al.,
593 2011), and the two options are made explicit later in the encounter. Several features
594 contribute to framing this stance as legitimate: First, it refers to a significant third party
595 (spouse and health care worker) capable of assessing the patient's situation. Second, it
596 downgrades the description of the patient's emotional state as being "a bit tired" (line 4), a

relatively moderate position compared to his major complaint. Finally, the patient's stance is not conveyed as opposing the physician's stance. Rather, the physician has indicated support to the presented problem in the previously mentioned characterization of the patient as "extremely patient". In subtle ways, the formulation seems to acknowledge, and maybe also indirectly suggest, that this situation warrants intervention, thus preparing the ground for proposing (invasive) treatment (Hudak et al., 2011). The patient's response in line 5 (a collaborative completion) with the upgraded stance from "a bit tired" to "fed up" (line 5-6) signals eager, unproblematic agreement (Lerner, 2002). This differs from the previous cases, in which the patients' responses are delayed or in other ways delivered in dispreferred turn shapes (Pomerantz, 1984). Nevertheless, the patient provides an account for his expressed strong stance (lines 6, 8) and, by pointing to the bright side, that is, what activities he *does* manage (lines 10, 12), displays 'troubles resistance' (Jefferson, 1984).

In this sequence, the physician indirectly establishes the patient's congruent (and thus legitimate) stance towards the relevance of treatment, preparing the grounds for a decision. So when surgery is brought up by the physician later, it is presented and accepted as an obvious and straightforward course of action (data not shown, but see Hudak et al. (2011) on how orthopedic surgeons present recommendations *for* surgery as straightforward as opposed to recommendations against).

Summary of findings

This article scrutinize how physicians formulate patients' stance for more than merely checking and establishing common ground and bringing up patients' preferences and views as a relevant topic in medical decision making. Extract (1)-(5) illustrate how the physicians' formulations of patients' stance bring the patient's stance 'on the record' as less than fully legitimate and portray them as responsible agents with a treatment wish. This may function as

a starting point for challenging and/or (re)negotiating opposing treatment preferences. The patients on the other hand work to justify (1)-(2), (4)-(5) or reject (3) the ascribed stance and agency, for instance by providing accounts or distributing the responsibility to third parties (Gill, 1998). That the formulation of the patient's stance in extract (6) is neither designed nor pursued in similar ways, might be related to the lack of opposing stances in this case, where it instead seem to establish agreement and prepare the grounds for proposing invasive treatment. This single example suggests that formulations of patients' stance may also be used for achieving other objectives than the ones described in extract (1)-(5). Further inquiry is needed to explore other potential functions achieved by formulations of patients' stance than those documented in our analysis, and to investigate to what extent patient stances portrayed as active treatment wishes are associated with being challenged.

Discussion

We have identified formulations of patients' stance as one conversational practice physicians use for eliciting and checking patients' preferences and views in relation to treatment. This is in line with central objectives in the process of making shared decisions (C. Charles, Gafni, A. and Whelan, T., 1997; Elwyn et al., 2012; Makoul & Clayman, 2006). However, this practice may be potentially Janus-faced compared to these objectives; By allowing the physician to transform and edit the patient's previous contributions (Antaki, 2008), they can contribute to delegitimizing the patient's stance and implicitly convey the physician's opposing stance. This suggests that physicians and patients also orient to and negotiate normative aspects of decision making, that is, what is a legitimate and appropriate treatment wish and what is treated as not in accordance with common sense or the physician's expertise. This is an aspect that has received little attention in SDM models, which rather tend to describe discussion of preferences as a neutral and straightforward sharing process (Coylewright et al., 2012). According to Eilon (1969) the crux of a rational decision (or free choice) is not to be

found at the stage of the final resolution, but in the ranking of alternatives based on some criterion. So “[i]f the decision-maker behaves rationally, he must resolve to select this superior alternative” (178). By indicating what stances are more or less legitimate, formulations of patients’ stance might be used as a resource for the physician to direct the patient towards a decision that is congruent with the physician’s stance in situations with potential disagreement, whilst (ostensibly) avoiding a more authoritarian or paternalistic approach. Keeping in mind that our examples are encounters with high score on patient involvement, our findings indicate that there is still some way to go from current ‘best practice’ to the ideal ‘best practice’ described in guidelines.

Another largely unaddressed aspect in SDM models is the possibility that patients, let alone physicians, enter the consultation with expectations or preferences for next action steps, as well as expectations about what the other may prefer, i.e. through charts and referrals. In orthopedic surgery, Hudak et al. (2011) demonstrate that surgeons’ recommendations are adapted to their patients’ expectations as a means of minimizing disagreement. How such preexisting expectations are dealt with and how it might affect the dynamics of decision making may be a question for further inquiry. It may for instance impede SDM models that propose to defer elicitation of preferences until the physician has informed the patient about available options, as is a requirement in the recently developed Observer OPTION⁵ Item (Elwyn et al., 2013).

Partnership is another established concept in SDM models, encompassing some degree of shared responsibility for the decisions (C. Charles et al., 1999; Da Silva, 2012). Formulations of patients’ stance that ascribe the patients as responsible agents can be seen to accommodate that requirement by involving patients as more active partners or agents in the decision. However, a potential disadvantage of increased agency is that it also makes one accountable and challengeable. After the patient’s stance has come ‘on the record’ as an active wish, the

physician can pursue and challenge the patient's rationale, and as Bolden and Robinson (2011, 115) point out, such actions are frequently accompanied by "negatively valenced actions". Again, an on-the-surface practice in accordance with a core concept in SDM models may also conceal competing physician objectives, such as well-intended persuasion of the patient to commit to the physician's opinion by delegitimizing the patient's stance. The accountability that seems to follow increased agency might contribute to understanding a well-established barrier to shared decision making, namely that many patients are reluctant to take more agency in the medical encounter (de Haes, 2006; Elwyn et al., 2012; Guadagnoli & Ward, 1998).

Implications

The vast literature on shared decision making has prioritized the development of conceptual models and tools for measuring the degree of shared decision making (e.g. C. Charles et al., 1997; Clayman et al., 2012; Elwyn et al., 2012; Elwyn et al., 2013; Makoul & Clayman, 2006). Detailed, empirical investigation of core elements, such as how patients' preferences and views are sought and dealt with in authentic consultations, has not been given equal consideration. Such investigations can inform SDM models by pointing to unspecified and underlying barriers and opportunities for realizing and implementing these models and specific objectives into practice (Ariss, 2009; Da Silva, 2012). Previous research on formulations in institutional settings have highlighted that core objectives, such as how to do 'active listening' "tends to be highly generalized and correspondingly vague" (Hutchby, 2005, 308), while the interactional realization of such objectives are far more complex than is generally assumed in guidelines and models. This study contributes to this line of research by providing insight into how a physician practice for bringing up patients' preferences may achieve other objectives than neutral deliberation. While existing measurement tools may identify whether patients' preferences are brought up and discussed, they fail to capture the

actual outcomes (consequences) they engender in interaction. Therefore, we suggest as an area for future research to explore specific and distinctive practices associated with SDM, such as eliciting patients' preferences, securing understanding and building partnership, and to examine the consequences of such practices for the interaction. This could inform guidelines and models that lay the ground for and advance practice developments within this field.

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 840 Psychoanalysis and Cognitive Psychotherapy. *Research on Language and Social Interaction*,
 841 46, 299-321.

842 **Appendix: Transcript symbols**

843	(1.5)	Time gap in tenths of a second
844	(.)	Pause in the talk of less than two-tenths of a second (micro pause)
845	[]	Marks the point of onset and end of overlapping talk
846	=	'Latching' between utterances, either by different speakers or between units
847		produced by the same speaker
848	?	Rising intonation, not necessarily a question
849	.	Falling or final intonation, not necessarily the end of a sentence
850	,	'Continuing' intonation, not necessarily a clause boundary
851	::	Stretching of the sound just preceding them. The more colons, the longer the
852		stretching
853	↑↓	Marked shift into higher or lower pitch
854	<u>word</u>	Stress or emphasis of underlined item, the more underlining, the greater
855		emphasis
856	WORD	Markedly louder volume than surrounding talk
857	° °	Talk between the degree signs is markedly softer or quieter than
858		surrounding talk
859	<word>	Slower speech rate than surrounding talk
860	>word<	Faster speech rate than surrounding talk
861	-	Cut-off or self-interruption of the prior word or sound, often done with a
862		glottal or dental stop
863	.hh	In-breath. The more h's the longer the in-breath
864	hh	Out-breath. The more h's the longer the out-breath

865	(h)	Aspiration within speech, usually laughter
866	#	Creaky voice
867	(())	Transcriber's comments on preceding talk, e.g. description of non-verbal
868		activities
869	(word)	Transcriber's best guess of an unclear fragment
870	()	Inaudible talk