

Negotiating patient involvement in treatment decision making
A conversation analytic study of Norwegian hospital encounters

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A reliable, empathic relationship with the caregivers may constitute a holding environment

(John Nessa & Kirsti Malterud, 1998)

Photo: Ingunn Viste¹

¹ The photograph of a coconut birdfeeder is taken outside our kitchen window in Sandefjord.

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Abstract

This dissertation presents an examination of how physicians and patients make treatment decisions in actual encounters in a Norwegian hospital. The overall aim of the study is to identify and describe aspects of the *interactional accomplishment* of treatment decision making when patients are involved in the decision making, since current guidelines promote patient involvement in making decisions (i.e., shared decision making). The method used is conversation analysis (CA). Based on video recordings of actual interactions, CA is a data-driven approach for examining both how participants in talk accomplish actions and what interactional consequences those actions yield. Article 1 examines encounters where more than one option is brought up. Article 2 identifies one specific practice physicians use to bring up the patient's stance towards treatment. Article 3 describes a physician's strategies to secure a non-native speaking patient's understanding and acceptance of an invasive treatment recommendation.

In sum, this study shows how physicians and patients negotiate treatment decisions in at least three areas: (1) Firstly, the participants negotiate what treatment to choose. (2) Secondly, in order to arrive at a treatment decision, the participants negotiate the terms on which the decision should be made. These terms involve negotiating *who* will make the decision (deontic rights), which is dependent on determining on *what grounds* the decision should be based, either on the patient's personal experiences and wishes (epistemics of experience), or on the physician's medical expertise (epistemics of expertise). (3) Thirdly, negotiation may also concern determining *which* treatment options are available and appropriate (cf. the Patients' Rights Act, § 3-1).

The study shows that physicians and patients orient to, and indeed expect, a *constrained form of patient involvement* in decision making, where the physicians set important terms for opportunities and constraints for patient participation. The ways in which physicians involve patients (e.g., providing choice, bringing up patients' views and securing patient acceptance) seem to curtail, rather than promote opportunities for patient involvement, in that the physicians' actions primarily work towards bringing the patient 'on board' on decisions that correspond to the physician's view. Nevertheless, patients also have ways of influencing decision making. Article 3 illustrates how a patient can even influence a decision through minimal participation, effectuated by an expectation of patients' acceptance (or rejection) of treatment recommendations. This dissertation expands previous knowledge about how

patients are actually involved in treatment decision making. Such fine-grained descriptions of authentic interaction may contribute to much needed empirical detail and specification that can be the basis for refining and developing recommendations for practice.

Sammendrag (abstract in Norwegian)

Denne avhandlingen er en studie av hvordan leger og pasienter tar beslutninger om videre behandling i autentiske konsultasjoner på et norsk sykehus. Det overordnede målet med studien er å beskrive hva som skjer i konsultasjoner der pasienten er involvert i beslutninger om valg av utredning og behandling, siden dette er i tråd med eksisterende retningslinjer for god pasientbehandling (samvalg). Metoden som er brukt i denne avhandlingen, er samtaleanalyse (CA). CA er en data-drevet tilnærming der videoopptak av autentiske samtaler benyttes for å studere hvordan deltagere utfører ulike handlinger, samt hvilke konsekvenser disse handlingene har i det videre forløpet. Artikkel 1 ser på konsultasjoner der pasienten får valg mellom ulike behandlingsalternativer. Artikkel 2 identifiserer en samtalepraksis leger benytter for å få fram pasientens ønsker eller ståsted med tanke på valg av behandling. Artikkel 3 beskriver hvilke samtalestrategier en lege anvender for å sikre at en minoritetsspråklig pasient både har forstått og er innforstått med et behandlingsforslag.

Samlet sett viser avhandlingen at leger og pasienter forhandler om videre behandling på minst tre områder: (1) For det første forhandler deltagerne om hvilken behandling som skal velges. (2) Denne forhandlingen utløser gjerne en forhandling om hvilke premisser og betingelser som skal ligge til grunn for beslutningen - både knyttet til *hvem* som skal ta beslutningen (deontiske rettigheter), og knyttet til *på hvilket grunnlag* beslutningen skal tas: på bakgrunn av pasientens personlige erfaringer og ønsker (epistemisk erfarings-domene), eller basert på legens medisinsk-faglige vurdering (epistemisk ekspert-domene). (3) I tillegg er deltagerne forhandlinger også orientert mot å avklare *hvilke* undersøkelses- og behandlingsalternativer som er «tilgjengelige og forsvarlige» (jf. Pasientrettighetsloven, § 3-1).

Studien tyder på at både leger og pasienter er orientert mot, og forventer, en *begrenset form for pasientinvolvering* i beslutningene, der legenes måter for å involvere pasienter (f eks ved å tilby valg, få fram pasientens ønsker og sikre pasientens aksept) på ulike vis snarere *motvirker* enn *medvirker* til involvering, ved at de først og fremst bidrar til å få pasienten med på beslutninger som er i tråd med legens oppfatning. Selv om det i hovedsak er legene som setter premisser og rammer for pasientinvolvering, har også pasienter ulike ressurser for å medvirke i beslutninger. Artikkel 3 viser hvordan pasienter til og med kan påvirke beslutninger gjennom minimal deltagelse, basert på en forventning om at pasienten skal akseptere (eller avslå) et behandlingsforslag. Avhandlingen utvider eksisterende kunnskap om hvordan

pasienter involveres i beslutninger om videre behandling. Slike detaljerte beskrivelser av autentisk interaksjon kan bidra til å spesifisere og utvikle empirisk baserte anbefalinger for god praksis.

List of papers

Article 1

Whose decision? Negotiating epistemic and deontic rights in medical treatment decisions.
Landmark, A.M.D., Gulbrandsen, P., & Svennevig, J. 2015. *Journal of Pragmatics* 78, 54-69.

Article 2

Negotiating treatment preferences: Physicians' formulations of patients' stance.
Landmark, A.M.D., Svennevig, J., & Gulbrandsen, P. 2016. *Social Science & Medicine* 149, 26-36.

Article 3

Patient involvement and language barriers: problems of agreement or understanding?
Landmark, A.M.D., Svennevig, J., Gerwing, J., & Gulbrandsen, P. *Submitted for publication*
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Table of contents

Acknowledgements	5
Abstract	7
Sammendrag (abstract in Norwegian).....	9
List of papers	11
Table of contents	13
1 Introduction	17
1.1 From original to final object of study	17
1.2 A shift in the medical enterprise: ‘the patient revolution’	17
1.3 Analytic approach and study aim	18
1.4 Outline of the study	19
2 Conceptual framework	21
2.1 Patient-centered care.....	21
2.2 Patient involvement and patient participation	21
2.3 An integrative model of shared decision making	22
2.4 Treatment decision making	23
3 Theoretical framework	24
3.1 Sequential organization of talk-in-interaction	24
3.1.1 Understanding as a co-constructed achievement	25
3.1.2 An emic perspective of participants’ actions	25
3.1.3 Preference organization and affiliation	26
3.2 Relevance of context	27
3.2.1 Institutionality, ethnographic knowledge and power.....	27
3.3 Epistemic and deontic rights.....	28
4 Review of previous research	30
4.1 Non-CA research on physician-patient communication.....	30
4.1.1 Some influential studies	30

4.1.2 Models of treatment decision making.....	32
4.1.3 Central measurements for shared decision making.....	34
4.1.4 SDM and patient involvement: challenges in implementation and research	35
4.2 CA research on physician-patient communication.....	37
4.2.1 Patient participation in primary care settings.....	38
4.2.2 Patient participation in treatment decision making.....	42
5 Research questions	47
6 Data and Method	48
6.1 Data.....	48
6.1.2 Participants.....	48
6.1.3 Selection of data for the present study	49
6.1.4 Ethical considerations	50
6.2 Conversation analysis as method.....	50
6.2.1 Approaching the video data and issues of reliability	50
6.2.2 Analytic procedures and issues of validity	55
7 Overview of the findings of the study	58
7.1 Article 1	58
7.1.1 Physicians' orientations to patient involvement: deontic rights	58
7.1.2 Patients' orientations to patient involvement: deontic rights.....	59
7.1.3 Exploiting a shared orientation to patient involvement	59
7.2 Article 2	59
7.2.1 Physicians' orientation to patient involvement: patient preferences	60
7.2.2 Patients' orientations to patient involvement: patient preferences	60
7.3 Article 3	61
7.3.1 Physician's orientation to patient involvement: acceptance and understanding.....	61
7.3.2 Patient's orientation to patient involvement: acceptance and understanding	62

8 Discussion	63
8.1 Knowledge interests	63
8.1.1 On balancing or compromising knowledge interests.....	63
8.2 Empiric-analytic contributions	64
8.2.1 Investigation of a sparsely researched setting.....	64
8.2.2 A shared orientation to constrained patient involvement.....	65
8.3 Practice-instrumentalist implications	67
8.3.1 The scope of empiric-analytic contributions.....	67
8.3.2 Implications for SDM models and patient involvement	68
8.4 On current practice in Norwegian hospital encounters and SDM	72
8.4.1 Implications for professional practice and training.....	73
8.4.2 Implications for health policy	74
8.5 Methodological implications and directions for future research	75
8.5.1 Combining qualitative and quantitative approaches	75
8.5.2 Integrating qualitative and quantitative approaches.....	75
8.5.3 Implications for research on patient preferences for involvement.....	77
8.6 Conclusions	77
References	79

1 Introduction

1.1 From original to final object of study

This study presents an examination of how physicians and patients make treatment decisions in actual encounters in a Norwegian hospital. But first, I devote a few words to how the topic of this project evolved. My original objective was to use conversation analysis as a method for examining how potential language differences and uncertainty, in a broad sense, might play out in videotaped encounters with non-native speaking interlocutors (whether patients, physicians, or both). However, when inspecting the videos, I found that with only a few exceptions (see article 3) did the language differences seem relevant to the participants.

Rather, I started noticing something else that puzzled me: In many encounters, what seemed to be at stake, and what participants ‘struggled’ with the most, was how to come to decisions about what treatments or examinations to choose. Meanwhile, I had joined a health communication research group, who introduced me to the field of *patient-centered care* and *shared decision making*. I became intrigued by this widespread, public imperative advocating greater involvement of patients in medical decisions (Coylewright et al., 2012). Together with the initial data-driven puzzle, my interest shifted towards what actually happens in decision making when patients are involved. As a result, I decided to include videotaped encounters with pairs of native-Norwegian speakers from the larger available dataset (see Chapter 6).

1.2 A shift in the medical enterprise: ‘the patient revolution’

Nothing about me without me.

Valerie Billingham, Through the Patient's Eyes, Salzburg Seminar Session 1998, in Barry & Edgman-Levitan (2012)

Over the past 40 years, in the medical enterprise, a radical shift towards more patient-centered health care has been promoted and characterized as ‘the patient revolution’ (Richards et al., 2013) or, more broadly, patient-centered care (Mead & Bower, 2000). These reform initiatives advocate a shift from a traditional physician-centered or paternalistic approach to a patient-centered one, where patients take on a more active role as partners, for instance in decision making. Such patient-centered initiatives have been justified from several perspectives. Most prominently, they rest on an ethical imperative based on a fundamental right to self-determination (autonomy), and are reflected in the right to consent or refuse medical intervention (Beauchamp & Childress, 2013; Nessa & Malterud, 1998). Along these

lines, Guadagnoli & Ward (1998, p. 337) have argued that “patient participation in decision making is justified on humane grounds alone and is in line with a patient’s right to self-determination”.

Another argument points to that patient participation will lead to increased quality of healthcare that will have beneficial health outcomes (Collins et al., 2007; IOM, 2001). Finally, patient-centered initiatives are also justified with a basis in patients’ rights and individual freedom, reflecting a more consumer-oriented approach to health care (Thompson, 2007). Through these various lines of argument, the principles of patient involvement have gained overwhelming support, influencing health policies (e.g. Department of Health, 2010; IOM, 2001; Lawrence, 2004; WHO, 1978) and medical communication curricula in many countries (e.g. Silverman, Draper, & Kurtz, 2005). In Norway, these shifts are visible in recent health policy initiatives that are built around ‘the patient’s health service’ (*Meld. St. 11 Nasjonal helse- og sykehusplan (2016-2019)*), in which the principle of “no decision about me, without me” plays a central part (see e.g. "Sykehustalen 2015" [The hospital speech 2015]). Moreover, the Patients’ Rights Act states that “The patient is entitled to participate in the implementation of his or her health care. This includes the patient’s right to participate in choosing between available and medically sound methods of examination and treatment” (“Lov om pasient- og brukerrettigheter [Patients' Rights Act]", 1999, § 3-1). Nevertheless, in spite of the fact that researchers, health professionals, patients, the general public, and policy makers are in wide agreement that patient involvement in treatment decisions is a desirable goal, several unresolved challenges remain concerning exactly *what* it means, *how* and *when* it should be implemented, as well as for *what reason*. This study does not set out to answer all these challenges, but aims to inform the debate with a sort of evidence that has been less explored, providing detailed descriptions about *how patient involvement is actually accomplished in real interactions between physicians and patients*.

1.3 Analytic approach and study aim

In spite of extensive policy and training initiatives towards patient-centered healthcare, little is known about how these initiatives are realized in practice. The present study takes a descriptive point of departure to illuminate how patient involvement in decision making actually occurs *in situ*, in real medical encounters. Using conversation analysis (CA), the study “puts interactional activity under the microscope” (Antaki, 2011b, p. 8) by detailed examination of recordings and transcripts. What distinguishes a conversation analytic

approach from other approaches in the field, is its capacity to document how health professionals' communicative choices impact patient participation there and then, in the sequential unfolding of talk (Drew, Chatwin, & Collins, 2001). The present study thus contributes to a line of research that Toerien et al. (2013) have proposed: “future CA studies should map out the range of ways – in addition to recommending – in which treatment decision-making is initiated by clinicians” in order to produce “further evidence-based contributions to debates on the related concepts of patient participation, choice, shared decision-making and medical authority” (p. 873).

The approach of illuminating professional practice places this study within ‘institutional applied CA’ (Antaki, 2011b). More specifically, the study seeks to *inform practice* by providing a more detailed and nuanced picture of professional practice than those described in “normative models and theories (...) about interaction” that “are part of the knowledge base of many professions” (Peräkylä & Vehvilfinen, 2003, p. 729). Peräkylä & Vehvilfinen describe these normative models and theories as ‘professional stocks of interactional knowledge’ (in short, SIK). For this study, the relevant SIKs that will be discussed are models conceptualizing patient involvement in decision making, in particular models of shared decision making.

The overall aim of the present study is to identify and describe aspects of the *interactional accomplishment* of treatment decision making that are more in line with current guidelines and policies promoting patient involvement in decision making. Such descriptions, based on fine-grained investigation of actual interaction, can contribute much needed empirical detail and specification about how ideals of patient involvement are realized in practice. These descriptions can in turn be used as a basis for refining and developing recommendations for practice (e.g. Braddock et al., 2008; Drew et al., 2001).

1.4 Outline of the study

In the next chapter, central concepts for the object of study (hereunder SIKs) are introduced and specified. Chapter 3 presents the theoretical framework of CA on which this study is built. Fundamental assumptions in CA concerning its view of interaction, understanding, and context will be presented, as well as the notions of preference organization and epistemic and deontic rights, as they are of particular relevance for this study. Chapter 4 provides an overview of previous research. The chapter is subdivided in two main sections. The first part gives an overview of advances, interests, and challenges in health communication research,

particularly in relation to patient involvement in decision making. The second part reviews previous CA research on physician-patient interaction, focusing on patient participation in general and treatment decision making in particular. Following the literature review, the thesis research questions will be introduced in Chapter 5, before the data and method used are presented in Chapter 6. Chapter 7 answers the overarching research question, posed in Chapter 5, with an overview of the empirical findings from the three research articles. Finally, Chapter 8 discusses contributions and implications more broadly in relation to the secondary research question presented in Chapter 5. The last part of Chapter 8 is dedicated to a discussion of possible directions for further research.

2 Conceptual framework

2.1 Patient-centered care

The Institute of Medicine defines *patient-centered care* as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (2001, p. 3). As indicated here and elsewhere (e.g. Barry & Edgman-Levitan, 2012), one central component of patient-centered care is the active involvement of patients in decision making, and it is this component this study seeks to explore.²

2.2 Patient involvement and patient participation

In the literature, ‘patient involvement’ and ‘patient participation’ are often used interchangeably as self-explanatory concepts (Thompson, 2007), and I have not been able to locate a source that clearly distinguishes between the two (but see Cahill, 1996). In this thesis, I understand ‘patient participation’ in a broad sense, ranging from minimal forms (e.g., merely requiring the patient’s presence in the medical consultation) to active forms (e.g., where patients propose treatments) (see Peräkylä, Ruusuvaori, & Lindfors, 2007, p. 122 for a similar account). Although ‘patient participation’ is the most common term within CA research (see e.g. Collins, Britten, & Ruusuvaori, 2007; Robinson, 2003), in this thesis, I use ‘patient involvement’ as the overarching term for two reasons. First, it foregrounds the focus on physicians’ undertakings and efforts to involve patients in decision making; a starting point for all three articles is what physicians say and do and what implications these actions have for patient participation (Drew et al., 2001). Second, I understand ‘involvement’ as forms of participation that go beyond mere co-presence, involving some responsibilities or expectations to take part in or contribute to the decision making. The three articles that this thesis is built on can be regarded as examining a continuum of ‘involvedness’ or ‘sharedness’ (Charles, Gafni, & Whelan, 1997; Makoul & Clayman, 2006), ranging from the lower end of the continuum, in which the patient is expected to merely accept (or reject) a treatment proposal (article 3) to the higher end of the continuum, in which patients are expected to decide (article 1) or bring up their treatment preferences (article 2).

² There is no clear conceptual definition of patient-centered care, but a common feature is a distancing from a ‘biomedical model’ of practicing medicine, instead acknowledging and bringing patients’ experiences, values and perspectives into the medical encounter (Mead & Bower, 2000; Scholl et al., 2014).

Importantly, both patient *involvement* and *participation* reflect a fundamental assumption permeating this thesis, namely, that involvement and participation in decision making is a collaborative achievement that cannot be carried out by the physician or patient alone (Costello & Roberts, 2001; Heritage & Maynard, 2006; Koenig, 2011; Maynard & Heritage, 2005). Rather, physicians and patients “jointly construct the medical visit as a real-time interactional product“ (Heritage & Maynard, 2006, p. 1). That medical decisions are jointly constructed contrasts with an underlying assumption in some decision making models, in which patient involvement may be understood, or at least assessed, based on the physicians’ conduct alone (see Section 4.1.4.3; 8.5.2).

2.3 An integrative model of shared decision making

Patient involvement in decisions is specified and operationalized within a plethora of conceptual models of shared decision making (SDM). For an integrated model, I draw on the influential and comprehensive work of Makoul & Clayman (2006). Their systematic review identified 161 articles comprising conceptual definitions of SDM and then developed a model that integrates these definitions and distills the ‘essential elements’ for achieving SDM.³ The articles in this thesis describe how some of these ‘essential elements’ play out in actual interaction. Article 1 considers encounters in which treatment options are brought up (approximating the essential element ‘present options’). Article 2 considers a conversational practice in which physicians elicit and check patients’ preferences (approximating the essential elements ‘patient values/preferences’ and ‘check/clarify understanding’). Article 3 considers a single encounter during which the physician and patient deal with core problems of mutual understanding and acceptability of a treatment recommendation (approximating the essential element ‘check/clarify understanding’).

Although this study addresses and seeks to discuss SDM as ‘stocks of interactional knowledge’ (see Section 1.3), I have chosen the broader notion of patient involvement in the overall characterization of the study for the following reasons. First, patient involvement can be seen as a general requirement and a goal that is common to all contemporary decision making models. Furthermore, models of SDM may be regarded as more narrow in scope than patient involvement, and may not be appropriate in all cases (cf. Charles, Gafni, & Whelan, 1997; Elwyn et al., 2000). Finally, SDM models are first and foremost linked to studies assessing SDM, which falls outside the scope of this study.

³ A simplified version of this model is found in Table 1, Section 8.3.2.

2.4 Treatment decision making

Following the overall interest in patient involvement in decision making, this thesis deals with decisions that participants orient to as yet ‘to be made’ (Collins et al., 2005), that is, decisions that project some kind of patient participation, unlike decisions oriented to as already made (see also Ofstad et al., 2014). Braddock et al. (1997, p. 340) define a clinical decision as “a verbal statement committing to a particular course of action”. In this thesis, I use the term ‘treatment decision’ in this sense, including *all next actions*, to be carried out by the physician, patient, or both (Gerwing, Indseth, & Gulbrandsen, 2015). More specifically, following Ofstad et al.’s (2016) recent typology of medical decisions, in this thesis, treatment decisions could be ‘gathering information’ (e.g. ordering tests/diagnostic procedures), ‘drug-related’ (e.g. start, stop or alter drug regimen), ‘surgery-related’ (e.g. start, or, importantly, refrain from surgical procedures), ‘legally-related’ (e.g. sick leave), ‘contact-related’ (e.g. discharge, schedule control), ‘advice and precaution’ (e.g. smoking, diet) and ‘deferment’ (e.g. wait and see, postpone decision). Furthermore, Braddock et al. (1999) discriminate between three levels of complexity, arguing that intermediate (e.g. new medications) and complex (e.g. invasive procedures) decisions would require greater patient participation than basic decisions (e.g. laboratory tests). The articles in this thesis mainly consider ‘complex decisions’, such as invasive diagnostic and treatment procedures, in which the effect on the patient is more extensive and potential outcomes are more uncertain.

Whereas the present chapter has specified central concepts for this thesis’ object of study, the next chapter deals with the theoretical framework and assumptions underpinning this study.

3 Theoretical framework

In the first instance, the social world is a pervasively conversational one in which an overwhelming proportion of the world's business is conducted through the medium of spoken interaction (Heritage, 1984, p. 239).

The research presented in this thesis belongs within the framework of conversation analysis (CA). The theoretical foundations of CA are inductive and derived cumulatively from data-driven studies. However, some basic influences have been ascribed Harold Garfinkel and Erving Goffman in their view that everyday interaction is a legitimate domain of sociological inquiry built on some sort of (normative) orderliness (Goffman, 1983; Heritage, 1984; Hutchby & Wooffitt, 2008). Moreover, Garfinkel's ethnomethodology, with its interest in discovering 'members' methods for producing accountable and recognizable actions, has been influential for CA. Garfinkel argues that:

the intelligibility of what is said rests upon the hearer's ability to make out what is meant from what is said according to methods which are tacitly relied on by both speaker and hearer (Heritage, 1984, p. 144).

Based on these assumptions, Harvey Sacks, a sociologist and developer of CA, started studying audio recordings of authentic interaction in order to explicate the "organization of talk-in-interaction in its own right, as a 'machinery'" (Hutchby & Wooffitt, 2008, p. 31; Sacks, 1984). In what follows, fundamental notions of CA, as well as some of which have particular relevance for the present study will be introduced.

3.1 Sequential organization of talk-in-interaction

In CA, ordinary talk, or talk-in-interaction, is viewed as systematically and deeply organized (Heritage & Atkinson, 1984; Sacks, 1984; Sacks, Schegloff, & Jefferson, 1974; Schegloff, 2007); in Sacks' terms, there is an 'order at all points' (1984, p. 22). Turns at talk are primarily viewed as accomplishing *social actions* (e.g. greetings, invitations, assessments, complaints, requests, etc.), and what action is performed is made recognizable with help of its *position* and *composition* (Schegloff, 1997a; Schegloff, 2007). Importantly, conversationalists rely on an utterance's *position within a sequence* in order to interpret what action it performs, not just its *linguistic composition*. For instance, an interrogative does not necessarily pose a question (Schegloff, 1984). Every turn at talk is thus both generated by and understood in relation to what comes before (e.g. does it answer the question or not), and it regularly

projects some next action (Sacks, Schegloff & Jefferson, 1974). This basic principle also applies to observers and analysts of conversation, and forms the basis of why CA rejects analysis of single, isolated utterances, and instead insists on analyzing sequences and turns-within-sequences (Heritage, 1984, p. 245).

The basic structure in conversations of paired action sequences, or *adjacency pairs*, is that first actions (e.g. an invitation) impose normative expectations or constraints on the next speaker's turn at talk (e.g. an acceptance of the invitation) (Sacks, Schegloff & Jefferson, 1974). As such, the adjacency pair structure constitutes a shared *normative framework* for actions, based on members' shared methods or tacit 'rules' that conversationalists orient to (Heritage, 1984, p. 247; Hutchby & Wooffitt, 2008). In this thesis, the related notion of alignment is particularly relevant. Alignment indicates whether a response cooperates with the *action* (or course of action) projected in the first action (e.g. provides acceptance/rejection to a proposal). *Misalignment*, conversely, indicates instances where a second action does not provide a normatively expected response (e.g. does not return a greeting). Alignment thus reflects negotiations on an action level, where participants work to resolve what actions and courses of action are relevant at that particular moment (Stivers, 2008).

3.1.1 Understanding as a co-constructed achievement

As already mentioned, the shared resources speakers use to *produce* actions are precisely the same resources that recipients use to *understand* what action the prior turn-at-talk is doing (Heritage & Clayman, 2010). Moreover, conversationalists use the same sequential organization described above for achieving and securing understanding: As every turn at talk provides traces of how the prior turn was understood, the speaker of the prior turn can use the recipient's present turn to evaluate whether the recipient understood what the speaker meant, providing the possibility of detecting, correcting, or repairing the misunderstanding in the next turn (Heritage, 1984; Heritage & Atkinson, 1984; Sacks, Schegloff & Jefferson, 1974; Schegloff, Jefferson, & Sacks, 1977). This machinery of mutual monitoring and negotiation of understanding is the basis for the CA view of *understanding as a collaborative and co-constructed achievement*.

3.1.2 An emic perspective of participants' actions

Following the view described above of how understanding is achieved, and of particular relevance for this thesis, is the conversation analytic insistence on detecting *participants'* orientations or understandings of what is going on (Schegloff, 1997b). According to Schegloff

(1996), this is a radical participant orientation, compared to other related disciplines, in that it seeks to account for participants' actions in their own terms, grounded "in the "reality" of the participants" (Schegloff, 1996, p. 172). Pike's distinction between *etic* and *emic* perspectives in linguistics has been used to describe CA's aim of capturing the participants' own orientations to what is going on in the interaction:

The etic viewpoint studies behavior as from outside of a particular system, and as an essential initial approach to an alien system. The emic perspective results from studying behavior as from inside the system. (Pike, 1967, p. 37, in Seedhouse, 2005, p. 252)

The conversation analyst's perspective, then, is constantly guided by what (actions, referents, contexts, etc.) participants make relevant through their talk as it unfolds *within* the sequential context, since that is where participants' activities and projects are continuously 'talked into being' (Heritage, 1984; Seedhouse, 2005).

3.1.3 Preference organization and affiliation

The notion of *preference*⁴ is also of particular relevance for the participants in this study.

Preference organization refers to how participants in talk-in-interaction build their turns at talk for promoting solidarity and minimizing conflict in sequences where first actions make relevant "alternative, but nonequivalent, courses of action" (Atkinson & Heritage, 1984, p. 53). Simply put, a range of first actions are biased towards favoring one type of response over another. For instance, invitations or proposals regularly favor, or *prefer*, acceptance over rejection. Similarly, most assessments prefer agreement over disagreement (Pomerantz, 1984). A related notion is that of *affiliative* actions, which indicate support and endorsement with the first speaker's displayed stance. *Disaffiliative* actions conversely, are destructive of social solidarity, indicating, for instance, disagreement (Heritage, 1984; Lindström, 2013; Stivers, 2008). In talk, second speakers regularly deploy resources for displaying whether their response-in-progress will be an optimal, preferred (affiliative) response, or a non-optimal, dispreferred (disaffiliative) response in that they are produced with systematic differences. Whereas second speakers produce preferred responses in a straightforward and unmitigated manner, they regularly make efforts to maintain solidarity when delivering dispreferred

⁴ The technical CA notion of preference should not be confused with the notion of preference as is used differently in the literature of e.g. shared decision making and elsewhere in this thesis, for describing a physician's or patient's *favoured* treatment option (i.e. treatment preference), or more generally, as patients' preferences (i.e. desires) for participation in decision making.

responses, using delays, mitigations and accounts, that, for instance, explicate inability to comply with the preferred response (Heritage, 1984; Pomerantz, 1984).

3.2 Relevance of context

An important consequence of CA's inductive, data-driven approach, as opposed to a theoretically driven approach, is CA's view and handling of context. In analyzing interaction data, there are, in principle, unlimited possible contexts and characterizations that can be used to describe and interpret a specific activity or participant. For example, a physician (or patient) could be described with a range of social identities as male, white, old, Pakistani, resident, surgeon, father, and many others. The problem for the analyst is to determine when and which of these characterizations are relevant and appropriate to bring in when interpreting the data (Heritage, 1984; Schegloff, 1997b). The CA solution draws on two principles: The first is to draw on the *endogenous* resources or contexts that participants orient to and make relevant while they are involved in the business at hand. This principle builds on the assumption that talk-in-interaction is unavoidably contextually oriented. Thus, following the emic perspective described in Section 3.1.2, it is the contexts and content that participants orient to as demonstrably relevant that is considered relevant for the analysis (Heritage, 1984). As Drew & Heritage (1992, p. 19) put it,

the CA perspective embodies a dynamic approach in which "context" is treated as both the project and product of the participants' own actions and therefore as inherently locally produced and transformable at any moment.

The second principle is closely related to the first and is concerned with this "locally produced and transformable" view of context. Heritage's widely-cited description of a speaker's communicative action as being both *context-shaped* and *context-renewing* (1984, p. 242) underlines the sequential view of context, in that every contribution is understood and shaped with reference to what came before, while simultaneously setting up constraints and opportunities for what is relevant next contributions.

3.2.1 Institutional, ethnographic knowledge and power

When considering the larger institutional context, as is germane to this study, the guiding principles remain: empirical observations should be able to show participants' orientations to the institutional character (Drew & Heritage, 1992), since "*it is within these local sequences of talk, and only there, that these institutions are ultimately and accountably talked into being*" (Heritage, 1984, p. 290, italics original). Thus it is not primarily through buildings,

titles, and other exogenous features that ‘institutions’ exist, but they are ‘talked into being’ (or not) on a turn-by-turn basis by the participants’ actions.

Nevertheless, it is not necessarily straightforward for ‘overhearing’ analysts to grasp what actions participants, especially professionals, are occupied with, as institutions may draw on specific knowledge that is not always overt, explicit, and known to outsiders (i.e. lay persons with no previous familiarity with an institution). Thus, in order to secure some degree of shared interpretative grounds with the participants, a requirement for analyzing institutional data is to have member-like knowledge about covert, specialized activities and procedures. This is necessary if the analysis is intended “to decipher participants’ competencies (or their lack of them) in doing the institutional tasks” (Arminen, 2000, p. 437). ‘Doctoring’ and medicine is a highly specialized discipline, not always transparent for others. Therefore, in this study, the experienced physician Pål Gulbrandsen, my supervisor, has played a central role in providing ethnographic knowledge about medicine, the health care system, and hospital organization.⁵

One final point to be made here is in regard to the notion of power: Although CA has been criticized for being “unwilling to make links between the “micro” phenomena of talk-in-interaction and the “macro” levels of sociological variables” (Hutchby, 1999, p. 85), in this study, following Hutchby’s argument, power will be viewed as “a set of potentials which, while always present, may be varyingly exercised, resisted, shifted around, and struggled over by social agents” (1999, p. 92). This is a central point for this study, which exactly makes the patients’ and physicians’ ‘struggles’ in making decisions to an object for analysis. But as already highlighted, the relevance of power “needs to be shown to be, a matter for members and not just for analysts”, it needs to be an *oriented to*-feature by the participants (Hutchby, 1999, p. 86).

3.3 Epistemic and deontic rights

In this thesis, the notions of epistemic and deontic rights are used as an analytic framework, and can be regarded as operationalizing aspects of ‘power’ and ‘authority’. Epistemic rights refer to someone’s rights to knowledge within specific domain(s), whereas deontic rights refer to someone’s rights to determine future actions, or in terms of authority, “epistemic authority

⁵ It is worth noting that ethnographic knowledge here is understood in a loose sense as familiarity and member-like knowledge with the researched institutions, and does not imply strict adherence to ethnographic methodology (Djordjilovic, 2012).

is about knowing how the world “is”; deontic authority is about determining how the world “ought to be” (Stevanovic, 2013, p. 298; Stevanovic & Peräkylä, 2012).

Furthermore, epistemic and deontic rights can be claimed with various strength, referred to as epistemic and deontic stance. Epistemic claims (about how the world *is*) display more or less certainty of the matter (e.g. “I think this is pneumonia”, compared to “this is pneumonia”). Similarly, deontic claims (about how the world *ought to be*) will display more or less obligation or necessity towards the proposed action (e.g. “you could take this tablet twice a day”, compared to “take this tablet twice a day”), which is consequential for the deontic rights allocated to the recipient. In talk about future action, participants establish, distribute, and negotiate their deontic rights. Moreover, deontic rights are also a resource participants draw on, for instance based on their institutional role or epistemic rights within a domain. As such, deontic rights can be considered as both *interactional achievements* and *interactional resources* (Stevanovic, 2013, p. 11) (see also article 1 for a more detailed description).

In medical encounters, patients and physicians occupy epistemic rights in different domains, with physicians’ ‘epistemics of expertise’ and patients’ ‘epistemics of experience’ (Heritage, 2013b, p. 392), and participants in interaction rely on these relative statuses as interactional resources (Heritage, 2012b). In accordance with the emic perspective outlined in Section 3.1.2, these rights are not merely viewed as static proprieties, but as oriented-to and negotiable features in interaction (see Heritage, 2012a; Stevanovic, 2013 for further discussions of epistemic and deontic stance and status). Unlike epistemic rights, deontic rights have mainly been recognized as belonging to the physician (i.e. the notion of doctor’s order, built on their epistemic rights). But this asymmetrical distribution of deontic rights is currently challenged with the imperatives of shared decision making that call for a more equal, or shared, distribution of rights to decide, and this is a central theme in this thesis.

4 Review of previous research

4.1 Non-CA research on physician-patient communication

4.1.1 Some influential studies

This section will review some of the widely recognized, classic studies of physician-patient communication in order to sketch out influential endeavors in this field of inquiry. The review focuses on empirical studies of medical encounters. As a sociological backdrop, I draw on Parsons' (1951) influential model of the patient role described in *The Social System*, as this model has persisted in remaining relevant, despite many efforts to break the patient free from it (cf. 'the patient revolution', section 1.2; Heritage & Maynard, 2006; Pilnick & Dingwall, 2011).

Parsons argues that there is a set of rights and obligations that comes with "being sick" or entering the 'sick role'. Firstly, the sick person is exempted from normal activities and responsibilities (e.g. work) under the condition that the 'sickness' is legitimated (e.g., by a physician). Secondly, the sick person is not responsible, or able, to get well by his own will or by "pulling himself together". Thirdly, the sick person is obligated to want to "get well", treating the sick role as an undesirable state and not taking advantage of "secondary gains". Fourthly, the sick person is obligated to seek *technically competent* help, usually from a physician, and to *cooperate* with the physician in trying to get well. This last obligation has been linked to a paternalistic physician-patient model (e.g. Roter & Hall, 1992), which will be described below.

A more recent stream of research is studies of audiotaped (and later, videotaped) encounters, which was made possible with new technological recording equipment. Broadly speaking, it has demonstrated physicians' massive control over the medical encounter and pointed to its consequences for patient participation.

Byrne & Long's (1976) pioneering study *Doctors talking to patients*, was based on approximately 2500 audiotaped primary care encounters. They identified six phases in the medical encounter: (1) Establishing a relationship with the patient, (2) eliciting the reason for the visit, before (3) conducting a verbal and/or physical examination of the patient, (4) evaluating the condition or providing a diagnosis, (5) detailing further treatment or investigation, and (6) closing the encounter. Moreover, Byrne and Long provided detailed

characterizations of physicians' behavior or style in each phase, ranging from physician-centered to patient-centered. Based on their finding that physician-centered behavior was highly prevalent in the encounters, Byrne & Long suggested that physicians should adopt more patient-centered styles. This suggestion gave way to initiatives towards more patient-centered care.

Beckman & Frankel's (1984) well-known study investigated how physician behavior influenced patient's opening statement of concern(s). They found that physicians interrupted patients in 69% of the audiotaped encounters. Whereas no complete (i.e., non-interrupted) patient opening statement took longer than 150 seconds, on average, physicians interrupted patients after 18 seconds. The consequence of these interruptions was a transition to the phase of physician-centered questioning before patients had completed their opening statement. The authors concluded that this behavior may lead to the loss of significant patient data and limit patient participation.

Mishler's (1984) discourse analytic study *The discourse of medicine: Dialectics of medical interviews* took a more dialectic approach in the study of medical interviews. He found a basic three part structural unit or cycle that served to maintain the physician's control and asymmetry of power between the physician and patient: the physician's request/question initiates each unit, followed by the patient's response, before the physician terminates the ongoing unit and initiates the next with an assessment/next question. Mishler concluded that this cycle entailed a fundamental conflict, where the physician's agenda (the 'voice of medicine') silences patients' efforts to introduce the 'voice of the lifeworld' in that "the physician controls the content of the interview, both through his initiation of new topics and through what he attends to and ignores in the patient's reports" (p. 70).

A notable exception from the 'physician-centered' line of inquiry, which focuses mainly on physicians' dominance in the medical encounter, is found in Ainsworth-Vaughn's study *Claiming power in doctor-patient talk* (1998). She takes the opposite starting point, exploring ways in which cancer patients claim power in the medical encounter, thus nuancing common descriptions of physician dominance. The study describes patients' ability to influence topics, diagnostic reasoning and treatment decisions, e.g., by using narratives and questions.

Another dominant and productive stream of research in the field is devoted to developing coding schemes. The Roter interaction analysis system (RIAS) (Roter & Larson, 2002) has

become one of the most widely used coding schemes. It enables large-scale analysis of recorded physician-patient communication, and has been used across various health care contexts and countries.⁶ Investigation is divided into two broad areas: 26 task-focused categories (i.e. information gathering, patient education and counselling) and 15 socioemotional ones (i.e. psychosocial aspects and emotional rapport). Other systems have been applied in Norwegian settings, including The Four Habits Coding Scheme (Fossli Jensen et al., 2011; Frankel & Stein, 1999; Gulbrandsen et al., 2008; Krupat et al., 2006), developed from a conceptually based teaching model. The Verona Coding system (VR-CoDES) (Del Piccolo et al., 2011; Mellblom et al., 2014; Zimmermann et al., 2011) is developed to identify patients' emotional cues (hints) and concerns (explicit utterances), as well as who elicits them, and whether the health care professional gives room for further disclosure of the cues and concerns.

4.1.2 Models of treatment decision making

An intertwined research interest has been devoted to developing models of the physician-patient relationship, pertaining to aspects related to treatment decision making (Charles, Gafni, & Whelan, 1997; Emanuel & Emanuel, 1992; Roter & Hall, 1992). The following description relies mainly on Charles et al. (1999; 1997), because of its prominent position in the SDM literature (Makoul & Clayman, 2006).

4.1.2.1 The paternalistic model

As mentioned previously, the paternalistic model is the traditional, physician-dominated way of practicing medicine (Byrne & Long, 1976). In paternalistic decision making, the physician makes the medical decisions, while the patient takes the role of a passive recipient, limited to, at best, providing consent to the recommended treatment. The physician is regarded as a “guardian of the patient’s best interest” in that he “does what he thinks is best for the patient, without eliciting the latter’s preferences” (Charles, Gafni, & Whelan, 1997, p. 683). The paternalistic model has been regarded as coinciding with Parsons’s formulation of the ‘sick role’, obligating patients to comply and collaborate with expert treatment regimen in order to get well. However, except for specific circumstances (e.g. emergencies), there is broad consensus that paternalism is inappropriate (e.g. Charles, Gafni, & Whelan, 1997; Emanuel & Emanuel, 1992), which has led to alternative models that promote greater patient involvement.

⁶ But see Sandvik et al.’s (2002) discussion of weaknesses of the RIAS system from a conversation analytic point of view.

4.1.2.2 Informed decision making models

On the other end of the scale from the paternalistic model, is informed decision making models (IDM). In this model, patients are viewed as the sole decision makers. Equipped with all relevant information from the physician, patients are assumed to be able to make informed decisions, in accordance with what matters to them. As a consequence, the physician's role is limited to providing the patient with necessary scientific knowledge about alternatives and risks and benefits of each. The rationale for the patient's decision-making role is that it is the patient's preference that counts, "because they are the ones who will have to live (or die) with the outcomes" (Eddy 1990, p. 442, in Charles et al., p. 654). In other conceptualizations of informed decision making, a more deliberative process seems to be put forward, in which informed decision making is defined as "informed participation [that] is the product of a thoughtful dialogue between physician and patient leading to a decision" (Braddock et al., 1997, p. 340).⁷ This latter conceptualization is more in line with SDM models.

4.1.2.3 Shared decision making models

Shared decision making (SDM) was first mentioned in 1982 in the *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research* and has since grown to a prominent subfield within health communication research and patient-centered care. SDM has been characterized as a 'middle ground' between paternalism (in which the physician is in control of the decision) and informed decision making (in which the patient is in control of the decision). In SDM, the physician and patient share information and responsibility for the decision. The model thus departs from IDM in that "both patients and physicians bring both information and values; it is not simply a question of physicians bringing knowledge and patients bringing values" (Charles, Gafni, & Whelan, 1997, p. 687). Nevertheless, Makoul & Clayman (2006, p. 307) acknowledge that sharing decision making equally is unlikely and propose a degree of sharing ranging from physician-led to patient-led decision making. Charles et al.'s (1997), in their seminal paper *Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)*,⁸ identified four necessary characteristics in SDM, summarized as follows in Charles et al. (1999, p. 652):

⁷ This IDM definition does not seem to be radically different from for instance Elwyn et al.'s (2012) proposition "that achieving SDM depends on tasks that help *confer agency*, where agency refers to the capacity of individuals to act independently and make their own free choices" (p. 1362, italics orig.).

⁸ This is the most cited SDM model, according to Makoul & Clayman's (2006) systematic review.

1. *At a minimum, both the physician and patient are involved in the treatment decision-making process.*
2. *Both the physician and patient share information with each other.*
3. *Both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences.*
4. *A treatment decision is made and both the physician and patient agree on the treatment to implement.*

Regarding the fourth requirement, not all SDM models concur that ‘agreement’ is necessary (Makoul & Clayman, 2006). However, Charles et al. specify that ‘agreement’ is not “that both parties are necessarily convinced that this is the best possible treatment for this patient, but rather that both *endorse it as the treatment to implement*” (1997, p. 688, italics added); hence, importantly, both parties share responsibility for the decision. Moreover, Elwyn et al.’s (2012) much-sited SDM model seems to depart from the third requirement that also physicians express their treatment preference. Rather, Elwyn et al. seem to suggest that physicians should not volunteer their treatment preference, and advises them to defer their view if patients say, for instance, “tell me what to do” (p. 1363-4).

As this brief overview suggests, no absolute consensus exists about what SDM is (and is not), except from the basic requirement that the patient is involved in the treatment decision making. Nevertheless, these models lay the ground for quantitative instruments developed for assessing SDM, to which we will now turn.

4.1.3 Central measurements for shared decision making

The vast majority of instruments for measuring decision making are designed to assess the degree of patient involvement (Ofstad, 2015, p. 33). These can roughly be divided into patient/and or physician-reported measures (e.g. questionnaires) (e.g. Barr et al., 2015; Elwyn, Barr, et al., 2013) and, more relevant for this study, observation measures, based on audio or video recordings. Some of the most used observation measurement tools are Elwyn et al.’s Option¹² (2003) and the revised, simplified version, Option⁵ (Elwyn et al., 2013). The more recent DEEP-SDM coding system (Clayman et al., 2012) is based on the integrative model of SDM described previously and is one of the first instruments to also code patients’ (and potential others’) behavior. MAPPIN’SDM (Kasper et al., 2012) may be regarded as the most comprehensive tool developed thus far, assessing SDM from three perspectives (physician, patient, and observer), in order to “account for the full picture of SDM” (p. 5). Moreover, it is

the first tool that assesses physicians' and patients' integrated behavior *as a dyad* (from the observer's perspective).

4.1.4 SDM and patient involvement: challenges in implementation and research

Despite the rapid development of the instruments described above, a range of obstacles has been identified and unresolved puzzles remain regarding how to implement and conduct research on how to enhance patient involvement in decision making. In what follows, I review some of the challenges identified in the literature.

4.1.4.1 Lack of implementation

Observation studies indicate that SDM is not widely implemented in practice, resulting in low levels of patient involvement in decision making (e.g. Braddock et al., 1999; Champion et al., 2002; Clayman et al., 2012; Coulter, 2002; Légaré et al., 2014; Pilnick & Dingwall, 2011). The literature has identified several barriers. On a system level, time constraints and treatment recommendation guidelines are some possible explanations (Braddock et al., 1997; Coylewright et al., 2012; Légaré et al., 2008). On a physician-level, barriers include lack of communication skills training and disbelief in the concept and its applicability in specific contexts (Dwamena et al., 2012; Elwyn et al., 2012; Frerichs et al., 2016). Patient-level barriers have also received substantial attention, suggesting that not all patients wish to participate in decision making (Thompson, 2007), although a review suggests that, especially in recent years, the majority of patients prefer to be involved (Chewning et al., 2012). Patient characteristics such as literacy, age, ethnicity, or particular health issue may also influence willingness to participate (de Haes, 2006; Seo et al., 2016). Finally, some researchers have suggested that the persistent findings of low levels of patient participation relate to the inherent and necessary asymmetry between patients' and physicians' epistemic knowledge, being constitutive and lying "at the heart of the medical enterprise" (Grimen, 2009; Måseide, 1991; Pilnick & Dingwall, 2011, p. 1374).

4.1.4.2 Lack of evidence on beneficial outcomes

In spite of a widespread belief in beneficial outcomes of patient involvement (IOM, 2001; "Salzburg statement on shared decision making," 2011; WHO, 1978), research has not yet been able to provide convincing evidence for its beneficial effects. Research focused on training physicians (or other health personnel) in communication skills associated with patient involvement and SDM has been unable to find clear evidence of whether (and especially what

kinds of) interventions are effective (Légaré et al., 2014). The stream of SDM research focused on developing and implementing decision aids designed to support patients' decision making (e.g. pamphlets, videos, web-based tools) has demonstrated the best effects so far: A recent Cochrane review found that patients exposed to decision aids are more active, gain increased knowledge regarding options, and choose elective surgery less often (Stacey et al., 2014). However, a review of the impact of patient participation found mixed evidence about whether increased patient involvement in decisions actually had a positive impact on outcomes (Clayman et al., 2015). Similarly, while a review of the effectiveness of SDM indicated possible positive outcomes on patients' understanding, trust, and satisfaction, it did not find clear evidence of improved patient behavioral or health outcomes (Shay & Lafata, 2015).

4.1.4.3 Lack of consistency in concepts and measurement

A lack of consistency and compatibility in the myriad of definitions and measurements has also been highlighted as a major challenge for implementing SDM and documenting links to outcomes (e.g. Mead & Bower 2001; Clayman et al. 2015; Clayman et al. 2012; Kasper et al. 2012; Makoul & Clayman 2006; Charles et al 1997). As Peter Salmon (2015) puts it in a recent editorial:

No-one would dispute any longer that clinical relationships should be partnerships, or that doctors should be patient-centred in their care. (...) The difficulties begin when we try to pin down what these imperatives mean in practice (p. 543).

For instance, in regard to measurement instruments, Clayman et al. (2015) documented 24 different established measures of patient participation, and Scholl et al. (2011) identified 28 measures of SDM. However, no measurement is regarded as a 'gold standard' (Clayman et al., 2012). Noticeably for our purpose, Scholl et al. (2011) and Kasper et al. (2012) emphasize that few SDM observation measures focus on *patients'* behavior, since the majority of measures only assess physicians' behavior. Similarly, Clayman et al. (2015) promote further efforts to consider patients' behavior in order to appropriately capture the dyadic aspects of SDM (as in DEEP-SDM and MAPPIN'SDM, described in Section 4.1.3). Although the aim of the present study is not to develop another measurement instrument, it can contribute to the calls for research "attuned to the co-production of decisions" (Clayman et al., 2015, p. 19), by

using the radically different tool of CA that places the co-construction of medical interaction at center stage (Maynard & Heritage, 2005).

Previous CA research has yielded a substantial body of findings about how patient participation is co-constructed in medical interactions. The present study builds on (and contributes to) this stream of research, which will be reviewed in the second half of this chapter.

4.2 CA research on physician-patient communication

In the recent *Handbook of Conversation Analysis* (Sidnell & Stivers, 2013), the contribution of medical CA research is summarized as having “revealed a range of phenomena that have been overlooked or empirically underspecified within research traditions that primarily focus on accounting for participants’ behavior or investigating its impact on various outcomes” (Gill & Roberts, 2013, p. 575). One particular contribution has been CA’s analytical strength in capturing patients’ contributions (see e.g. Drew et al., 2001), complementing the research streams described above, which have predominantly focused on physicians’ behavior. As a result, “a more nuanced picture of patient agency” (Gill & Roberts, 2013, p. 586) has been a central finding throughout CA studies, documenting a variety of ways in which patients influence encounters while simultaneously “attending to the opportunities and constraints posed by the organization of medical inquiry” (Gill & Roberts, 2013, p. 587).

This section will present a selective overview of research from the expanding field of medical CA, illuminating two areas that are of particular relevance for this study: The first part, mainly based on key studies reported in the comprehensive volume *Communication in Medical Care*, edited by John Heritage & Douglas W. Maynard (2006), focuses on how patient participation is achieved within the constraints of the medical encounter. To provide a broader overview of how interactants manage the tasks at hand of being a patient and physician, this section will present findings about the core activities in medical encounters that precede the treatment decision phase, from the initial opening and problem presentation, to information gathering (history taking/and or physical examination) and diagnosis/evaluation of the patient’s condition. The second part focuses specifically on research on making decisions regarding treatment in various contexts.

4.2.1 Patient participation in primary care settings

In an influential study, Robinson (2003) proposed that the way in which acute visits are sequentially structured serves as an explanatory framework for patients' low levels of participation. The study demonstrates that in primary care encounters during which patients present new medical problems, participants orient to (and make relevant) progression through a large-scale structure consisting of a series of activities (similar to Byrne & Long's (1976) phases described above) that lead towards a solution to the patient's problem (i.e. treatment): First participants establish a reason for the visit, then they gather additional information through history taking and/or physical examination. These activities are performed in the service of reaching a diagnosis, which, in turn, makes relevant a solution to the presented problem with a treatment recommendation. The study suggests that patients withhold participation that may interfere with the progression towards finalizing the project. For example, patients may withhold additional concerns and (extended) responses to diagnosis in the service of moving towards a treatment solution. Thus, instead of explaining patients' low levels of participation with an exogenous variable (e.g., power asymmetry), Robinson argues that "it is actions, activities, and projects of activities, and their constitutive relevancies, that account for asymmetry" (2003, p. 51). These activities will now be reviewed more closely in terms of patient participation.

In the opening phase of establishing reason for the visit, Robinson (2006) demonstrated that physicians routinely use different question formats tailored to soliciting patients' new, follow-up, or chronic/routine reasons for the visit. Furthermore, the study shows that patients hold physicians accountable for using inappropriately fitted formats, by working to 'clear up' or correct discrepancies such as the physician's ill-fitted assumptions. These findings nuance and counter the common text book advice of using (any) open-ended questions for soliciting patients' chief concern. Gafaranga & Britten (2003; 2007) have reported similar findings in that patients participate in significant interactional activities, such as contributing to define the encounter as either "new" or "follow-up consultation". Nevertheless, the problem presentation phase that follows the physician's initial solicitation has been recognized as patients' only structurally provided opportunity during the encounter for presenting their problem(s) in their own terms (Heritage & Robinson, 2006).

However, when examining how patients' problem presentation comes off, patients simultaneously orient to a number of social, moral, and sequential constraints. Heritage and

Robinson (2006) showed that patients construct their medical concerns such that they are oriented to justifying the need to seek medical attention. In cases of no obvious or acute injury, the participants work to sort out whether the presented problem is “doctorable”, that is, “whether (or not) the patient has a legitimate reason for making a medical visit” (p. 63): Patients are occupied with portraying themselves as persons that do not seek medical help without a “good reason”, while physicians routinely validate patients’ reasons for visiting. Halkowski (2006) showed how patients orient to portraying themselves as reasonable in their narratives of symptom discovery. He calls it the “patients’ problem” to convey the “doctor-relevance” of a candidate problem, while balancing involvement and detachment: Patients’ narratives are shaped to neither be too preoccupied with (potentially insignificant) bodily symptoms nor neglectful of significant symptoms (i.e. fulfilling the Parsonsian obligation of the “sick role” to seek competent help).

Robinson & Heritage (2005) provided an account of how the problem presentation phase is a coordinated, joint construction, thus offering a different explanation than Beckman & Frankel’s (1984) finding of physicians’ premature interruptions (see Section 4.1.1). The authors identified a social–interactional organization in patients’ problem presentation that makes them recognizable as to whether they are complete or incomplete. The study shows that participants normatively orient to patients’ presentation of current symptoms as signaling the completion of problem presentation. Patients use interactional resources for invoking a transition space in which physicians are allowed (indeed expected) to take over the ‘baton’ and start history taking. This transition space starts where the patient either shifts from a narrative in past tense to describing one or more current symptoms in present tense, or by indicating diagnostic issues. These subtle shifts are regularly picked up by physicians, taking over the lead by shifting over to history-taking questioning. Alternatively, when the physician fails to shift into history taking at this point, patients regularly use ‘exit devices’ indicating the problem presentation is complete⁹.

Boyd & Heritage (2006) and Heritage & Clayman (2010) examined physicians’ question design during history taking. By elucidating the following four fundamental features of questions, the studies provide comprehensive analyses of the moral and structural constraints

⁹ These explicit completions (‘exit devices’) are similar to what Beckman & Frankel (1984) coded as complete patient statements, whereas Robinson & Heritage suggest that explicit completions occur when physicians fail to pick up on patients’ completion cues.

and opportunities that physicians' questions inevitably establish. First, by setting both topic and action agendas, questions impose major constraints on the patient's next turn. Second, by embodying presuppositions, questions inevitably leak information to patients (e.g. revealing physicians' assumptions about the patient's social life and health) that the patients can then confirm or attempt to alter. Third, different question formats reveal various degrees of certainty in terms of knowing what the patient's answer will be. These epistemic stances range from a relatively "unknowing" stance, typically formatted as yes/no interrogatives (e.g., "are you married?") to invitations to confirm "known information" through declarative formats (e.g., "you're married?"). Fourth, various grammatical forms of yes/no questions have built-in expectations or *preferences* for a particular type of answer (see also Section 3.1.3). Nevertheless, patients do not necessarily align with physicians' question constraints and have resources for doing other actions as well, for instance "answering 'more than the question'" (Stivers & Heritage, 2001). As Boyd & Heritage conclude: "patients can and frequently do break free of these constraints, and exert initiative and agency in proposing alternative agendas, challenging presuppositions, and maintaining contrary preferences" (2006, p. 184).

Still within the information-gathering phase, Gill (1998) and Gill & Maynard (2006) have taken the patients' contributions as the starting point for describing interactional strategies patients use for offering "lay" explanations for their illness¹⁰ without disrupting physicians' information-gathering activities. How patients design and place their explanations avoids portraying themselves "as authorities in the realm of analysis or inference" (Gill, 1998, p. 345). For example, patients produce explanations as speculative, or they downplay knowledge claims in ways that do not impose conditional relevance of an evaluative response, keeping the constraints to respond an option and not an obligation. As a consequence, Gill & Maynard (2006, p. 147) argue that the information-gathering phase is a bilateral, co-constructed achievement, where both participants orient to the overall organization of the information gathering activity within the medical interview.

Turning to the physical examination phase of the information-gathering, Heath (2006) has demonstrated how patients actively constitute their bodies as an object available for clinical inspection and manipulation. Their "seeming absence of participation allows the doctor to coordinate his actions with regard to the principled organization of particular clinical

¹⁰ Similar concepts in the health communication literature have been described as e.g. the 'patient's perspective' (e.g. Four Habits) or as the 'voice of the lifeworld' (Mishler 1984).

procedures” (p. 193). Heath concludes that this distanced cooperation with the physician’s examinations may be “an embodiment par excellence of the sick role (...) to place themselves in the hands of the physician” (p. 201).

Moving forward through the consultation, a series of studies have investigated the delivery of diagnosis as a significant activity that results from what happened before (problem presentation and information gathering) and that forms the basis for what comes after (treatment/management). In terms of patient participation, Heath (1992) found that patients routinely do not respond to physicians’ diagnoses, or they do so only with minimal acknowledgement.¹¹ Heath identified some exceptions, in which patients responded to diagnoses in “occasions in which there is incongruency between the professional opinion and the lay understanding of the condition” (s. 261) (i.e. no-problem diagnosis or one that is counter to the patient’s expectation). In their investigation of the delivery of diagnostic news, Maynard & Frankel (2006) found structural differences in the way good and bad news is delivered to patients. Whereas good news is presented relatively straightforward *as* positive, bad news (i.e. cancer) is shrouded, and delivered as “neutral”, working to maintain the discourse of “rational medicine” (p. 271), disfavoring emotional or “irrational” expressions. Another discrepancy of ‘rationality’ was found when symptoms were left unexplained (i.e. the symptom residue) after potential diagnoses were ruled out. Although being presented as good news (from a medical point of view), patients may disalign with the “positiveness” and bring up remaining symptoms or concerns that are not accounted for by the good news. The authors point to the interactional difficulties in these circumstances and how it may jeopardize physician authority.

Another take on physicians’ authority is proposed in Peräkylä’s (1998; 2006) studies of Finnish primary care interactions. He demonstrated how physicians “do not rest on their authority alone” when delivering diagnosis (1998, p. 302), but they balance authority with accountability by offering some evidential basis for how they arrived at the diagnosis. Peräkylä found that physicians accompanied *plain assertions* of diagnosis, a seemingly authoritative format, with recognizable and relevant evidence (e.g. delivered while holding up an X-ray picture), making the inferential evidence of the diagnosis directly available. The two other diagnostic delivery formats Peräkylä identified either *referred explicitly to evidence*, or

¹¹ Whereas Heath suggested that patients’ non-responses orient to physicians’ authority (i.e. physician-patient asymmetry), Robinson (2003) proposed another account, briefly mentioned above, namely that patients’ non-responses orient to the overall progressivity, towards the treatment/solution of the ongoing project.

incorporated it inexplicitly through “evidential” verbs (e.g. *to appear, seem, sound*) that allude to what sensory perceptions the conclusion is based on. The study shows that the two latter formats are used in circumstances where the evidence is either opaque to the patient, distanced in time from the diagnosis delivery, or related to diagnostic uncertainty or disagreement between physician and patient. The two latter circumstances may especially undermine the physician’s authority as an expert, and Peräkylä points to physicians’ additional work explicating the evidence in order to account for, or justify the diagnosis. In a related study, Peräkylä (2002) found that although patients orient to physicians’ diagnostic authority, they respond more often to diagnoses in which the evidence is explicated, with responses that either indicate agreement, rejection, or that interpret the evidence or describe symptoms.

Heritage & Stivers’ (1999) study of physicians’ talk during the physical examination echoes and develops the abovementioned findings of Heath and Peräkylä regarding physicians’ interactional work in environments in which they deliver no-problem diagnoses or ones that counter patients’ expectations. Heritage & Stivers identified a physician practice of ‘online commentary’, which they defined as a physician’s description or evaluation of what he “is seeing, feeling or hearing during the physical examination of the patient” (p. 1501). In routine check-ups, online commentary mainly functioned to reassure, whereas, more importantly, in acute visits, online commentary describing mild or absent signs are used to forecast upcoming no-problem diagnosis, shaping parents’ (or patients’) expectations for non-antibiotic treatments, while simultaneously legitimizing the decision to seek medical help (cf. the patient’s problem described above). The potential of online commentaries for reducing inappropriate antibiotic treatment was explored in a follow-up study (Mangione-Smith et al., 2003), and the authors conclude that no-problem online commentary may be an effective strategy for physicians to avoid inappropriate antibiotic prescribing. Nevertheless, in a discussion of these studies, Heritage (2005) concluded that “it is clear that the act of diagnosis remains a fulcrum in the exercise of medical authority” (p. 98). When it comes to treatment decision making, to which we will now turn, the picture looks quite different.

4.2.2 Patient participation in treatment decision making

Costello & Roberts’ (2001) study of general medicine and oncology consultations demonstrated that patients participate actively in the establishment of a treatment plan. Drawing on mechanisms from everyday talk, participants work to minimize disagreement and

maximize agreement about treatment. In general medicine, in the face of patient disagreement to treatment recommendations (whether incipient or overt), physicians would typically adjust their original recommendation. In contrast, in oncology, the physicians provided more evidence for the patient to accept or reject the (standardized) treatment recommendation. As such, Costello and Roberts argue that patients in both settings contribute to the final treatment plan by displaying agreement or disagreement.

These findings are supported and developed further in a series of studies examining treatment decision-making in both primary care pediatric visits (Stivers, 2005a, 2005b, 2006) and adult visits (Koenig, 2011). Compared to the diagnostic phase described above, these studies show other expectations for patient participation at this point in the encounter (Heritage & Clayman, 2010): Here, patients/parents and physicians orient to treatment recommendations as *proposals* that must be accepted or rejected before completion. As a consequence, patients' withholding of acceptance (i.e. responding with simple receipt tokens as "mm", "yeah") is regularly treated as *passive resistance*, extending the treatment decision phase with a negotiation. In response, physicians recurrently add additional accounts, explanations and the like, re-opening the conditional relevance of patient acceptance (or rejection) after every new increment in pursuit of acceptance. Furthermore, in the face of more *active resistance*, physicians sometimes modify their recommendation to be in accordance with what the patient may expect (e.g., by prescribing antibiotics inappropriately).

In a Finnish study of primary care encounters for upper respiratory tract infections, Ijäs-Kallio et al. (2011) found a somewhat different pattern than in the US studies. The study indicated that physicians did not expect patients to respond to 'unilateral'-formatted recommendations (see Collins et al., 2005). For example, physicians would type on the computer while prescribing, treating the decision as complete. That patients treat physicians' unilateral decisions as adequate is evidenced in the patients' alignment to progress to next activities. Notably though, although minimal (or absent) responses are treated as sufficient to accept decisions in the Finnish data, these patients also claim rights to assess, and to some extent even direct physicians' decisions through extended responses that initiate negotiation. Compared to the US studies, it may seem that the US patients' resource for initiating negotiation through *passive* resistance (or incipient disagreement) may be less available to patients in the Finnish study.

A handful of recent studies has examined treatment decision making in secondary care encounters. In a study of Polish physician-patient encounters, Weidner (2012) found extended treatment recommendation sequences about invasive procedures, compared to the two-part recommendation-acceptance structure outlined above: First, the physicians' recommendations are stretched over a number of turns. After the physician's recommendation, the participants orient to contingencies and feasibility of the proposed treatment before patient's acceptance is expected. Furthermore, accounts in support of the invasive recommendation (i.e. medical evidence) are expected, and patients pursue these accounts when they are not offered. Weidner suggests that this additional interactional work may be related to the higher-stake decision making of invasive procedures.

In orthopedic settings, Hudak et al. (2011) showed that surgeons attune to patients' anticipated or expressed expectations already in their design of treatment recommendations as a means for minimizing disagreement and 'getting the patient on board'. This attentiveness to patients' expectations is balanced with an overall bias favoring recommendations *for* surgery compared to recommendations *against* surgery (Clark & Hudak, 2011; Hudak, Clark, & Raymond, 2013). In psychiatric settings, Quirk et al. (2012) identified a spectrum of pressure in 'shared decisions',¹² ranging from *pressured decisions*, exhibiting a cycle of psychiatrist pressure and patient resistance, to *directed decisions*, in which the patient do not show signs of resistance, but the participants collaborate in 'letting the patient have it the doctor's way' (p. 105) to *open decisions*, allowing the patient to decide, while keeping the possibility to change her mind open. McCabe et al. (2002) examined how patients with psychotic illness actively attempt to discuss their psychotic symptoms (e.g. by asking questions both in sequentially appropriate and inappropriate positions), while physicians display discomfort and reluctance to engage with patients' concerns.

A few studies have also explored ways in which patients exert influence through subtle means, managing to exercise agency, while orienting to physician authority. Hudak et al. (2010) identified how compliments to surgeons positioned before recommendations are treated as (concealed) pressure for particular treatments. Gill (2005) demonstrated ways in which a patient can "demand" specific medical interventions without overtly requesting it (in part, by praising the physician's predecessor). Bergen & Stivers (2013) showed how patients disclose

¹² The criteria for 'shared decisions' was decisions resulting in explicit agreement, following Charles et al. (1997).

medical misdeeds (i.e. failing to take prescribed medicine or adhere to healthy lifestyle) in order to pursue various objectives, including specific treatment outcomes. In a study of medical encounters across national contexts (New Zealand primary care and Swedish secondary care), Lindström & Weatherall (2014) demonstrated how epistemic and deontic forces of expertise and experience shape negotiations about treatment recommendations. The study shows patients' responses ranging from deference to the physician's deontic authority, based on medical expertise (e.g. "you're the boss") to displays of independent deontic rights and outright resistance. In the face of resistance physicians invoke patients' deontic right to reject recommended treatment.

Some studies have examined decision-making sequences during which patient participation is sought more actively. Collins et al. (2005) identified a spectrum ranging from 'unilateral' to 'bilateral' physician approaches throughout decision-making trajectories. The study included both primary care (diabetes consultations) and secondary care (ear-nose-throat oncology) encounters in the UK. In the more 'bilateral' approaches, physicians invite or pursue patients' contributions throughout the trajectory, for instance by eliciting their opinion and building on their contributions. In the more 'unilateral' approaches, physicians make decisions more independently from patient contributions, presenting decisions as 'news' or as already 'made', limiting patient participation to displays of understanding and agreement.

The first extensive study focusing on 'bilateral' physician approaches is found in the recent study *Delivering patient choice in clinical practice*, carried out in UK neurology clinics and reported in Reuber et al. (2015) and Toerien et al. (2011; 2013). By combining conversation analysis with post-visit questionnaires, the authors identified three interactional components ('full-form option-listing'), that, when present, were perceived by both parties as offering choice.¹³ The three components of full-form option-listing comprise (1) an announcement of an upcoming decision, (2) a list of options, and (3) an invitation to the patient to announce their view or make a choice from the proposed options. In these trajectories, both parties treat the decision as handed over to the patient, although the patients did not necessarily align with this decision responsibility. The authors highlight that this option-listing trajectory projects another type of patient participation than what had been described in previous CA studies on the recommendation-acceptance structure, in that "option-listing creates a slot where the

¹³ This may refute findings in the quantitative SDM literature reviewed above, that has not been able to find congruence between observer measures and self-reported measures of SDM (see Kasper et al., 2012).

patient's announcement of their selection from the list is relevantly due" (Toerien et al., 2013, p. 881), involving a markedly stronger deontic right than a (mere) acceptance of a recommendation. This also has consequences for the physicians' participation, in that they refrain deontic rights to tell what they think the patient should do, saying only what options are available.¹⁴ Importantly, the study shows how components from the same option-listing machinery, with subtle modifications, work to curtail patient choice through small, but significant changes: When the neurologists indicate their view *prior* to the patient's invitation to decide, it is treated as a recommendation, and not a choice. Thus, the authors conclude that key characteristics of shared decision making, in fact, can be used to do the opposite.

Similar findings of curtailed choice have been reported in the setting of antenatal pre-screening consultations in the UK. Pilnick (2008) showed that although midwives *introduce* the screening decision as a choice, in the subsequent talk, it is not treated as such by the midwives or parents. Instead, more in line with Ijäs-Kallio et al.'s (2011) findings, active objection is required to decline screening, whereas the "lack of active declining is taken as acceptance" (p. 521). Interestingly, a reversed dynamic is found in the context of antenatal screening consultations in Hong Kong, where "the assumption that the professional is always the agent of unilateral decision-making does not hold" (Pilnick & Zayts, 2015, p. 13). Here, in order to avoid influencing decision making, professionals refrain from sharing their knowledge. Instead, the professionals cast the decision as lying solely within the pregnant woman's domain, based on her level of concern or worry about potential foetal abnormality.

From both a CA and non-CA perspective, this review points to a range of challenges in conceptualizing, assessing, and realizing patient involvement and shared decision making. Researchers from both the fields of health communication (e.g. Clarke, Hall, & Rosencrance, 2004; Clayman et al., 2015; Da Silva, 2012) and CA (Toerien et al., 2013) have identified a lack of fine-grained studies on patient involvement in decision making. A motivation for this study is thus to contribute to unpacking some of these 'black boxes', especially in regard to how patient involvement is actually realized. I argue that the CA approach, with its inherent strength to analyze the dyadic, or interactional, nature of human conduct on a microlevel, is well-suited for the current purpose: In regard to the scope of examining patient involvement, Maynard & Heritage have pointed out that "analysing co-construction [using CA] is a direct research embodiment of patient-centredness" (2005, pp. 433-434).

¹⁴ This physician approach may resemble the informed decision making model described in Section 4.1.2.2.

5 Research questions

This study differs from the vast majority of studies within the field of health communication research reviewed in Section 4.1. It takes the stance that existing quantitative measurement tools do not in fact “account for the full picture” (cf. Kasper et al. 2012, Section 4.1.3) of patient involvement in decision making. If we are to better understand the interactional mechanisms of patient involvement in decision making, we must address at least one more piece that is largely overlooked, and that is made available for inspection through the CA microscope: How participants orient to and manage patient involvement sequentially, at the detailed turn-by-turn level of interaction. This qualitative approach contributes to the existing health communication literature in two ways: First, the level of granularity and sequential approach engender detailed descriptions of *how* patient involvement is actually accomplished. Second, the *emic* perspective (see Section 3.1.2) may be regarded as an alternative approach for integrating the participant and observer perspective, in that it, through observation, first and foremost tries to “capture the participants’ *own* orientations to what is going on in interaction” (Stevanovic, 2013, p. 50). As such, in this study, the participants’ perspectives are pursued through their actual conduct.

Following the overall aim of this study (see Section 1.3), and the research and implementation challenges outlined in Chapter 4, this study takes a radically dyadic approach in order to answer the following overarching research question in three empirical studies:

How do physicians and patients orient to and negotiate patient involvement in treatment decision making in a Norwegian hospital setting?

Following the secondary aim to *inform practice* with empirical detail and specification of actual interaction that is more in line with current guidelines and policies, the study also seeks to answer the following question:

In what way(s) may the study findings inform SDM models, research and practice on patient involvement in treatment decision making?

The overarching research question is answered in Chapter 7. The secondary question is addressed in Chapter 8. But first, in Chapter 6, follows a further description of the data and method used.

6 Data and Method

6.1 Data

6.1.1 Study setting and data collection

The setting of this study is Akershus University Hospital (Ahus), located in the capital area of Norway. Ahus is one of the largest hospitals in Norway with 953 beds (Ahus.no, <http://www.ahus.no/om-oss/om-helseforetaket>, 26.01.16). During 2007-2008, Bård Fossli Jensen and Pål Gulbrandsen collected 497 videotaped physician-patient encounters for a randomized controlled trial (hereafter referred to as the original study) investigating the effect of a training course in general communication skills, following the Four Habits model (Fossli Jensen et al., 2011; Krupat et al., 2006, see also Section 4.1.1). The encounters were filmed using one stationary video camera and an external microphone. The researchers were not present during the encounters (Jensen, 2011). 380 of the videotaped encounters were made available for further research through broad consent from the participants, and this data set was made available for the present study.

The data set comprises encounters from non-psychiatric clinical specialties (internal medicine specialties: cardiology, respiratory medicine, nephrology, gastroenterology, endocrinology, hematology, infectious diseases, oncology and surgical disciplines: gastro surgery, urology, thorax & vascular surgery, orthopedics, ear-nose-throat, anesthesiology, as well as gynecology/obstetrics, neurology and pediatrics). The encounters are distributed amongst outpatient (77%), ward rounds (15%) and emergency room (8%) (Ofstad, 2015). Outpatient clinics are an integrated part of hospitals in Norway, and, in the present study, the majority of encounters are drawn from outpatient clinics. Further selection of data for the present study will be described below.

6.1.2 Participants

All physicians under the age of 60, working in non-psychiatric departments were available participants. Physicians were randomly selected for participation in the randomized controlled trial and 69% of the approached physicians agreed to participate. Further characteristics of the physicians can be found in (Fossli Jensen et al., 2011).

Patients were recruited consecutively by Bård Fossli Jensen or Pål Gulbrandsen while waiting to see the physician. A post-recruitment confirmation of consent was obtained after 24 hours

by SMS in order to accommodate ethical requirements. 94 % agreed to participate (Gulbrandsen & Jensen, 2010). Patients were excluded if they were found unable to understand what was being said or to fill out questionnaires due to lack of Norwegian skills or serious illness (Jensen, 2011).

6.1.3 Selection of data for the present study

For the original study objective (see Section 1.1), 71 encounters with non-native speaking physicians and 18 with non-native speaking patients were selected. In six of these encounters, both the patient and physician were non-native speakers. Thus the original selection was 83 encounters. As a consequence of the change in focus towards decision making, described in section 1.1, the data was expanded in three stages. The first expansion took place during the initial phase, during which I concurrently selected a random sample of 43 videos with native speaking physicians and patients in order to look for potential differences and similarities in the two subsets. After this, I made the decision to focus primarily on decision making in general. The second and third expansion was therefore a more strategic, inductive sample aimed at including cases from disciplines in which patients would potentially be more actively involved in decision making. As there seemed to be more substantial patient involvement in gynecology/obstetrics, all encounters from these disciplines were selected. This resulted in 9 additional videotaped encounters, in addition to the 25 that were already included through the first two subsets. Finally, 12 additional videos were included, based on observations of SDM-like behavior, made by Eirik Hugaas Ofstad, who conducted a parallel study involving observation and coding of medical decision making in the full data set of 380 videos (Ofstad, 2015). The final selection was therefore 147 videotaped encounters.

In article 1, 11 encounters met the inclusion criterion of options being explicitly brought up, where at least one option was invasive in character. In article 2, 17 encounters met the inclusion criterion of the physician explicitly orienting to the patient's preferences or views towards treatment through various forms of treatment questions, or 'patient view elicitors' (Reuber et al., 2015). As with the selection for article 1, the majority of cases concerned invasive procedures. In article 3, the decision-making sequence in one single case was the object of study, representing an extreme case in terms of troubles reaching mutual understanding and a decision about an invasive procedure. In this article, the participants' 'non-nativeness' is an *oriented-to* feature in the interaction (see Hutchby, 1999, and Section 3.2).

6.1.4 Ethical considerations

The original study was accepted by the Regional Ethics Committee for Medical Research of South-East Norway in 2007 (1.2007/356). Based on broad consent from participants in 380 videos in the original study, the Regional Ethics Committee for Medical Research of South-East Norway accepted the present study in 2011 (2011/725-1). The privacy ombudsman for research in Norwegian universities also accepted the study, under the condition that the videotapes were stored on an encrypted hard-drive situated in a locked facility and only used on a PC without internet access.

For anonymity purposes I have, throughout, referred to participants in their role (e.g., as physician, surgeon, patient), removed all names, and altered other details that could constitute identifying information. I was particularly cautious when presenting data in data sessions and at conferences: In small data sessions with co-researchers (an integral part of the research process in CA), I used audio-recordings,¹⁵ while anonymized transcripts have been used in conference presentations and papers.

6.2 Conversation analysis as method

from close looking at the world we can find things that we could not, by imagination, assert were there (Sacks, 1984, p. 25).

Hutchby & Wooffitt define CA from the perspective of what it does: “CA is the study of recorded, naturally occurring talk-in-interaction” (2008, p. 12). The theoretical framework introduced in Chapter 3 is closely intertwined with how CA is used as an analytic tool, with direct implications for how the video data are approached, transcribed and analyzed. The present chapter describes these three steps of the research process in regard to issues of reliability and validity as this is central for judging the *objectivity* and *credibility* of the research, which relates to whether, and to what degree, analytic descriptions “in some controllable way correspond to the social world that is being described” (Peräkylä, 2004, p. 284).

6.2.1 Approaching the video data and issues of reliability

6.2.1.1 ‘Motivated’ versus ‘unmotivated looking’

The data-driven approach in CA implies that the analyst should be guided by the data, what has been described as ‘unmotivated looking’ (Hutchby & Wooffitt, 2008; Sacks, 1984). This

¹⁵ See also Section 6.2.2

principle is grounded in that CA seeks to describe what matters to the participants, and not what matters to the analysts (cf. Section 3.2). However, institutional CA research is often more or less ‘motivated’ by specific institutional tasks or challenges (Antaki, 2011a). This was also the case for the present study, which set out to investigate aspects of ‘non-nativeness’ (see Section 1.1, 6.1.3). However, ‘motivated looking’ at the video data with this perspective in mind yielded limited observations that could be associated with the ‘non-nativeness’ of the participants (i.e. language or cultural differences). This may be related to that the data was not originally collected for studying interactions between non-native speaking physicians and/or patients, limiting the fit between the data and the original purpose the study (Peräkylä, 2004), in that patients with limited Norwegian skills were excluded (see Section 6.1.2). Furthermore, most of the non-native speaking physicians in the data set were experienced doctors who had lived in Norway for many years, perhaps reflecting more the hospital’s physician staff than targeting for instance newly arrived international medical graduates. This does not mean that issues of non-nativeness is not relevant at all, but that the nature of the data itself may have limited the extent to which it struck me as ‘puzzling’ when scrutinizing the videos.

Rather, perhaps ‘motivated’ by looking for traces or expressions of uncertainty¹⁶ in a broad sense, I kept noticing long sequences, sometimes whole encounters, where the participants worked to come to a decision about future treatment actions. I got the sense that the participants in these decision making sequences were occupied with resolving additional and related tasks (or uncertainties) more than simply deciding what to do next. These observations, together with being acquainted with the SDM field (as described in section 1.1) led to the decision of focusing the study on decision making about treatment.¹⁷

From this interest, I located decision making sequences broadly. Sequences were included when the physician, patient (or other party present) initiated talk about treatment in a broad sense. The notions of epistemics and deontics (see Section 3.3), inspired by the work by Stevanovic (2013; 2012), gave direction to article 1, in which I aimed to examine decision-making sequences in which patients were given a choice (i.e. deontic rights). During my visiting stay at UCLA, my advisor there, John Heritage, directed my observations to the

¹⁶ The notion of uncertainty was central in the original study, together with the immigrant perspective.

¹⁷ Further reflections about challenges in regard to balancing and combining interests that have motivated this research will be provided in Chapter 8 in relation to Habermas’ (1974) knowledge interests, especially related to *empiric-analytic* and *practice-instrumentalist* knowledge interests (see Section 8.1.1).

analytic strategy of collecting and analyzing physicians' 'treatment questions' in particular. This led to the identification of the physician practice of formulating a patient's stance towards treatment, which is reported in article 2. Article 3 is based on analyses of the initial data selection, motivated by looking for participants' orientations to understanding difficulties and the notion of uncertainty. As this study pertains to both the original and final object of study (see Section 1.1), it felt appropriate to develop and incorporate it as the third study in the thesis.

6.2.1.2 Video recordings as data

CA's basis in using recorded and transcribed interactions together with its comprehensive data treatment has been highlighted as a particular strength in terms of credibility and reliability of CA research (Peräkylä, 2004; Silverman, 2006, p. 303). This relates to the fact that recordings and transcripts are publicly accessible and accurate, making it easier to be subjected to empirical testing (as opposed to, for example, ethnographic field notes). The accuracy of recordings, by no means claims to capture every aspect of the event, as "other things, to be sure, happened, but at least what was on the tape had happened" (Sacks, 1984, p. 26). Importantly, the recordings have analytic primacy, while transcripts are used to support the analytic process by making visible details of what was going on in the recordings, enabling presentation of findings in written form (Heath, Hindmarsh, & Luff, 2010).

Moreover, the reliability of the research relies on the quality of the recordings and transcripts, that is, what and how much was recorded, as well as the technical quality (Peräkylä, 2004, p. 288). Starting with the last, the fact that the study is based on *video* recordings is essential in terms of reliability, in that it gives access to embodied actions and orientations of the participants (e.g. body orientation, gesture, gaze, nodding). With few exceptions, all participants were visible on screen in the videos. One limitation is that the use of one camera captures the interaction from only one angle. The camera was usually placed to capture the physician from the front, so patients were occasionally viewed from the side or from the back, limiting a fuller view of facial expressions of both participants. Physical examinations were only audio-recorded due to ethical considerations, but this was not a limitation in this study since decision making rarely occurred during examinations.

In terms of *what* and *how much* was recorded (inclusiveness), a strength of this data is that the physicians were randomized for participation. This is rare in CA research (Peräkylä, 2004, p. 289), which generally has to rely on sampling strategies based on convenience. This may have

provided a sample less based on physicians' personal interests or motivation for the original communication skills training study. More importantly, it is a relatively large dataset, consisting of 380 available encounters, with large variation in terms of specialties, medical problems, and types of encounters.¹⁸ An advantage of this variation is the potential for discovering phenomena and practices with relevance beyond one particular setting. However, this broad variation has also shown to be a main challenge in this study. Firstly, because of the lack of "similar" medical situations (e.g. several encounters with the same type of medical problem and/or treatment options), it has been difficult to develop phenomena that can reasonably be compared across several cases. Robinson & Heritage (2014) pointed out that "the more that research teams select data in terms of these five issues [physician specialty, subspecialty, level of physician training, visit type and reason for visit], the more quickly and easily conversation analysts are able to identify systematic and differential practices of action" (p. 206). Also, the fact that the phenomenon studied here (patient involvement in decision making) does not occur very frequently has resulted in relatively small number of cases in the final subsets (see Section 6.1.3), in spite of the large data set available. Conversely, the size of the data set may have been crucial for building such a subset after all.

In terms of reliability, a final challenge with this data has been the temporal, continuous nature of hospital encounters (see Peräkylä, 2004, p. 286). Unlike other types of encounters for which there is often no prior history between the parties (e.g. acute care), the encounters in this dataset are often only one segment in a series of encounters, either with the same or with other health care professionals. As such, the participants may rely on knowledge, prior events, and contexts that are unknown to the researcher. Also the fact that no written documents, such as medical records, were collected, and the fact that I have not collected the material myself, has resulted in limited supplemental resources and first-hand knowledge of the contextual environment. As a consequence, the research is based on what is made available in the video recordings, supported by ethnographic knowledge by the physicians Pål Gulbrandsen and Eirik Hugaas Ofstad (see also Section 3.2.1). Finally, the video recordings were originally part of a training intervention in communication skills (Jensen, 2011), which might have affected physicians' behavior, especially after the intervention. However, patient involvement

¹⁸ In CA research, broad data sets from hospital settings (secondary care) are rare (but see Lindström & Weatherall, 2014; Weidner, 2012).

in decision making was not taught specifically, although more general aspects of patient-centered care were.¹⁹

6.2.1.3 Transcription

The quality of transcriptions is another central issue in terms of reliability, and in CA studies, exactness is a central criteria of quality (Ayaß, 2015). The transcripts in this study are based on the conventions developed by Gail Jefferson (2004). Although this is a well-established, rigorous system within CA, developed for capturing temporal aspects (e.g. pauses, overlapping talk), speech delivery (e.g. intonation, stress, changes in pitch, speech rate), and other features (e.g. visual aspects, in breath, laughter particles), a transcript neither can, nor should, provide a complete representation of the recorded interaction. Too much detail can interfere with the readability and assessment of transcripts (Ochs, 1979), and inaccessibility of transcripts is also a well-known critique of CA transcription (Hepburn & Bolden, 2013). Thus, recognizing that transcripts are necessarily selective, especially when it comes to visual aspects, the transcripts should reflect the particular interests of the researcher (Ayaß, 2015; Ochs, 1979, p. 44). For the purposes of the present study, I have prioritized accuracy in pauses and overlapping talk, as well as various forms of word stress, since these aspects seemed to be analytically important in the decision-making sequences, often characterized by negotiation and/or opposing views. As such, transcription is also inevitably ‘interpretation of data’, and what an analyst chooses to include (or not) in a transcript “mirrors the transcriber’s interpretive efforts” (Ayaß, 2015, p. 510).

While most decision making sequences (and often whole consultations in the final subsets) were transcribed verbatim, only a limited amount was transcribed in detail, following the development of interests. Throughout the analytic process, decision making sequences were inspected in detail several times and in several rounds, leading to transcriptions being revised and developed continuously.

The need to translate transcripts in order to present the research for English-speaking audiences generated additional challenges (Hepburn & Bolden, 2013). I have been able to keep the original language in the articles, and all analyses are based on the Norwegian data. A three-line transcription is common for translated CA transcripts, especially in languages

¹⁹ During the whole project phase I have been blinded to whether the physicians in the videos have received training intervention or not. If this was necessary to know, Pål Gulbrandsen has drawn out the information, as was the case during the review process of article 2, where one reviewer inquired about training in the study material.

where the word order departed extensively from English. In addition to the original language, a three-line transcription includes an intermediate line with word-by-word translations as well as a third line with a more idiomatic gloss of the interactional meaning (Hepburn & Bolden, 2013). Since the word ordering in Norwegian and English are quite similar, I have used a two-line transcription. Another more practical reason for doing this is related to readability and space restrictions, working with relatively long stretches of talk. A particular challenge has been how to deal with particles, since they are difficult, or indeed impossible, to translate, even though they have played an important role in several of the analyses. Again, the analyses are derived from the particles' Norwegian function, and particles are either left untranslated in the transcripts or glossed roughly.

6.2.2 Analytic procedures and issues of validity

Validity “concerns the interpretation of observations” (Peräkylä, 2004, p. 289). CA methodology requires that the analyst grounds analytic claims in observable conduct, with reference to transcripts. This strict procedure contributes to the transparency of analytic claims, which is a strength in regard to validity. Furthermore, working with audio/video recordings and transcripts in data sessions and with co-authors has been important in order to validate and improve analytic claims as well as adequacy of transcripts compared to direct viewing of the video data. This relates to CA's scope to be a ‘natural observational science’, where “anyone else can go and see whether what was said is so” (Sacks, 1984, pp. 21, 26).

6.2.2.1 Next-turn-proof-procedure

Another fundamental validation procedure in CA is the ‘next-turn-proof-procedure’ (Hutchby & Wooffitt, 2008; Peräkylä, 2004). This analytic procedure concerns *what* should guide the analysts' interpretation, since an utterance, “if considered in isolation, is extremely open-ended, [whereas] any utterance that is produced in talk-in-interaction will be locally interpreted by the participants of that interaction” (Peräkylä, 2004, p. 291). Following the emic perspective described in Section 3.1.2, it is exactly the participants' understanding of what is going on that the analyst seeks to capture. The ‘next-turn-proof-procedure’ builds on the fact that, in interaction, participants, in their next turn, display some understanding of the prior speaker's turn that is made publicly available and used as a resource, primarily for the participants in the interaction, but also available for overhearing analysts (Heritage, 1984, p. 256). Sacks, Schegloff & Jefferson (1974, p. 729) describe this as an intrinsic analytic resource:

But while understandings of other turn's talk are displayed to co-participants, they are available as well to professional analysts, who are thereby afforded a proof criterion (and a search procedure) for the analysis of what a turn's talk is occupied with. Since it is the parties' understandings of prior turns' talk that is relevant to their construction of next turns, it is THEIR understandings that are wanted for analysis. The display of those understandings in the talk of subsequent turns affords both a resource for the analysis of prior turns and a proof procedure for professional analyses of prior turns – resources intrinsic to the data themselves.

However, this analytic procedure also has its limitations, since participants in talk do not always display unambiguous and explicit interpretations of prior turns in their next turns. Rather, more than understanding being topicalized per se, it is often a “byproduct or indirect outcome of the sequentially organized activities” (Heritage, 1984, p. 259). Such ambiguous or lacking displays of understanding in next actions may occasionally not only be the analysts' problem, but also a problem for the participants in the interaction. This is the case in article 3, where the patient's minimal responsive actions are treated as problematic for the physician in order to accomplish the task at hand. Here, the physicians' interactional work while he pursues more extended responses is made into the object of study.

6.2.2.2 Deviant cases

Deviant case analysis is also related to validity in CA, and often receives particular analytic attention (Peräkylä, 2004). None of the three studies in this thesis incorporate deviant case analysis in the strictest, classical sense, in which several 'regular' cases establish a pattern, while deviant cases that do not fit this pattern either provide additional support or alternatively lead the analyst to reconceptualize her claims. Nonetheless, all three articles in this thesis involve cases in which patients' actions may depart from expected courses of action by not acting fully in accordance with the physician's expectations for appropriate behavior, either by participating in the decision making *too much* (a patient having a strong, surgical treatment wish in article 1 and 2) or *too little* (a patient that do not fulfill the expectation to accept or reject a recommendation in article 3). As possible departures from 'regular' involvement may make the norms to which participants orient more explicit and observable, these cases may be particularly suitable for illustrating and explicating boundaries of norms and expectations related to patient involvement in decision making, although they may provide less evidence of what might be 'regular'.

6.2.2.3 Generalizability

The relatively small subsets used in the three studies limit the generalizability of the study findings. However, in a parallel study coding medical decisions in all 380 available recordings, Eirik Hugaas Ofstad has generously provided me with video numbers where he observed patients to be involved in decisions, and these were drawn on in the subset of article 2 (cf. the third expansion of the data described in Section 6.1.3). This may indicate that the findings are representative of this particular dataset, but it is beyond the scope of this study to provide generalizable findings about patient involvement in Norwegian hospitals in general.

Subsequent studies would have to confirm or adjust the robustness and distribution of findings reported here. Rather, Pomerantz (1990) argues that the validity of CA findings is based on another sort of claim than generalizability: The value of CA studies is the ability to characterize social actions, to describe what methods and resources participants use for accomplishing these actions, and to propose how these methods work, that is, what interactional consequences they might have. As such, CA studies “are able to identify features of interactants’ interpretive work that otherwise are undefined, hazy, and undifferentiated” (Pomerantz, 1990, p. 234). So what the study does offer is proof of *possible social practices* (Peräkylä, 2004, p. 296) that are explicated so that other professionals and educators can potentially learn from them. Notably, a method for systematically reviewing conversation analytic health care studies is a recent initiative built for developing more generalizable findings that can inform healthcare practice and policy (Parry & Land, 2013). Implications of this study for research and practice is the topic of Chapter 8, but first, an overview of the findings of the study will be provided.

7 Overview of the findings of the study

Overall, articles 1-3 illustrate a continuum of how physicians involve patients in decisions about treatment, ranging from higher to lower degrees of patient involvement or ‘sharedness’: Article 1 concerns encounters where patients are invited to decide (choose between treatment options). Article 2 examines a physician practice for bringing up and discussing patients’ preferences towards treatment. As treatment options and patient preferences are key characteristics of shared decision making (Makoul & Clayman, 2006), articles 1 and 2 investigate patient involvement on the higher end of the continuum. Article 3 examines an encounter on the lower end of the continuum, where the patient is expected only to accept (or reject) a proposed procedure.

Moreover, a related theme that runs through this thesis, is the other side of the coin, that of *physician* involvement in decision making, which often remains implicit or overlooked in models about *patient* involvement. But as patient *and* physician involvement (or influence) has been shown to be closely intertwined in actual decision making, the interplay between these notions will surface throughout the discussion. The analytic framework of epistemic and deontic rights, explicitly applied in article 1, and introduced in Section 3.3, will be used for operationalizing this interplay.

In what follows, the findings of the three articles will be summarized in relation to the overarching research question: *How do physicians and patients orient to and negotiate patient involvement in treatment decision making in a Norwegian hospital setting?*

7.1 Article 1

Article 1 examines how ‘sharedness’ and patient involvement is negotiated and maintained through epistemic and deontic resources when patients are given a choice between invasive and non-invasive treatment options. The study demonstrates physicians’ and patients’ negotiation about *who* should make the decision (deontic rights), a question that regularly releases negotiation about another question: *on what grounds* (epistemic rights) should the decision be made; the patient’s ‘epistemics of experience’ or the physician’s ‘epistemics of expertise’.

7.1.1 Physicians’ orientations to patient involvement: deontic rights

The study demonstrates how the physicians orient to patient involvement by conferring the

right to decide (deontic right) to the patient. This is achieved either by presenting treatment options or by inviting the patient to decide. The physicians ground the patient's deontic right on the patient's 'epistemics of experience', such as their subjective experience or personal treatment preference. Simultaneously, physicians constrain the same involvement by drawing heavily on their epistemic and deontic authority: Firstly, by regularly conveying their deontic stance towards the options, indicating what option they favor (what Toerien et al. (2013) refer to as tilted option-lists). This deontic stance gains additional weight through their 'epistemics of expertise', which is conveyed implicitly or explicitly. Secondly, physicians seem to claim the right to decide *when* it is that patients' experiences count, setting important terms for the relevance of patients' deontic rights.

7.1.2 Patients' orientations to patient involvement: deontic rights

The patients, on the other hand, seem oriented to restraints of their involvement by resisting allocated deontic rights in at least two ways: Patients resist deontic rights or responsibility based on a lack of epistemic authority (disclaimer of knowledge), pointing to physicians' expert knowledge, or based on inferior deontic authority (disclaimer of rights), making decisions contingent on the physician taking a stronger deontic stance (e.g. "if I have to"). In a case where the patient does claim strong deontic rights, she simultaneously orients to the inappropriateness of claiming these rights.

7.1.3 Exploiting a shared orientation to patient involvement

The study suggests that, in cases with opposing treatment preferences, both parties may exploit the shared orientation to patient involvement in decisions, circumventing 'unilateral' decisions while subtly working to influence the final decision. More specifically, both parties can utilize an inverted form of deontic authority by conferring the decision (and deontic right) to the other as a means for pursuing their favored outcome: Physicians can give patients deontic rights in pursuit of achieving independent commitment to their favored option, maintaining 'sharedness'. Patients, on the other hand, can orient to physicians' epistemic and deontic authority, eschewing commitment, as a means to resist the physician's favored option and possibly to also avoid decision responsibility.

7.2 Article 2

Article 2 identifies and describes a physician practice for eliciting and clarifying understanding of patients' preferences and views towards treatment, what we have described

as *formulations of patients' stance*. The study explores what (other) objectives formulations of patients' stance can achieve while negotiating treatment, and discusses how these objectives relate to SDM models.

7.2.1 Physicians' orientation to patient involvement: patient preferences

Physicians occasionally orient to the relevance of patients' treatment preferences by paraphrasing or drawing inferences about treatment preferences from patients' previous talk. Such formulations of the patient's stance also clarify understanding, by seeking confirmation or disconfirmation from the patient. What physicians seem less oriented to, is exploration of the patients' preferences in an open and 'neutral' way, as implied in SDM models. Conversely, they may be used as a resource for directing patients towards decisions more in line with the physician's view, while, on the surface, maintaining an orientation towards 'sharedness' or patient involvement. The physicians' orientation to patient involvement is maintained first and foremost by engaging with patient preferences per se. Secondly; patient involvement is maintained by treating patients as responsible agents, with agency, which is also a goal in SDM models.

What counteracts the same orientation is that physicians indirectly can convey their (opposing) stance, with help of formulations that enable subtle transformation and editing of the others' talk. Analysis suggests that physicians' formulations can be used as a resource for indirectly assessing the legitimacy of a patient's treatment preference. Once a treatment preference is conveyed as not in accordance with common sense or the physician's epistemic expertise (less than fully legitimate), it can be subject to challenge. As such, physicians may orient to normative constraints of patient involvement, by indicating the (lack of) legitimacy or appropriateness of a treatment option. In epistemic and deontic terms, physicians claim superior epistemic authority in the domain of treatment options, by exercising the right to devaluate or approve the legitimacy of a patient's treatment preference. This suggests that physicians' formulations of patient stances may serve other objectives than neutral deliberation, objectives that may counteract central objectives in shared decision making models.

7.2.2 Patients' orientations to patient involvement: patient preferences

Turning to patients' orientations towards talk about treatment preferences, the study demonstrates that patients work to justify or reject ascribed stances or agency. This is done for

instance by providing accounts for their position or by distributing responsibility for the stance to authoritative third parties. This indicates a potential burden of having and upholding a treatment preference (or in deontic terms, claim a deontic stance), namely the risk of being challenged and having your treatment preference devaluated.

7.3 Article 3

Article 3 examines how a physician attempts to secure a non-native speaking patient's understanding and acceptance of an invasive treatment recommendation in a series of treatment recommendation sequences drawn from a single encounter. The study describes an array of strategies the physician uses for dealing with minimal responses that occur where a more elaborate response would have been expected, which the physician treats as indicating potential problems of understanding or acceptance.

7.3.1 Physician's orientation to patient involvement: acceptance and understanding

In this case study, there is a pattern during a series of decision-making sequences in which the physician repeatedly recommends an invasive procedure (biopsy), to which the patient responds minimally (e.g. "mm", nods). In the physician's next actions, which are responses to the patient's minimal responses, he displays a strong orientation towards pursuing acceptance or commitment to the invasive procedure (e.g., by incorporating arguments favoring biopsy and reformulating the recommendation as being in the patient's best interest). In the face of repeated non-acceptance, the physician also introduces the option of doing nothing. When the patient occasionally exhibits potential problems of understanding, the physician orients towards achieving understanding with reformulations and repair strategies that work to maximize understanding.

This orientation can be characterized as a constrained or minimal form of involvement, in which the physician's main objective is oriented towards achieving acceptance, whilst securing understanding is treated as a necessary prerequisite. The physician, throughout, claims strong epistemic and deontic rights by claiming what is best (medically), whilst upholding the patient's deontic right to refuse. However, the right to refuse is made difficult by framing the patient's strong unwillingness or non-desirability as the only possible ground for rejection (epistemics of experience), whereas the patient may have proposed potential grounds against biopsy based on medical reasoning (epistemics of expertise).

7.3.2 Patient's orientation to patient involvement: acceptance and understanding

In this case, the patient seems to cooperate and align with the physician's work to secure understanding, but he does not align with the physician's repeated attempts to secure acceptance (or refusal). What may cause this lack of alignment is never made evident, whether it is the patient's lack of understanding, reluctance to undergo the procedure, reluctance to participate in the decision, or other reasons. Instead, the patient orients to the repeated proposals as a recipient of information, avoiding any projections of deontic rights, even the right to accept/refuse, whereas he may subtly claim epistemic rights within the medical domain of expertise by interpreting blood tests and evaluating the effect of natural medicine.

This extreme case (in the patient's resistance or non-understanding of the requirement to accept or reject a proposal, and the physician's matched effort of pursuing understanding and acceptance) demonstrates a patient's resource for participating and affecting the outcome even through non-participation or minimal responses, effectuated through the strong expectation from the physician to contribute with a commitment or refusal.

In the last chapter of this thesis, these findings will be discussed more broadly in relation to the secondary question posed in Chapter 5: *In what way(s) may the study findings inform SDM models, research and practice on patient involvement in treatment decision making?*

8 Discussion

8.1 Knowledge interests

In human sciences, “the problem of achieving objectivity is that of learning to counter our own biases. It requires us to make explicit, and to make allowances for, the interests and values that we ourselves bring to our research” (Toulmin, 2001, p. 96). In the ensuing discussion, I will firstly attempt to be explicit about what interests I have brought into this research, drawing on Habermas’ three *knowledge interests* (1974). Secondly, I provide a brief reflection about the exercise of balancing the knowledge interests influencing this study.

This thesis is firstly driven by an *empiric-analytic interest* into how interactions between physicians and patients unfold in Norwegian hospital encounters. This is consistent with the conversation analytic approach of studying “how social action is brought about through the close organisation of talk” (Antaki, 2011b, p. 1).

Secondly, the study has been guided by a *practice-instrumentalist interest*, for instance, an interest in solving practical problems or alleviating challenges for practitioners. The decision to focus on patient involvement in treatment decision making was led by an interest in gaining knowledge about the relation between ‘best practice’ guidelines (SDM and patient involvement) and actual practice, in the hopes of also contributing to improving practice. The fact that all three studies take physician actions as analytical starting points also reflects the interest to inform professional practice by describing how physician practices influence patient involvement. The practice-instrumentalist interest in this study aligns with ‘applied’ CA, aiming to illuminate how institutional tasks or problems are handled, which in turn may be used as a basis to propose improvements or intervene (Antaki, 2011b).

Thirdly, although the study was not driven by an *emancipatory/critical interest* from the outset, this interest has evolved throughout the project, mainly as a critique of the ideological and methodological interests dominating the field of SDM.

8.1.1 On balancing or compromising knowledge interests

A particular challenge in this study has been to balance and combine the empiric-analytic and practice-instrumentalist knowledge interests: If prioritizing one interest, it seemed to be at the expense of the other. Nonetheless, I have prioritized the empiric-analytic interest as the primary interest in this study, led by an emic line of inquiry. If I would have compromised

that, the results might have reduced the practice-instrumentalist scope anyway. The practice-instrumentalist interest has guided the study object towards challenges of implementing SDM and patient involvement in practice, but in the analytic phase, the empiric-analytic interest has been prioritized. As such, the aim of a practice-instrumentalist contribution has preconditioned a primary commitment to the empiric-analytic interest. But after the analytic phases, when discussing findings in the three studies, I have focused on implications that may be salient in regard to practice-instrumentalist interests. The aim of a practice-instrumentalist contribution is also the reason why I have devoted a considerable amount of room to this area of interest in this thesis.

8.2 Empiric-analytic contributions

8.2.1 Investigation of a sparsely researched setting

This study contributes to medical CA research with investigations from a setting that has previously received little attention, both in regards to geographical placement and medical context. Whereas the vast majority of medical CA research has studied primary care interactions from US and UK (see Section 4.2), this study has investigated secondary care interactions from a Norwegian hospital, broadening our knowledge of physician-patient interactions into those contexts. In their review of physician-patient interaction, Heritage and Clayman (2010, p. 155) suggest that the interactional dynamics are “likely to be significantly different with more serious illnesses” compared to the moderate illnesses examined in primary care. The present study contributes to specifying the dynamics involved when making decisions about invasive procedures. This may be considered a heavier burden than non-invasive procedures, in which unilateral decisions (either made by patient or physician) could impose responsibility for potential adverse outcomes. Further research is needed to unpack generic versus more context-specific orientations to patient involvement in other contexts (Pilnick & Zayts, 2015).

Moreover, article 1 and 2 investigate decision making sequences during which patients are expected to be more actively involved than through a mere acceptance or rejection of a treatment recommendation. This departs from the recommendation-acceptance structure taken for granted in most CA research as being equivalent to the phase during which physicians and patients plan what to do next (Toerien et al., 2013; Weidner, 2012). As such, this study may contribute to the call for revising the “standard conversation analytic account of the treatment phase” (Toerien et al., 2013, p. 887), which has recently been pointed out as a direction for

future research (Reuber et al., 2015).²⁰ The study seeks to go deeper into what *else* might be going on within and between recommendation/hybrid/option-list structures, in order to explicate and expand our understanding of interactional forces and resources participants draw on in treatment decision making.

The following section will further specify these interactional dynamics in relation to prior research in medical CA.

8.2.2 A shared orientation to constrained patient involvement

All three articles describe how physicians and patients orient to and negotiate the degree, grounds and terms for patient involvement. Across articles 1-3, both the physicians and patients orient to constraints of patient involvement, what might be characterized as *constrained patient involvement*. First, a shared orientation is that both parties orient to patients' independent and explicit commitment as a minimal requirement, imposing strong obligations to commit to (or reject) undergoing invasive procedures (articles 1-3). This is consistent with a series of previous studies from US primary care (Koenig, 2011; Stivers, 2005b, 2006) and various other countries and contexts (Lindström & Weatherall, 2014; Weidner, 2012), but it does not fully confirm findings from Finnish primary care, in which patients' minimal or absent responses were oriented to as sufficient to complete the decision (Ijäs-Kallio et al., 2011).²¹ Put differently, in the present study, there seems to be a shared dispreference for unilateral decisions about invasive procedures, both on the part of the patient and the physician, even when the patient or physician is given the right (article 1).

Furthermore, the present study corresponds with Weidner's (2012) findings from Polish secondary care about invasive procedures in at least two areas; First, in that such decision-making sequences regularly are extended beyond the simple recommendation-acceptance structure. Second, in that during these extensions, physicians and patients orient to the necessity of the physicians' accounts for the procedure (i.e. why this particular procedure). In the present study, this second point is framed in terms of the physicians' epistemic and deontic rights. However, findings from this study may depart from the Polish data in that the physicians in the present study also seem oriented to patients' epistemic and deontic rights as

²⁰ If I were to place the study findings according to the well-established recommendation-acceptance structure and the full-form option-list-structure recently proposed by Reuber et al (2015), articles 1-2 would lie somewhere in between (what Reuber et al. call hybrid forms), whereas paper 3 would fall within the recommendation-acceptance structure.

²¹ Notice that this expectation may not be shared in the case analyzed in article 3; There, the physician oriented to patient acceptance as required, but it is uncertain whether the patient shared the same orientation.

relevant for making invasive decisions (i.e., rights to decide, treatment preferences, and willingness concerning invasive treatment options, in that the patient, as a minimum, has the right to refuse based on unwillingness). This physician orientation may suggest a more patient-centered approach in the Norwegian data.

However, the present study also indicate that, when patients gain access to the epistemic and deontic domains of medical reasoning, and judging what is appropriate treatment options, it also entails additional challenges for the participants to clarify these terms through negotiation. For example, the physicians in this study seemed oriented to such a limit for patient involvement by dismissing or challenging patient claims within the physicians' domain of expertise. This may indicate that physicians maintain and guard their epistemic authority as experts, potentially sanctioning or correcting patients' expert claims. From a medical point of view, this may be an obvious part of physicians' responsibility for patient education.

In terms of the patients' right to decide (deontic rights), the physicians' orientations may seem contradictory. On the one hand, patients are occasionally given the right to decide (article 1) and physicians occasionally orient to their treatment preferences (article 2). Simultaneously, physicians make it difficult to decide against the physician's opinion: First, by indeed conveying their opinion, drawing heavily on their epistemic and deontic authority (articles 1-3), which is consistent with what Reuber et al. (2015) described as *tilted* option lists. In the Norwegian data, tilted option lists may seem more prevalent than in the UK neurology data, where non-tilted or 'neutral' option lists also were common.²² However, whereas Reuber et al. suggested that tilted option lists change the patients' relevant response slot from choosing from a list to accepting a recommendation, article 1 suggests that physicians can provide tilted option lists while insisting on the patient's ultimate deontic right to decide. Furthermore, patient involvement can be constrained when physicians evaluate patients' treatment preferences as more or less appropriate and open to challenge (article 2). And third, physicians can set up constrained grounds for a patient to reject a proposal (e.g. extreme unwillingness) (article 3). In sum, the study illustrates how physicians may trump the negotiation process, relying on superior epistemic rights, while insisting on patients' deontic rights to decide (paper 1) or to accept/reject (paper 3).

²² In the third expansion of selected cases (see section 6.1.3), not included in article 1, an encounter with a non-tilted option list was identified. Notably, the patient there also resisted making a decision.

Patients also orient to constrained involvement. Starting with the latter part (involvement), patients can influence decision making by claiming deontic rights (article 1) and treatment preferences (article 2), and paradoxically, even by orienting to the physicians' epistemic and deontic rights (articles 1, 3). When it comes to what might constrain involvement, patients seem oriented towards a limit in deontic rights that goes between the right to *accept/reject* and the right to *decide*, where the right to decide seems to be treated as beyond, or at least at the boarder of their deontic domain. In the extreme end, patients may also resist the basic requirement to accept/reject a recommendation (article 3). Notably, when patients are afforded (or claim) greater influence and rights in decision making, it may seem to require some justification on the part of the patient, for instance, by legitimizing and accounting for a specific treatment option (articles 1, 2). Thus, compared to acute primary care, in which patients work to justify the decision to seek medical help (Heritage & Robinson, 2006, see Section 4.2.1), the patients in our data were not held accountable for visiting the physician (probably because these decisions are generally not made by them). Rather, in our data, the patient's problem, "to be perceived as a reasonable, credible patient" (Gill & Roberts, 2013, p. 583; Halkowski, 2006), seemed to permeate through to the decision making phase in cases where patients were given the right to decide (article 1), were wanting a specific treatment (article 2), or were resisting to accept or reject a treatment recommendation (article 3). As such, physicians' accountability for invasive procedures (Weidner, 2012), may also apply to patients when they are involved in making decisions about invasive procedures.

The subsets in this study are characterized by opposing treatment preferences, disalignment in regard to how patient involvement should be exercised, and they mainly concern invasive procedures. I have not been able to consider fully whether and what resources are mainly oriented to disagreement, disalignment, or the invasive character of the decisions, let alone disentangle these elements. But what the study does suggest is that these characteristics may trigger and make evident such negotiations of patient involvement.

8.3 Practice-instrumentalist implications

8.3.1 The scope of empiric-analytic contributions

Following the discussion of knowledge interests in Section 8.1, a main point concerns the value of pursuing an *empiric-analytic knowledge interest* in its own right. At best, the "detailed study of small phenomena may give an enormous understanding of the way humans do things" (Sacks, 1984, p. 24). The CA approach applied in this study has enabled

descriptions of what actions participants carry out, the workings of resources participants use, as well as its interactional consequences (Pomerantz, 1990). This inductive, emic approach, investigating actual interaction, is a different starting point than quantitative approaches, which may be driven by normatively oriented models (i.e. SIKs, see Section 1.3) of what patient involvement in decision making *should* look like. Rather, in order to improve practice, I argue that it is essential to know how things work, at ‘baseline’. Thus, Bagian’s famous words concerning patient safety reforms may also hold true for reforms on patient involvement: “You can’t fix what you don’t know about” (Bagian et al., 2001). A central argument in this thesis is thus that reform initiatives concerning patient involvement in decision making would benefit from drawing on specific knowledge about how these activities work at ‘baseline’, and identify what practitioners are already doing and build on that as a resource. This may also be used as a knowledge base informing the stream of research that works towards resolving the confusion and inconsistency in SDM models, which we will turn to now.

8.3.2 Implications for SDM models and patient involvement

As described in Section 2.3, this study has drawn on the integrative SDM model by Makoul & Clayman (2006) in order to discuss study findings in regard to one influential model. I have attempted to link what Makoul & Clayman define as ‘essential elements’ in SDM to elements described in the three articles (see Table 1). The simple overview suggests that the three articles examine seven out of nine of the essential SDM elements to a larger or smaller extent (graded in the table as central, relevant, or touched upon). In addition, some of Makoul & Clayman’s ‘ideal elements’ in the model (‘define roles (desire for involvement)’, ‘present evidence’ and ‘mutual agreement’) are more or less evident across the articles, as well as some ‘general qualities’ (‘deliberation/negotiation’, ‘involves at least two people’ and not least ‘patient participation’). These ‘ideal elements’ and ‘general qualities’ are not included in the table. Although only a rough mapping, the table suggests that this study engages with SDM associated *practices*, although it is an open question whether it deals with SDM *actions* (Schegloff, 1997a). This small mapping exercise may suggest that even a detailed model such as that of Makoul & Clayman may be too general in order to correspond with actual accomplishments of SDM-like behavior.

Table 1. Essential elements in Makoul & Clayman's (2006) integrative SDM model in the left column. Right column indicate whether and to what extent the elements are made relevant in the three articles of this study, graded as central-relevant-touched upon.

Essential SDM elements	Relevance in articles 1-3
Define/explain problem	
Present option	Central in article 1, relevant in article 2
Discuss pros/cons (benefits/risks/costs)	Touched upon in articles 1-3
Patient values/preferences	Central in article 2, relevant in articles 1, 3
Discuss patient ability/self-efficacy	
Doctor knowledge/recommendations	Relevant in articles 1-3
Check/clarify understanding	Central in articles 2, 3
Make or explicitly defer decision	Relevant in articles 1, 3
Arrange follow-up	Touched upon in article 3

As described the review in Section 4.1.4, prominent researchers in the field of SDM have recognized the inconsistency in definitions, models, and assessment tools of SDM as a challenge for research and implementation (Charles, Gafni, & Whelan, 1997; Clayman et al., 2015; Makoul & Clayman, 2006; Scholl et al., 2011). The empiric-analytic findings in this study may support, and perhaps also illuminate that the confusion and inconsistency in SDM models is also evident in participants' own undertakings of patient involvement, from within the participants' worlds. Based on participants' orientations in actual encounters, the ideals of SDM do not seem to be norms that are fully integrated in actual practice, and neither does the parties seem to fully align in terms of how patient involvement should take place. This may point to a challenge of SDM models, that they are mainly developed from ideal, conceptual trajectories, and only to a limited extent, if at all, built on systematic analyses of actual interaction. This may also contribute to the gap between models and actual practice. As a consequence, this study suggests that research on participants' orientations to patient involvement in situ, should be taken into account and addressed when developing SDM models and associated reform initiatives.

8.3.2.1 'Physician as partner or salesman?'²³

An issue that seems to be central, both for the participants in the present study and in debates about what SDM is, or should be, is whether physicians should be 'neutral' and support patients' autonomous choice, or whether physicians should also express and promote their values and preferences in regard to treatment options (see e.g. Emanuel & Emanuel, 1992; Labrie & Schulz, 2015; Pollak, 2015). Although an underlying assumption indicates that physician argumentation (or persuasion) does not fit with SDM (Salmon, 2015), a recent study found that encounters in which physicians provided more arguments were associated with more participatory decision making (Labrie & Schulz, 2015). This may be in line with the findings of this study, in which patient involvement often seemed oriented to resolving opposing views, in that physicians pursued agreement to their favored option (see Section 8.2.2).

An orientation to the physician as 'salesman' also seems to be congruent with two self-report studies of physicians' and patients' respective views: In a recent qualitative study, the attitude of a majority of healthcare providers in Germany were assigned to the paternalistic decision making model. The authors specify this paternalistic attitude in forms of persuasion and sale:

Particularly dominant was the attitude that physicians are able to influence the decision of a patient (e.g., "I believe WE lead the patient, we decide, what he is going to do. And it depends on how we sell this to him."). Physicians reported that they could not be neutral throughout the deliberation process (e.g., "I don't think it is possible to inform a patient in a way that you do NOT influence him with your own thoughts.") (Frerichs et al., 2016, p. 7).

Interestingly, another study of patients' perceptions found that the physician's opinion was the most important type of information for patients when making (shared) decisions about invasive procedures (Mazur et al., 2005). Thus, these two self-report studies and the present CA study may indicate that physicians and patients are more aligned with each other in respect to the central role of physician's opinion, whereas SDM models seem to be more mixed about whether physician's opinion is compatible with doing SDM (Charles, Gafni, & Whelan, 1997; Elwyn et al., 2012; Emanuel & Emanuel, 1992; Frerichs et al., 2016). So, whereas many SDM models seem to have the expectation of "epistemic asymmetry [expert knowledge in separate domains] and deontic symmetry" (Stevanovic, 2013, p. 65), this

²³ The heading is borrowed from Karnieli-Miller & Eisikovits (2009), entitled "Physician as partner or salesman? Shared decision-making in real-time encounters".

expectation is not always shared by the participants involved if you ask them (cf. Frerichs et al., 2016; Mazur et al., 2005), or if you look at what they do, as in the present study.

8.3.2.2 Who decides when SDM is appropriate?

Another debated issue in the field of SDM is *when* SDM is at all appropriate. Different positions range from SDM being appropriate 1) for patient preference-sensitive decisions, 2) in cases with equipoise 3) in “serious” decisions, or, most radically, 4) in *all* decisions (Clayman, HØKH research forum, 27.1.2016). Representing the latter view, and citing David Eddy, it has been argued that:

an intervention should be considered a “standard” only if there is “virtual unanimity among patients about the overall desirability . . . of the outcomes.” For the vast majority of decisions in which there is no intervention that meets this high bar, patients need to be involved in determining the management strategy most consistent with their preferences and values (Barry & Edgman-Levitan, 2012, p. 780).

In spite of these different conceptions about when SDM is appropriate, there seems to be an underlying assumption that the “appropriateness” of SDM, and what are “good” or “equal” options are self-evident matters. These assumptions are also reflected in the Norwegian Patients’ Rights Act, previously cited: “the patient’s right to participate in choosing between available and *medically sound methods* of examination and treatment” (“Lov om pasient- og brukerrettigheter [Patients' Rights Act]", 1999, § 3-1, italics added). What is, in fact, “medically sound” is not always straightforward, let alone who should decide what should be considered so (e.g. evidence-based medicine and guidelines, physicians’ clinical judgement, or patients’ values and goals) (Reuber et al., 2015). The empirical findings in the present study indicate that participants within the encounters orient to and deal with determining the appropriateness of specific options (article 2) or the relevance of SDM at all (article 1), that is, to the participants, these matters might not have been so self-evident.

8.3.2.3 Balancing authority and autonomy

The tension between the respect related to autonomy and the concern for welfare is at the heart of the patient-professional dialogue (Nessa & Malterud, 1998, p. 400)

The Hippocratic Oath has been a pillar in medical ethics since ancient times. In modern patient-centered approaches, these ancient principles are combined with patient autonomy as a guiding ethical principle, and SDM models often seem to be built on the assumption that patient autonomy will lead to increased beneficence (see Section 4.1.4.2). However, several

researchers have pointed to the potential conflict between autonomy and beneficence (Beauchamp & Childress, 2013; de Haes, 2006). Nessa & Malterud (1998, p. 397) point out that “In clinical medicine (...) it is an everyday dilemma to decide whether to respect the patient’s apparently autonomous resistance to well-intended clinical intervention”.

In the present study, the participants also orient to issues of authority and autonomy. Patients want interventions that the physician might consider to be harmful (articles 1-2), or resist interventions that the physician may consider to be beneficial (articles 1, 3). In these cases, the patient “violates a duty traditionally associated with the sick patient role – the patient’s duty to seek competent help and follow the doctor’s advice”, and he perhaps also violates the “obligation to get well” (Nessa & Malterud, 1998, p. 397; Parsons, 1951). As such, a patient exercising autonomy may simultaneously violate the beneficence principle. What might be observable in the physicians’ conduct, then, is that physicians can counter these patient violations through constraining the patient’s autonomy, which may be at odds with autonomy and SDM.

Furthermore, the present study demonstrates that both parties orient to the privileged status and close interrelation between the physicians’ epistemic and deontic authority. This corroborates the view of medical practice being about transforming epistemic authority (medical expertise) to deontic authority (in prescribing medications and interventions) (Heritage, 2013a, personal communication). As such, the ideals of deontic symmetry, or patient autonomy, might not be in line with participants’ expectations. Rather, the participants’ expectations seem to be more in line with the duty for physicians to make consent or refusal possible for the patient (Nessa & Malterud, 1998).

8.4 On current practice in Norwegian hospital encounters and SDM

The main contribution of this study is empirical evidence regarding how patients are involved in actual decision making. Although these analyses are purely descriptive, it is possible to evaluate the findings in regard to descriptions of SDM.

Overall, the physicians in the three articles oriented to involving patients in treatment decision making, which is generally assumed to be the goal or realization of SDM. Nevertheless, the study has illustrated that behavior associated with SDM (see Table 1, Section 8.3.2) may not primarily be oriented towards actually achieving SDM. It may be a short path between the

physician offering the patient a choice to directing the decision (article 1); a communicative practice for eliciting patients' preferences may work to devalue that stance and direct patients towards decisions more in line with the physician's favored stance (article 2); a physician's efforts to secure understanding and commitment may not be successful in terms of patient-centeredness (article 3). Thus, the physicians can be seen to persuade (and perhaps even coerce) patients using a range of subtle resources that, on the surface, look like patient involvement and SDM. Such strategies may curtail a discussion on more overt terms (although not necessarily equal terms) in which the physicians' positions and underlying aims would be more transparent. In sum, one might say that the subtle nuances between coercion and shared decision making are evident in this study. These subtle nuances and dynamics, with their contradictory consequences, may go unrecognized in SDM models.

One final remark in regard to the data analyzed is the following: Based on these discouraging findings, it might look as if the analyst deliberately sought examples of 'bad practice'.

However, the contrary is rather the case, with the exception of the case study reported in article 3. Ofstad's (2016) qualitative assessment, based on the full dataset of 372 videotaped consultations, indicated that there were few cases that aligned with SDM trajectories. These analyses and indications might question the feasibility and applicability of SDM models.

There seems to be a long way to go before the ideals of SDM are implemented in regular practice, and one step might involve addressing and disentangling concepts and goals in the models in relation to constitutive structures and mechanisms, as they are played out in the medical enterprise.

8.4.1 Implications for professional practice and training

In order to make recommendations for 'best practice', one has to be clear about identifying the practice goals, since "what counts as 'effective' depends on what the goals are" (Toerien et al., 2011, p. 158). For instance, the practices described in the present study may be effective in terms of overcoming resistance or pursuing commitment to (evidence-based) recommendations, but they may be less effective in terms of delivering patient choice or promoting patients' deontic authority (cf. Reuber et al., 2015). Thus, as Toerien et al. further point out:

the question of what [professionals] should be trained to do is not, then, only an empirical one; because it depends on the purpose of the [encounter], it is also a question of policy and politics" (2011, p. 157).

Instead, I want to point to a more general implication to be drawn from this study. Based on the challenges in the field of SDM of developing accurate and coherent models for best practice (cf. Section 4.1.2), I argue that recommendations for ‘best practice’ “need to be founded upon information about the interactional consequences of adopting a given practice” (Drew et al., 2001, p. 67). Recent medical CA studies along these lines have shown promise (e.g. Heritage et al. 2007; Jenkins et al., 2015; Jenkins & Reuber, 2014). Moreover, a CA-based communication skills training method (CARM), has been developed as an alternative to more traditional simulated role-play methods (Stokoe, 2014). In CARM, training participants ‘live through’ segments of real interactions, and reflect upon various (alternative) ways of dealing with specific interactional projects and tasks. An advantage of looking at authentic, interactional data, is that it has the potential of increasing professionals’ interactional awareness; on how subtle details in talk work, and how they may affect communicative trajectories. However, in an eloquent discussion of the gap between the descriptive and prescriptive domains of negotiation research, Maynard (2010) puts forward a reservation about the scope for all communication skills training, pointing to the challenge of teaching negotiators ‘effective practices’ as this is inherently linked to their local, specific context, where:

their skill lies in fitting, molding, or tailoring their proposals, tactics, and practices to the “unpredictable moments,” developing courses of action, and interactional environments in which the tactics and practices are embedded. Accordingly, prescription is not just about procedures and rules; it is also and very much about timing, sensitivity, and tailoring to the context of the talk (Maynard, 2010, p. 141).

I think such a context sensitive approach and awareness are equally relevant when developing physician training of patient involvement in decision making, as these activities are fraught with unpredictabilities and complex dynamics.

8.4.2 Implications for health policy

One implication to be drawn from this study is that patient involvement or SDM cannot be mandated purely from the political realm, for instance, through the Patients’ Rights Act. If these political and juridical goals are to be realized in practice, more research is needed that attempts to bridge the gaps - between normative models (SIKs) and practice, and between descriptive and prescriptive approaches. Some directions for future research that could address these gaps are discussed in what follows.

8.5 Methodological implications and directions for future research

Until recently, there has been a limited degree of exchange and interdisciplinary influence and contact between CA (and other observation based micro-analytic disciplines) and mainstream healthcare research communities (e.g. *European Association for Communication in Healthcare*, EACH). Further research initiatives should combine and exploit these different approaches in order to further develop the field.

8.5.1 Combining qualitative and quantitative approaches

One proposed line of research could follow Braddock et al.'s (2008) study, in which they first coded encounters for informed decision making. Encounters with high score were subsequently analyzed at a more granular level to identify concrete, actual strategies accomplishing good and time-efficient informed decision making. As the authors suggest, this approach provides the much-needed detailed guidance for professionals on how to implement 'best practice' informed decision making. Similar undertakings could be done, by first identifying high score SDM encounters, which in turn could be analyzed using CA in order to detect specific practices and its interactional consequences.²⁴

8.5.2 Integrating qualitative and quantitative approaches

A more comprehensive approach could be to develop coding schemes that integrate a quantitative and qualitative approach, grounded in sequential, fine-grained analyses (see also Heritage & Maynard, 2006 for a similar line of argument). In the relatively short history of health communication research, insights to physician-patient communication have developed continuously, beginning from the initial 'indirect methods' (e.g., self-reports of perception or recall), which were found to be unreliable in terms of describing what actually happened (e.g. Braddock 1997). The next steps included the development of a myriad of observation instruments, assessing audio or video recordings, first focusing only on physician behaviors (from Byrne & Long's study and onwards) to recently recognizing the necessity of a dyadic approach, assessing also patient behaviors (Clayman et al., 2015; Kasper et al., 2012; Scholl et al., 2011, see also Section 4.1.4.3). According to these authors, the dyadic approach is a promising direction for future research in SDM. Drawing on insights from the present study, one could propose taking the observation dyadic approach even further, by applying a CA

²⁴ Such an approach will be presented in the upcoming symposium "Assessing Shared Decision-Making - Analyzing The Same 32 Encounters Using Six Different Methods", at the *14th International Conference on Communication in Healthcare*, September 2016, Heidelberg, Germany.

approach that takes into account that accomplishing actions is indeed an interactional, co-constructed achievement (e.g. Schegloff, 1997a).

Furthermore, by taking into account *position* as well as *composition* of utterances, which have significant bearings for what actions are accomplished, such an approach could reveal not only whether this or that occurs, but also what specific practices were used, what actions were performed, and, importantly, what interactional outcomes they yielded (i.e. constraints and opportunities for patient involvement). These affordances may give this ‘bottom-up’ approach an advantage both for training purposes and for developing empirically-derived coding schemes. Stivers’ (2015) recent description of quantitative applications of CA provides methodological guidance about how such undertakings could be carried out.

The bottom-up approach departs from traditional ‘top-down’ methodologies that risk the massive reduction of complex behavior to simplistic codes (Stivers, 2015), with the result that significant phenomena could pass unnoticed under the radar. Mainstream research on health care communication may have underestimated the fundamental building blocks and detailed dynamics involved in the organization of human interaction. In comparison, in other fields of medicine, advanced in research and practice have been built on a strong foundation of basic research (e.g., in chemistry or biology). Research on clinical communication, in contrast, has not been connected to a coherent theoretical and empirical foundation. Perhaps biased by the dominant medical research paradigm of quantitative, evaluative aims, it may have disregarded the extent to which communication research has a foundational parallel to basic medical research, functioning as important building blocks. Without a firm analytic foundation, it may be difficult to disentangle effects or outcomes from the interactional, underlying mechanisms generating these outcomes. The search for quick and efficient methods of research may have eclipsed foundational research considered to be far too time-consuming and labor intensive. This quest for efficiency at the expense of validity is rarely seen in other fields:

no one suggests faster alternatives in other sciences, such as neuroscience, deep space astronomy, and higher mathematics, where painstaking and time-intensive analysis is the norm. Some phenomena are simply not visible except at a micro-level (Bavelas et al., 2016, p. 142).

The potential payoff of the approach sketched out here could be substantial, in terms of empirically grounded coding schemes more apt to capture and identify *actions* in interaction,

instead of *practices* that have been shown to be malleable (Reuber et al., 2015; Schegloff, 1997a).

8.5.3 Implications for research on patient preferences for involvement

The CA approach used in the present study contributes with a different *type* of evidence than what is common in studies of patients' preferences for involvement in decision making.

Common methods in the field have included various forms of self-reports, such as interviews, focus groups, or questionnaires (see Chewing et al., 2012; Sinding et al., 2010; Thompson, 2007). What may have received less attention is how participants' actions, *in actual interactions*, provide a source for investigating participants' orientations to preferences for participation.²⁵ The emic CA approach may afford evidence of participants' subtle displays and negotiations about preferences, whilst unavoidably distributing deontic rights and responsibilities, as is evidenced in the present study.

8.6 Conclusions

This study has documented physicians' and patients' own orientations to patient involvement when making treatment decisions, in situ, in real hospital encounters. Three areas central to patient involvement in decision making have been explored in the three articles: (1) providing treatment options (2) bringing up patients' preferences towards treatment (3) seeking understanding and commitment/agreement to treatment recommendation. Taken together, these articles reflect a continuum of patient involvement from a lower level (article 3) to higher levels of involvement, examining details in interactions that has characteristics of shared decision making (articles 1-2).

In sum, the studies show that physicians and patients orient to a *constrained form of patient involvement in decisions making* concerning invasive procedures. The studies document particular ways in which the physicians set terms for patient involvement, while also describing patients' resources for influencing the decision making. Although physicians, to a certain extent, involve patients in treatment decision making, they simultaneously employ subtle strategies for directing patients towards decisions more in line with their own views (e.g., by drawing on their epistemic and deontic rights as medical experts); Physician

²⁵ Patient preference for involvement was one of twelve items in the widely used SDM tool Option¹² (Elwyn et al., 2003). In the simplified, revised version, Option⁵ (Elwyn et al., 2013), this item was removed, partly because it was not observed in encounters (Elwyn, 2013). This may point to one area where the fine-grained analytic tools of CA could inform SDM tools in order to also capture subtle actions of establishing role preference.

activities like bringing up options and patient preferences, as well as pursuing understanding and commitment can thus work towards other goals (i.e. patient agreement to the physician's favored option) than those of more profound patient involvement, which is promoted in current guidelines, policies, and legal rights. Furthermore, the study demonstrates that the achievement and terms of patient involvement is negotiated and established by the participants in each case. Finally, the participants' expectations for patient involvement in decision making, as displayed in their interactional conduct, may not correspond with current Norwegian guidelines of patient involvement in decision making.

This thesis is the first elaborate conversation analytic study of decision making in Norwegian medical interactions, and one of few CA studies investigating treatment decision making across a variety of secondary care settings. The findings of this study contribute to much needed empirical detail and specification of how patients are involved in actual treatment decision making and should be used as a basis for refining and developing recommendations for practice in the future.

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