

Whose decision? Negotiating epistemic and deontic rights in medical treatment decisions

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Abstract

Shared decision making has become an ideal in contemporary clinical practice, and guidelines recommend exploring patients' preferences and providing them with options so they can make informed decisions. This paper examines how the ideal of sharedness is maintained and negotiated through epistemic and deontic resources in secondary care consultations where patients are given a choice between invasive and non-invasive treatment options. The analysis suggests that the physician's presentation of treatment options is often tilted in favor of one proposal over the other, yet giving the patient the right to make the final decision. The patients on the other hand regularly resist this responsibility by claiming lack of epistemic authority (e.g. *I know nothing about it*) or by making the decision contingent on the physician taking a stronger deontic stance (e.g. *if you think so*). This may be characterized as an inverted use of deontic authority from both parties: Physicians give patients deontic rights in their pursuit of independent commitment to their preferred option, while patients orient to physicians' epistemic and deontic rights as a way of resisting to commit to the physicians' propositions. These conflicting orientations to epistemic and deontic authority counteract the ideal of shared decision making.

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1. Introduction

Patient autonomy has gained a prominent position in medical ethics. It is generally recognized and implemented in health policies and contemporary clinical guidelines through the principles of patient-centeredness that encourage patient involvement in care, especially through shared decision making (Barry & Edgman-Levitan, 2012; Kristvik, 2011; "Lov om pasient- og brukerrettigheter [Patients' Rights Act]," 1999; Mead & Bower, 2000). Evidence indicates beneficial outcomes of interventions on patient-centeredness and shared decision making, although central outcome measures such as health status and concordance are limited or provide mixed results (Crawford et al., 2002; Dwamena et al., 2012). More unambiguous are reports from observational studies, indicating that the doctor-centered approach is tenacious and that patients still have a limited degree of participation in decision making (Braddock III et al., 1999; Campion et al., 2002).

Studies also indicate that preferences for being informed and participate in decision making vary amongst patients (de Haes, 2006; Degner & Sloan, 1992; Swenson et al., 2004), and Elwyn (2012, p. 1363) notes that: "Some patients initially decline decisional responsibility role, and are wary about participating". de Haes (2006) takes a step further by pointing out that patient-centeredness, understood as "paying attention to psychosocial issues, to stimulate autonomy and empowerment, among

others by giving information and sharing decisions” might not be appropriate or effective for all patients. Rather, being patient-centered “in the original sense may imply the opposite” (2006, p. 296). de Haes suggests that this may be related to the potential burden of making choices as described in Schwartz (2004), i.e. through anticipated regret, where “one may worry about the outcome and feel responsible if such outcome turns out to be negative” (2006, p. 296). Thus, the assumption within patient-centered approaches that patients want to (and should) be involved and participate actively in decision making has been contested in various ways.

This brief overview indicate a complex and ambiguous picture that calls for closer investigation on an area that has received less attention: how *participants themselves* understand and orient to the task of making and sharing decisions in actual consultations (Seedhouse, 2005; Toerien et al., 2013). More specifically, we will explore how the ideal of sharedness is maintained in secondary care consultations where patients are given a choice between invasive and non-invasive treatment options. Drawing on conversation analytic (CA) principles and findings, we will focus on how participants deploy epistemic and deontic resources in negotiating these decisions.

Conversation analytic studies have nuanced the general picture of patients’ limited participation in decision making. Subtle practices patients deploy for participating in treatment negotiations and even influencing outcomes have been identified (e.g.

Teas Gill, 2005), and Stivers' (2006) influential studies have documented that treatment decisions are oriented to as the responsibility of both physician and patient (or parent), in that acceptance of physicians' treatment recommendations regularly are treated as relevant upon completion. Most of the CA literature has until recently focused on primary care interactions, and described medical decision making as a three-part structure, where physicians' treatment recommendations are treated as proposals that must be accepted before moving on to a next activity. When patient resistance is forthcoming, e.g. by withholding acceptance, negotiation regularly follows (Koenig, 2011; Stivers, 2005).

However, recently, in examining interactions from Polish secondary care, Weidner (2012) suggests that invasive treatment recommendations are presented more cautiously than non-invasive recommendations in that physicians' provision of accounts (i.e. a medical rationale) seem to be treated as appropriate before acceptability can be reached. Studying British neurology interactions, Toerien et al (2013) has called for studies with a broadened scope that also includes evidence of physicians' efforts to offer choice; thus examining practices more in line with current policies. In their recent study, Toerien et al (2013) compare 'recommending' and 'option-listing' and show that these two practices provide different response slots for patients. While recommendations make acceptance the relevant next action, option-listing provides a more open-ended slot for patients' announcements of their selection. The authors argue that this has implications for the distribution of medical

authority, where “option-listing is a practice whereby doctors relinquish at least a little of their authority” (p. 885).

This study will go further in that vein, in examining consultations from Norwegian secondary care where patients are given a possibility to choose between invasive and non-invasive treatment options. Invasive treatments are diagnostic and treatment-related procedures that involve entry into the body (i.e. biopsy, surgery, and anesthesia). Non-invasive treatments include all other treatments and minor tests, i.e. self-administrated drugs, blood tests, as well as the option of “watchful waiting” (Elwyn et al., 2000). As invasive treatments are always associated with some degree of medical uncertainty and risk, the decisions to be made may be seen as more serious and difficult, especially for patients (Grimen, 2009). This may affect the dynamics of the interactions in that the question of who is responsible for making the decisions is unclear: On the one hand, patients seem to resist making decisions based on their lack of knowledge, while on the other hand physicians resist making the final decisions with reference to the fact that the patient’s preference or experience of illness should be the basis of the decision. This may be seen as a two-way struggle of avoiding sole responsibility, in that both physicians and patients confer the right to decide and thereby also the responsibility for the decision to their interlocutor.

These negotiations seem to operate at the intersection of two questions: First, who should make the decision, which falls within the deontic domain, and second, what

knowledge should be the basis of the decision, which falls within the epistemic domain.

1.1. Epistemic and deontic rights

A person's epistemic domain comprises his or her knowledge and personal experiences (Heritage, 2012; Stivers & Rossano, 2010). Within medicine, patients' and physicians' epistemic domains are complementary, or even constitute a knowledge gap (Grimen, 2009): Patients have primary epistemic rights to knowledge about their experience of symptoms, preferences and life-world circumstances, while physicians have primary epistemic rights to knowledge about diagnoses, treatments etc. A person's rights to knowledge within a certain domain can be described as *epistemic status*, and in conversation, speakers rely on their relative statuses as interactional resources (Heritage, 2012).

Deontic rights on the other hand relate to someone's right to determine future actions (Stevanovic, 2013). While in traditional medicine this has been seen as the physicians' responsibility (i.e. the notion of "doctor's order"), based on their medical expertise and experience (epistemic status), contemporary guidelines for patient-centered approaches recommend a more even distribution of these rights, acknowledging also patients' deontic rights; For instance the Norwegian Patients' Rights Act (1999) states that patients have the right to participate in choosing between available and appropriate examination and treatment methods. Thus, the

epistemic status associated with medical knowledge has traditionally given physicians superior deontic rights, i.e. the right to decide what treatments to choose. Patients' epistemic and deontic rights on the other hand, have traditionally *not* been acknowledged, but as already mentioned, this is currently undergoing change due to the movement of patient-centered care which encourages patients to become equal partners in the decision-making based on their expertise on own health and a recognition of patient autonomy.

Deontic rights can be claimed with varying strength or degree of necessity, positioning them on a *deontic gradient* (Stevanovic, 2013). Expressions of possibility (e.g. *you **can** have a short anesthesia for that*) and desirability (e.g. *I **would like to** refer you to...*) set up shallower deontic gradients compared to stronger claims of necessity (e.g. *you **have to** quit smoking*), setting up a steeper gradient. Claims along this deontic gradient will be referred to as *deontic stance*. Physicians' provision of options can thus be seen as setting up a shallower deontic gradient compared to recommendations, suggesting a more equal distribution of rights (Toerien et al., 2013). Nevertheless, differences in deontic stance may constrain the patient's deontic rights to varying degrees. While examples as the first one ("you can have") allocate substantial deontic rights to the patient, implying a shallow deontic gradient, the latter ("you have to") marks the decision as non-negotiable, hence suggesting a steeper deontic gradient. This implies that the response of the interlocutor is crucial in accepting or resisting the claim to authority. As Stevanovic (2013, p. 20) points out,

“authority is not primarily about someone *claiming* authority, but it is about others *accepting* someone as an authority” (orig. emphasis).

2. Data and method

Videotaped non-psychiatric consultations in a Norwegian teaching hospital form the data for this study (see Fossli Jensen et al., 2011). The physicians who participated were randomized, so inclusion was not based on physicians’ interests or own choice.¹ For the objectives of this study a subset of approximately 100 consultations were reviewed. Out of these, we identified 11 consultations where more than one treatment alternative was explicitly brought up as a possible option, and where at least one of the options were invasive in character (i.e. surgery). The consultations are drawn from gynecology, urology, gastroenterology, internal infection medicine, orthopedics and anesthesia. Examples from four of these consultations will be presented in this paper. They represent variation in regard to the medical problem at hand and involve four different physicians. Ongoing studies of the larger data corpus (320 consultations) indicate that only a minority of the consultations involve characteristics of shared decision making such as provision of option (Ofstad, pers. comm.), so the selected consultations are examples from the more patient-centered consultations in the corpus.

¹ Out of 103 physicians asked to participate, 72 were included (see Fossli Jensen et al., 2011).

CA was used for analyzing the data (Heritage, 1984; Schegloff, 2007; Sidnell & Stivers, 2013) (for reviews of medical interactions, see Gill and Roberts (2013); Heritage and Maynard (2006)), and the selected consultations were transcribed according to Jefferson's (2004) transcription system. We analyze sequences where physicians introduce a choice about treatment plans, thus making a decision from the patient conditionally relevant (e.g. to make a choice, express preferred option or commitment). In these sequences treatment decisions are presented as 'to be made', implying co-decision (Collins et al., 2005), or in deontic terms; set up deontic gradients that give the patient a certain degree of authority in making the decision. Analysis includes first mentions of alternative options (1), as well as subsequent initiatives to reach a decision (2-6), since no cases in our data are resolved in the same sequence as the treatment options are first presented (see Weidner, 2012 on negotiation of invasive treatment recommendations).

In presentation of options or invitations to decide, we have considered the physicians' claims of distribution of deontic rights and responsibilities, and what kind of deontic gradients it sets up. Of equal importance was the inquiry of whether patients' responses displayed acceptance of the deontic claims put forward in the physicians' invitations to decide: While (dis)alignment indicates whether the response cooperate with and support the action (or course of action) projected in the first pair part (e.g. provides acceptance/rejection to a proposal), (dis)affiliation indicates whether the recipient endorse the *affective stance* displayed by the speaker (e.g. signals

agreement towards the physician's favored option) (Stivers, 2008; Stivers et al., 2011). Finally, accounts were of particular interest as they display what reasons speakers provide for (responsive) actions that may depart from expected, affiliative actions (Heritage, 1984). That was also central in the analysis of subsequent turn(s) following patients' responses, as these negotiations may shed light on how the participants worked to resolve multiple questions involved in negotiating decisions; whose decision; on what grounds, and finally; what decision.

3. Analysis

This section serves to illustrate variation within deontic gradients, starting with an example (1) where options are introduced for the first time and the deontic gradient is shallow, that is, presented with the most equipoise. Equipoise refers to situations where two or more treatment options have different but equally acceptable outcomes (de Haes, 2006). Example (2-5) illustrate subsequent initiatives where physicians express less equipoise, thus setting up steeper deontic gradients. Example (6) constitutes a contrast in that the patient takes a markedly different deontic stance compared to the other cases.

3.1. *Introducing options*

Example (1) and (2) are drawn from a urology encounter where the aim is to make anesthetic arrangements before a surgical intervention. The extracts illustrate how

the physician and patient confer to the other the deontic right to decide as a way to promote their own action-plans.

In (1) the physician introduces for the first time two anesthetic options: spinal anesthesia or general anesthesia. The alternatives are presented as nearly, but not completely, equal in terms of what option the physician presents as favorable. Prior to where this extract begins the patient has expressed fear of the surgical procedure, and line 1 can be heard as addressing this concern, while simultaneously introducing talk about specific types of anesthesia:

(1) ANESTHESIA (0:03:52.8)

1 D: men du ska:l jo få en form av narkose til det?
but you a:re *jo² gonna get some form of anesthesia for that?

((9 lines omitted))

11 D: så vi: kan gjøre det enten i spinalbedøvelse?
so we: can do it either in spinal anesthesia?

12 (.)

13 P: m,

14 (.)

15 D: >det er noe vi f:oretrekker egentlig?<
>that is something we pr:efer actually?<

16 P: m[m,]

17 D: [og] så kan du få en kort narkose til det.
[and] then you can have a short general anesthesia for that.

18 P: mt[ja.] je:g vil jo helst det nest- v- ja
mt[yes.] I: would *jo rather the nex- w- yes

19 D: [.h]

20 P: (så men) jeg ka:n ingen[ting om det?=?]

² The Norwegian common ground marker “jo” (Fretheim, 1991) is not translated in the transcripts, but marked with an asterisk (*).

(so but) I don't kno:w any[thing about it?=
((arms out))

The two options are introduced in lines 11-17. The projection of two alternatives is signaled early in the turn ("either") in line 11, and the patient does not treat it as completed before the second alternative is presented in line 17. Although more than one option is projected from the outset, and the same modal verb "can" is used in both, they are not presented as equally favored. Most obvious is the parenthetical assessment of spinal anesthesia as "something we prefer" (line 15), following a delayed acknowledgement token from the patient that may signal resistance towards this option (lines 12-14). More subtle is the shift from "we" in line 11 and 15, to "you" in line 17, implying a shift in *whose* decision it is; while the medical "we" would choose spinal anesthesia, "you" have the possibility of choosing something else, hence conveying a subtle shift in responsibility, where the responsibility lies with the patient in choosing the latter option. This is also explicated in the increment in line 15 that portrays spinal anesthesia as the routine option, indirectly drawing on the deontic authority of the medical community.³

The patient's response (lines 18, 20) first treats the presentation of options as eliciting a display of preference: "mt yes. I would rather the nex-", probably heard as referring to the second alternative, where "next" is an unidiomatic reference to "the latter". This interpretation is strengthened by the fact that he starts his response by a positive response token, which is interpretable as a confirmation of the latter

³ Later in the consultation the physician explicitly states that spinal anesthesia is the routine option for this kind of procedure.

alternative, given the preference for contiguity in conversation (Sacks, 1973). Also the before mentioned delayed acknowledgement of the first option (lines 12-14) and the non-straightforward, hesitant response (lines 18-20) indicate disagreement towards the physician's favored option. However, the patient cuts off just before completion ("nex-"), suggesting that he treated the abandoned turn in line 18 as somewhat inappropriate (Drew et al., 2013). The patient instead provides a disclaimer of knowledge: "(so but) I don't know anything about it" (line 20). The self-interruption (line 18) and disclaimer (line 20) works to withdraw, or at least reduce, the deontic stance implied by the abandoned statement, namely that the patient decided to have general anesthesia in opposition to the physician's opinion. That would have been a disaffiliative action claiming strong deontic rights. Note also that the patient's altered response draws on their asymmetrical epistemic status: in claiming lack of knowledge he indirectly confers to the medical expert to be the knowledgeable, hence the proper decision-maker. Nevertheless, the patient also manages to convey his favored, but opposing option, but the abandoned turn together with the disclaimer works to avoid making it hearable as decision-implicative.

3.2. Subsequent invitations to decide

The following example (2) is from the same encounter and exhibits where the physician several minutes later again moves towards reaching a decision since the patient has not yet committed to any of the options. In the meantime the physician has performed a physical examination that confirmed spinal anesthesia to be

possible and pointed to advantages of that option. In this subsequent invitation to decide, the deontic gradient has become steeper in that the physician only mentions one of the options by explicitly asking for permission to try spinal anesthesia first (lines 1-2):

(2) ANESTHESIA (0:12:28.0)

1 D: .hh e#(je-) (0.4) er det greit for de:g at de prøver
.hh e#(I-) (0.4) is it okay for yo:u that they try

2 deg e:n [gang eller to?]
you o:[nce or twice?]

3 P: [ja:da:, jeg-] hvis du mener det?
[oka:y, I-] if you think so?
(big head shake)

4 så skal jeg selv[(følgelig ikke gjøre det)]
then I will of [(course not make it)]

5 D: [så je:g-]
[so I:-]

6 P: vanske[li(h)g(h),]
diffi[cu(h)lt(h),]

7 D: [ja.] jeg (.) kan bare anbefale de:t, det [er] be:dre
[yeah.] I (.) can only recommend i:t, it [is] be:tter

8 P: [m,]

9 D: når du: puster selv [og] ikke får en dyp
when you: breath by yourself [and] don't get a deep

10 P: [°okey.°]

11 narkose.
anesthesia.

12 P: [ja,]
[yeah,]

13 D: [.hh] men sier du nei jeg vil ikke ha det i det he:le tatt?
[.hh] but if you say no I don't want it at a:ll?
((animated facial expression and hand gestures))

14 .h[h] du <må: ikke ha spin[al.]>
.h[h] you <don't ha:ve to have spin[al.]>

15 P: [mm,] [nei] det jeg er mest

[no] what I am most
16 redd for er at
afraid of is that ((turn continues))

The physician's request for permission (lines 1-2) refers to the option of trying spinal anesthesia as a first option, and if that doesn't work satisfactory, they will turn to general anesthesia. The request seems to balance two contrasting deontic stances. The formulation "is it okay for you", with a prolonged "yo:u", represents a request for permission, thus acknowledging the patient's deontic right to accept or reject this option. However, the polar interrogative presenting only one of the options, displays a preference for a confirming response (Raymond, 2003), thus adding pressure to affiliate with the physician's deontic stance. And even more importantly, it does not refer to the contingency that the patient had previously expressed a personal preference for the other option.

The patient responds ambiguously. The Norwegian response particle “jada” (composed of the response word “ja” (yes) and the reinforcing particle “da”) conveys granting of a request, but can be heard as implying some reluctance. The disaffiliative stance is further expressed by the patient’s simultaneous head shake and subsequent account: “if you think so? then I will of (course not make it) difficu(h)lt(h)?” (lines 3-6). This account reduces his own deontic rights by inviting the physician’s medical opinion and concerns for practical efficiency to be the proper grounds for the decision. Also the interspersed laughter in the word “difficult” indicates an orientation to the potential delicacy of rejecting the suggestion

(Haakana, 2001). So the patient gives the final deontic responsibility for the decision back to the physician, displaying willingness to collaborate and act as a “good patient”.

In response, the physician first confirms spinal anesthesia as her favored option with a “yes” produced with final intonation (line 7). However, she immediately backs down from her confirmation by reducing the deontic force of her previous actions to a ‘mere recommendation’, thus portraying herself as recommender and not decision-maker (line 7). This works to pursue a more independent expression of commitment from the patient. At the same time the ‘recommendation’ gains authority from her epistemic status as a medical expert, and is further reinforced by the addition of an argument that orients to a risk factor of general anesthesia (lines 7-11). Notably, the patient only responds minimally (lines 8, 10, 12), withholding any signs of commitment (Stevanovic, 2012). The physician orients to this potential resistance by further backing down in that she explicitly confers to him the right to decline, hence insisting on the patient’s deontic right despite the adverse medical recommendation (lines 13-14). Once again, the patient refrains from making a decision (lines 15-16), and instead restates his fear of going through a painful procedure and being awake to observe what is going on “down there” (data not shown) (Koenig, 2011).

In (1) and (2) the physician claims a rather strong deontic authority, with a steeper deontic gradient in (2). This is evidenced by the fact that only one of the options is

explicitly mentioned, and that the patient's deontic right is transformed from expressing a personal preference to giving permission to follow the physician's recommendation. Nevertheless, in the face of potential resistance, the physician backs down and claims a shallower deontic gradient by holding the patient responsible for making the final decision. The patient similarly responds to the physician's potential resistance to his preferred option by backing down and renouncing his deontic rights. In that way he manages to push the responsibility for the decision back to the physician and avoids committing to an option he is unsure about. Thus, in dealing with opposing treatment preference they both confer the decision to the other, renouncing their own rights to decide and insisting on the other's deontic (and in the physician's case also epistemic) authority. So both parties can be seen to use an inverted form of deontic authority as a means for pursuing their favored outcome, whilst simultaneously avoiding taking full responsibility (Heritage, pers. comm.).

Example (3) illustrates a similar case, but here it is the physician who advocates the most invasive option. This is from gynecology, and the elderly patient, who has been suffering from incontinence, has expressed to have only minor symptoms with a less invasive treatment; a vaginal coil she has had for six months. The physician has nevertheless introduced a more invasive treatment option (surgery) as a favorable

option (data not shown).⁴ So the following case is not the first attempt at proposing a decision, but a subsequent pursuit of acceptance (Davidson, 1984). Here the physician reissues decision-talk with two formulations of the patient's stance towards treatment, (lines 2-4, 8,10) (Dalby et al., 2013), projecting agreement and thus a decision.

(3) GYNECOLOGY (incontinence) (0:04:11.3)

- 1 P: [jeg mer]ker jo'ke no til at jeg har ↑det,
[I can't fe]el *jo that I have ↑it,
- 2 D: nei. (.) det er så bra da.=så du foreløpig så vil du
no. (.) that is so good then.=so you so far you want to
- 3 (0.4) liksom gå me:d ringen? framfor å bli utsatt
(0.4) kind of u:se the coil? instead of being exposed
- 4 til en operasjon e- hvis du er så fornøyd med det,
to surgery e- if you are so satisfied with that,
- 5 P: .h ja:, jeg veit jo 'ke, jeg veit jo' ke?
.h ye:ah, I don't *jo know, I don't *jo know?
((head shakes, gaze towards nurse (N), hand on throat))
- 6 D: .hh [nei. .hh]
.hh [no. .hh]
- 7 N: [kan jo tenke] (°på det.°)
[can *jo think] (°about it.°)
- 8 D: e[:: ja i:] jamen det e'ke sånn at du er helt
e[:: yeah i:] yeah but it's not like you're completely
- 9 P: [ja, det er jo:]
[yeah, it is *jo]
- 10 D: ne:gativ mot en operasjon heller? hvi[s: e:]
ne:gative towards surgery either? i[:f e:]
- 11 P: [ja hvis] jeg ↑må:,
[yeah if] I h↑a:ve to,
- 12 D: hvis du må:.=
if you ha:ve to.=
- 13 P: =hvist jeg må:.
=if I ha:ve to.

⁴ There are no clear medical reasons in favor of surgery in this case, but the relevant physician may anticipate that the elderly patient's tolerance towards surgery with anesthesia might decrease over time, reducing the scope of surgery at a later point.

In line 2 the physician's positive evaluation acknowledges the patient's report in line 1 of not being bothered by the coil. Latched with this follows a formulation that transforms the patient's "satisfied as it is"-stance to an active treatment wish to keep the coil in lines 2-4 (Dalby et al., 2013). The reference to what the patient 'wants' frames her as responsible for the decision, and grounds it on her subjective experience ("if you are so satisfied with that"). So similar to the physician's less favored option in (1) of general anesthesia, the physician in this turn reduces his deontic responsibility by placing both the deontic responsibility and the epistemic grounds within the patient's domain.

The formulation strongly projects agreement (Antaki, 2008), but the patient's curled "ja" (yes), projecting non-alignment (Lindström, 2009), is modified immediately with a repeated claim of insufficient knowledge (line 5). As in (1), this patient also hesitates to choose the option that she seems to favor, by accounting for her lack of knowledge (Keevallik, 2011). Furthermore, the claim is modified by the Norwegian particle "jo", which is a common ground marker (Fretheim, 1991). The particle may contribute to turning this into a "*your* fault" account, "accusing the questioner of asking an epistemically ill-fitted question" (Heinemann et al., 2011, p. 123), implying that the physician should know that this is a question she is unable to answer.

Instead of e.g. treating the patient's response as a request for more information, the physician treats it as a potential disconfirmation in that he reverses the formulation to

not being “completely negative towards surgery either” (lines 8-10). By continuing to draw inferences about the patient’s treatment preferences, the physician ignores her claim of not having sufficient epistemic grounds for making the decision. While the physician is initiating a turn increment in the form of a conditional clause (line 10), the patient produces an overlapping response, also in the form of a conditional clause, thus seeming like a collaborative completion: “[yeah if] I have to” (line 11). However, the response is disaffiliative with respect to the stance expressed by the physician in that it is presented as only a partial agreement, with acceptance being presented as contingent on necessity (“if I have to”). Determining whether this option is necessary is indirectly portrayed as belonging to the physician, based on his medical judgment. Thus, by using a similar contingent acceptance as in (2), the patient confers the deontic responsibility back to the physician. In response, the physician seeks confirmation with a repeat (line 12), giving the patient an opportunity to modify her conditional acceptance. However, the patient confirms with a repeat, produced with falling intonation and additional stress on “must”, upgrading the assertiveness of the claim (line 13). So the patient implicitly maintains her previously expressed deontic stance that it is not mainly up to her personal preference to decide, but that the decision should be informed by medical efficacy and necessity, thus implying that it is the physician’s responsibility.

The cases so far have involved expressions of conflicting treatment preferences. The preference for agreement might be a plausible explanation of patients’ reluctance

towards making decisions in opposition to physicians' deontic stances (Pomerantz, 1984). However, that doesn't fully explain the next example, where the patient refrains from making a decision although both parties have moved towards the option of surgery as the most appropriate, compared to the other option of "watchful waiting" (data not shown).

The male patient in (4) and (5) has been suffering from heavy stomach pain caused by his gall bladder for over a year, but the last few months he reports to have had no attacks. Early on in the consultation the physician has proposed to either wait and see or do surgery, and the subsequent talk moves towards an agreement on scheduling the patient for surgery a few months ahead, so that the patient can allow some time to pass to see whether it might stabilize without intervention (data not shown). And in the beginning of this extract (lines 1-3) the physician sums up this previous talk, introducing it by the inference marker "så" (so):

(4) GASTRO (gall bladder) (0:04:37.3)

- 1 D: (så) hvis vi skal begynne å summe:re hele sykehistorien?
(so) if we should start to su:m up your complete history?
- 2 (.)
- 3 D: så e:r vel du kandidat for å få
then I suppose you a:re a candidate to have
- 4 fjernet (den galleblæren).
(that gall bladder) removed.
- 5 (0.3)
- 6 D: °>er du'ke det?<°
°>aren't you?<°
- 7 (0.5)
- 8 P: .hhh ↑jo, detta kan dere

.hhh ↑yeah, this you know
 ((hands out to the sides, palms up))

9 m[:ye bedre enn meg, hehehehe ikk(h)esant?]
 m[u:ch more about than me, hehehehe rig(h)t?]

10 D: [jo, jo, men asså (0.4) det ha-]
 [yeah yeah but well (0.4) it ha-]

11 det har med liksom [kvalit]:eten? .h asså
 it has to do with kind of [the qua:li]ty .h

12 P: [j(HH)a:?]
 [y(HH)ea:h?]

13 D: livskvaliteten når du har anfallene?
 the quality of life when you have the attacks?

14 P: ja,
 yeah,

15 D: er (du-) sån- sånn på en måte s:- s:lår deg helt ut?
 are (you-) tha- that sort of t- takes you down completely?

16 (0.5)

17 D: eller er det sånn som du kan gå på jobb me:d og fungere n-
 or is it like that you can go to work wi:th and function n-

18 normalt bare du har en eske med smertestillende
 normally if you only have a box of pain killers

19 ikke sant.=det er jo det [de]t går på.=
 right. =that's *jo what [it's] about.=

20 P: [e-]

21 P: =#ja, jeg tar faktisk ikke smertes[till]ende når jeg
 =#yeah, I actually don't take pain k[ille]rs even when I

22 D: [nei,]
 [no,]

23 P: får dem engang?
 get them?

24 D: nei,
 no,

25 P: e: jeg har et helvete? men går for meg sjæl for å si det så(h)nn?
 e: I go through hell? but go by myself so to say(h)?

26 D: (°nt.h°)((micro nod))

27 (0.4)

28 P: æ:: [og går] på rommet og der blir jeg fra:
 e:: [and I go] to my room and stay there fro:m

29 D: [.hhhh] ((turns towards PC keyboard))

30 P: [tjue minutter til ei time asså.]
[twenty minutes to an hour.]

The physician's proposal (lines 1-3) is formulated as a conclusion following naturally from the previous talk, thus constituting an upgraded claim of deontic rights. The assertiveness of the claim is mitigated by the Norwegian hedge "vel", glossed as "I suppose". The particle is an "alter-oriented" epistemic modifier (Fretheim, 1981), indicating that the truth of the claim is contingent upon acceptance by the interlocutor. So the proposal does not only invite the patient to agree, but also to share epistemic responsibility for the claim. Receiving no uptake, the physician pursues agreement by adding a tag question as a turn increment (line 6).

A confirmation is then provided, but in a dispreferred format. The response token is considerably delayed, both by a 0.5 second silence and a lengthy in-breath (lines 7-8). It is also mitigated by a hand gesture conventionally signaling lack of knowledge (line 8) and a subsequent claim of not being sufficiently knowledgeable (lines 8-9). While a straightforward confirmation could have made the way short to a definitive decision, the patient's extended response resists the deontic responsibility, based on a lack of epistemic authority. In this way he simultaneously treats the physician as the one who knows, thus the one with deontic authority to decide.

In overlap, the physician rejects this claim about his deontic authority using a "yes, but-format". And the subsequent account redefines the grounds for the decision as belonging within a different epistemic domain from the medical, namely within the

patient's subjective experience; his "quality of life" (lines 10-13). After minimal uptake, the physician specifies this point by providing two candidate descriptions for the patient to choose between (lines 15-19). The first indicates an extreme and severe state, and thus seems to imply a need for surgery, whereas the latter describes less serious attacks without major effects on everyday function, implying that surgery may not be needed.

The patient's response first displays "troubles resistance" by not taking pain killers under any circumstances (lines 21-25) (Jefferson, 1988), before he provides a description that is hearable as a personalized version of the former candidate description, using "extreme case formulations" such as "hell" and describing periods of isolation as his way of dealing with the attacks (lines 25-30) (Pomerantz, 1986). The response thus aligns with the physician's implicit request for information about his personal experience, but does not display deontic rights to proceed to a decision-implicative conclusion. The physician then prepares to speak with an in breath and turns firmly towards his computer (line 29), possibly indicating that a conclusion has been reached. The rest of this sequence is analyzed in (5) below.

What has characterized the examples so far (1-4) is that the physicians ask the patients to make a treatment decision, but that the patients persistently resist, claiming insufficient knowledge relative to the physician. The physicians claim some epistemic and deontic rights by conveying their stance towards the options as more

or less recommendable, but insist on the patients' right to decide. The result is a process of negotiation where both parties disclaim their own deontic authority and instead confer it to the interlocutor. The participants' deontic stance is here explicitly grounded in two competing epistemic domains in that the parties invoke different types of knowledge and experience as relevant for making the decision: Somewhat paradoxically, the patients claim that it is the physician's assessment of medical necessity that grounds deontic authority, whereas the physicians claim that it is the patient's subjective experience or preference. Furthermore, the physicians seem to exert an additional type of authority, in that they are the ones who determine when it is the patient's knowledge that counts.

3.3. *Reaching a decision*

Example (5) illustrates how the participants in the previous example (4) manage to reach a decision. After the physician has clearly recognized that he is committed to the option, the patient accepts the proposal. The extract follows immediately after (4):

(5) GASTRO (gall bladder) (0:05:11.9)

- 30 P: [tjue minutter til ei time asså.]
[twenty minutes to an hour.]
- 31 D: [ja. asså j- je-] jeg vil ikke legge noe føringer.=
[yes. well I- I-] I won't tell you what to do.=
- 32 D: =det eneste jeg ve:t? det er at (.)
=the only thing I kno:w? is that (.)
- 33 med den sykehistorien som du presenterer? så
with that illness history that you present? then
- 34 e:r det (1.0) veldig veldig sikkert? at du kommer til å få:
it i:s (1.0) very very likely? that you will ha:ve
- 35 (0.3) større eller mindre (.) e#: anfall.

[illegible]

The physician's multi-unit turn in lines 31-37 follows immediately after the patient's symptom description in (4). It starts by a turn preface in the form of a disclaimer, denying any intention by the physician of exerting deontic pressure (line 31). As a projective disclaimer, the preface both prepares the interlocutor for what is to come, namely something that might be considered inappropriate, and simultaneously instructs him not to take it that way (Hewitt & Stokes, 1975). In the rest of the turn, the physician provides evidence of negative prospects, taking a strong epistemic stance ("the only thing I know" and "it is very very likely") and drawing on medical authority ("with that illness history"). So the physician claims strong epistemic rights, defining the grounds for the decision, whilst insisting on the patient's deontic right to make the final decision. That surgery is indeed the logical consequence of the

preceding talk is also evident in the subsequent proposal, initiated with the concluding particle “så” (so): “so if you give me a green light then I can set you up” (lines 39-40). This formulation conveys that the physician is committed to the proposal; he only needs a green light from the patient. And the patient, in overlap with an inaudible alternative option projected by the incrementally added adverb “otherwise” (line 41), affiliates with the proposal: “yeah (give) then I give you I’ll give you a green light” (line 42). The recycled wording and extended turn format makes it hearable as a commitment to a future course of action (Lindström, 1999).

In (5) the physician seems to exploit his epistemic authority to railroad the patient into a decision for surgery. Thus this sequence may be more in line with the traditional proposal-acceptance format as described in e.g. Stivers (2006), in that the patient is only required to accept the proposal instead of making a more independent commitment. Nevertheless, the physician maintains the patient’s ultimate deontic right, and he builds his proposal on epistemic insights from the patient’s life-world experience and medical experience, actions associated with patient-centered approaches. Furthermore, somewhat paradoxically, the responsibility for the (outcomes of the) decision may thus be more evenly distributed here compared to e.g. the option-listing in example (1), where the responsibility for choosing general anesthesia seemed to be placed mainly with the patient. This may point to some underestimated outcomes of what constitutes a patient-centered approach.

On some occasions, patients claim stronger deontic rights, and in disagreement with the physician. The following, and last case is a striking example of that.

3.4. *Patient claiming deontic rights*

Early in this gynecological consultation the patient has confirmed, on the physician's request, that she wishes to remove her uterus due to serious bleeding disturbances. The physician subsequently discourages this repeatedly, and recommends a less invasive procedure as a possible first step (data not shown). The following extract is therefore a short glimpse of a long negotiation, but may illustrate some core characteristics. In lines 1-4 the physician highlights risks of doing surgery, before he urges her to have removal of uterus as a "last resort" in line 7:

(6) GYN (uterus) (0:10:12.4)

- 1 D: mm, e:: det er en del e ting som er forbundet med
mm, e:: there are some things that are related to
- 2 operasjon? komplikasjoner med blødning,
surgery? complications with bleeding,
- 3 P: m,
- 4 D: infeksjon ikke sant?
infection right?
- 5 P: mm,
- 6 (0.5)
- 7 D: .hh h:a det som si:ste utvei.
.hh h:a:ve that as a la:st resort.
- 8 (2.0)
- 9 P: .hhhhhhh[hh ((cross arms animatedly))]
- 10 D: [stol på meg.]=
[trust me.] =
- 11 P: =jeg er ve:ldig
=I'm ve:ry

12 best(H) [e(hh)m jeg O:rker ikke me:r? eH:e.]
 dete(H) [rmi(hh)ned I can't Ha:ndle it any mo:re? eH:e.]

13 [HeHeHe.hehehehehe] h .h je:ss,
 [HeHeHe.hehehehehe] h .h oka:y,

As the list of risk factors (lines 1-4) doesn't trigger any uptake that could signal agreement (lines 5-6), the physician's directive (line 7) pursues it explicitly. The imperative form and marked stress on "h:ave" claims strong deontic stance that heavily projects agreement, while simultaneously orienting to the patient as the ultimate decision-maker, thus with the deontic right to decide.

The patient's response is prepared with strong markers of dispreference: There is a remarkably long gap of two seconds followed by a long, audible nasal in breath that, together with an animated crossing of her arms (lines 8-9), marks what to come as a highly disaffiliative action. This is oriented to by the physician, who starts bolstering his proposal by an appeal to trust in him (line 10) even before she has started talking. Although the preparatory work builds up to a confrontation, the rejection itself is not articulated explicitly, possibly due to the fact that her opposing stance has already been stated previously. Instead follows a twofold account that does not respond to the physician's arguments in any way: "I'm very dete(H)rmi(hh)ned I can't handle it any more?" (lines 11-12). The first part accounts for her strong deontic stance, implying that she will not change her mind. The laughter particles in the key word "determined" also displays awareness of her inappropriate patient behavior in not accepting the physician's recommendation (Haakana, 2001). The second part constitutes an account for her rejection, produced with an emphatic voice on the verb

“O:rker” (handle). The adverb “anymore” shows “troubles resistance” by indicating that this is something she has endured for a long time (actually over 30 years, according to her problem presentation, data not shown), and implies grounds reaching beyond a personal wish. The patient’s response thus in several ways displays a struggle for deontic authority, while attending to its inappropriateness. So in this extract the patient does extra interactional work to uphold her right to decide, in opposition to the physician’s clearly formulated recommendation. In order to counter the physician’s strong deontic stance, the patient has to herself take a strong and unambiguous deontic stance.

4. Discussion

4.1. *Summary of findings*

The present study has examined sequences where patients were offered a choice between invasive and non-invasive treatment proposals, focusing on how the ideal of sharedness was maintained and negotiated through epistemic and deontic resources. We have demonstrated how participants negotiate the distribution of epistemic and deontic rights and responsibilities, and that this was relevant in the process of reaching a treatment decision. The participants negotiated these rights and responsibilities both in regard to the question of whose decision or deontic right it was to decide, as well as on what epistemic grounds the decision should be made.

Resolving these interrelated questions involved negotiation on multiple epistemic and deontic levels: Physicians consistently conveyed their deontic stance towards the options, indicating whether a particular option was treated as a possibility on a shallower gradient, or more of a necessity on a steeper gradient. There are no cases in our data where options are presented as completely equipoised. At the same time, physicians conferred deontic rights and responsibility to patients through invitations to decide. These contradicting deontic gradients may obscure the question of whose decision it is, and support Toerien et al.'s (2011) findings that the physician's option-lists could function more as a recommendation for a particular solution, and did not necessarily imply a fully open choice.

Moreover, the question of what grounds the decision should be made on circled around two epistemic domains: 1) the biomedical domain of expertise and experience belonging to the physicians and 2) the subjective domain of preference and experience of illness, lying within the patient's primary domain. Claims within these domains seemed to be invoked or explicated especially in responsive positions, i.e. in patients' non-aligning responses and/or physicians' subsequent turns. This question seemed to be consequential for who was assigned as decision-maker: If the grounds were agreed to belong within the biomedical domain, the responsibility for the decision would fall on the physician, while the decisional responsibility would fall on the patient if the patient's subjective experience was given priority. This negotiation can be characterized as a struggle between 'epistemics of expertise' and 'epistemics

of experience' (Heritage, 2013, p. 392), here used mainly as a resource for decreasing the speakers' own deontic responsibility in favor of their interlocutor, by reference to the other's primary epistemic domain. However, important epistemic asymmetries seemed to be maintained through the physicians' indication of degree of necessity (deontic stance) in the proposed options, and in that the physicians seemed to be the ones who determined whether the patient's experience was relevant or not.

Furthermore, patients recurrently drew upon epistemic and deontic resources in their disaligning responses to physicians' claims of deontic rights and responsibilities.

Patients resisted deontic rights to decide based on inferior epistemic or deontic authority. In the former case, patients oriented to a lack of own knowledge or to physicians' superior knowledge (e.g. "I don't know", "this you know much more about than me"). Stevanovic (2012) found that recipients of proposals treated *access* to the subject matter as a precondition for joint decisions, thus not-knowing may function as a way to avoid responsibility. Patients seemed to use such accounts when they were invited to choose in accordance with their own expressed option, as in (1), (3, line 5) and (4). When patients on the other hand were confronted with options that went against their own expressed preference, but were the physicians' recommended option, patients regularly provided acceptance that was contingent on the physician taking a stronger deontic stance (e.g. "if I have to"), thus conferring the deontic responsibility back to the physician, as in (2) and (3, line 11). This might be

characterized as an inverted use of deontic authority from both parties: Physicians gave patients deontic rights in their pursuit of independent commitment to their preferred option, possibly relying on their epistemic status as medical experts, while patients oriented to physicians' epistemic and deontic rights as a way of resisting to commit to the physicians' propositions (Heritage, pers. comm.). Thus, displays of subordination (Griswold, 2007) may also be a way to promote one's own action-plans while maintaining the ideal of sharedness, that requires commitment from both parties for reaching a decision (Stevanovic, 2012).

4.2. *Implications for conversation analytic research*

We will briefly point to two contributions of this study to conversation analytic research. The first is a theoretical contribution, where we have started to explore the complex interplay between epistemic and deontic resources and gradients in an institutional setting of decision making. Further studies are needed to understand more fully the complexities and relations between these concepts in medical, as well as other (institutional) settings where decisions are made.

Additionally, the study contributes to a growing body of CA research on medical decision making in secondary care interactions. The study supports and expands on previous findings that indicate that the sequential pattern found in primary care settings is challenged, suggesting that the classical proposal-acceptance structure needs adjustments to also capture shallower deontic gradients that provide wider

response options for the patient (Toerien et al., 2013). The more invasive and high-stake character of many secondary care treatment proposals seem to affect the deontic gradient: Patients' may be given more deontic rights (and thus responsibility) as decision-makers, suggesting a shallower deontic gradient in line with the ideals of shared decision making, whilst especially patients seem oriented to objective medical facts (epistemic authority) as a prerequisite for undergoing invasive treatments. So, characteristics in secondary care seem to adjust the dynamics of medical decision-making towards a shallower deontic gradient on the one hand (patient as final decision maker), while physicians' epistemic and deontic authority still pervades the process.

4.3. Implications for research on patient-centeredness and shared decision making

This study contributes with empirical, interactional evidence on how epistemic and deontic rights and responsibilities are negotiated in the *interactional process* of doing shared decision making (Pilnick, 2008). A detailed analysis has pointed to the fine lines between empowerment and abandonment (Kristvik, 2011), where the ideal within patient-centered approaches of empowering patients through offering choice in reality may be closer to abandonment when physicians simultaneously renounce responsibility for options they may not prefer. This resonates with Toerien et al (2011, p. 319) that suggest that the concept of choice "is not as simple as the literature may suggest, and that the simple course of telling clinicians to "offer patients more choice"

may not achieve its objective”. The unpredictable and potential long-lasting (negative and positive) consequences of invasive procedures as well as uncertain and contested medical knowledge (Grimen, 2009) may affect both parties’ reluctance to make these decisions. Hence, this study offers insights to educators and researchers about specific dynamics that enhance or hamper the interactional realization of intended clinical practice, and indicating willingness to share epistemic and deontic responsibility for proposed options seems to be a crucial point for patients’ willingness to participate.

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Appendix: Transcript symbols

(1.5)	Time gap in tenths of a second
(.)	Pause in the talk of less than two-tenths of a second (micro pause)
[]	Marks the point of onset and end of overlapping talk
=	'Latching' between utterances, either by different speakers or between units produced by the same speaker
?	Rising intonation, not necessarily a question
.	Falling or final intonation, not necessarily the end of a sentence
,	'Continuing' intonation, not necessarily a clause boundary
::	Stretching of the sound just preceding them. The more colons, the longer the stretching
↑ ↓	Marked shift into higher or lower pitch
<u>word</u>	Stress or emphasis of underlined item, the more underlining, the greater emphasis

WORD	Markedly louder volume than surrounding talk
◦ ◦	Talk between the degree signs is markedly softer or quieter than surrounding talk
<word>	Slower speech rate than surrounding talk
>word<	Faster speech rate than surrounding talk
-	Cut-off or self-interruption of the prior word or sound, often done with a glottal or dental stop
.hh	In-breath. The more h's the longer the in-breath
hh	Out-breath. The more h's the longer the out-breath
(h)	Aspiration within speech, usually laughter
#	Creaky voice
(())	Transcriber's comments on proceeding talk, e.g. description of non-verbal activities
(word)	Transcriber's best guess of an unclear fragment
()	Inaudible talk

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