Negotiating treatment preferences: Physicians’ formulations of patients’ stance

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Abstract

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

Our analysis demonstrates that formulating the patient’s stance is a practice physicians use in order to elicit, check, and establish patients’ attitudes towards treatment. This practice is in line with general recommendations for making shared decisions, such as exploring and checking patients’ preferences and values. However, the formulations may function as a device for doing more than merely checking and establishing common ground and bringing up patients’ preferences and views: Accompanied by deprecating expressions, they work to delegitimize the patients’ stances and indirectly convey the physicians’ opposing stance. Once established, these positions can be used as a basis for challenging and potentially
altering the patient’s attitude towards the decision, thereby making it more congruent with the physician’s view. Therefore, in addition to bringing up patients’ views towards treatment, we argue that physicians may use formulations of patients’ stance as a resource for directing the patient towards decisions that are congruent with the physician’s stance in situations with potential disagreement, whilst (ostensibly) avoiding a more authoritarian or paternalistic approach.

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

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

Formulations of patients’ stance and core SDM concepts

The present study draws on a body of prior research on the practice of ‘formulating’, first described by Garfinkel and Sacks (1970) and further developed by Heritage and Watson (1979; 1980). A formulation “involves summarizing, glossing or developing the gist of an informant’s earlier statements” (Heritage, 1985, 100). For the purpose of investigating talk about ‘patient values and preferences’, we have selected physician formulations of the
patient’s stance or preference related to treatment. Although formulations have been described as summaries of immediately preceding talk (Antaki, 2008; Heritage & Watson, 1980), we have included formulations of patients’ stances expressed in previous encounters (e.g., made available through charts or referrals), since continuity of care across encounters is the nature of medicine.

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

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

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

Formulations in medical settings

To some extent, these findings contrast with the few studies that have been conducted on formulations in medical settings. Formulations in general practice consultations were found to foster mutuality, not exert power (Gafaranga & Britten, 2004). Formulations during history-taking were found to display empathic understanding, shifting to psychological aspects of the illness, a shift regularly resisted by patients (Deppermann & Spranz-Fogasy, 2011). However, in a health appraisal interview, Beach and Dixson (2001) found conflicting functions. Here, formulations both attend to the patient’s emotions, soliciting elaborated disclosure of adverse experiences in a non-judgmental way, while also disattending and
closing down other topics brought up by the patient. Based on this single case study, the
authors suggest further research should investigate what detrimental impacts and problematic
consequences formulations might reveal across a broader set of medical encounters. The
present study contributes to this by showing that formulations of patients’ stance may
delegitimize that stance as a way of challenging and potentially altering the patient’s position
towards a decision more congruent with the physician’s view.

Data and method

Our data set consists of 380 video-recordings of actual encounters in a university hospital in
Norway, collected in 2007-08 as part of a randomized controlled trial investigating the effect
of communication skills training (see Fossli Jensen et al., 2011), and available through broad
consent. The research was approved by the Regional Ethics Committee for Medical Research
in Southeast Norway. The data represents a wide range of non-psychiatric specialties,
increasing the scope for detecting communicative practices with applicability beyond a
particular medical setting. Physicians were randomly selected for participation, and 69%
accepted; patients were recruited consecutively, and 94% accepted (Fossli Jensen et al., 2011;
Gulbrandsen & Jensen, 2010). A subset of 140 video-recordings was included inductively in
order to identify decision making sequences where physicians elicited patients’ views and
preferences. Starting broadly, we identified some disciplines where characteristics of SDM
seemed to be more prevalent. We proceeded to include encounters from these disciplines
strategically to maximize efficiency, as going through 380 could not be done. In the 140
encounters, we first identified decision making sequences where decisions were presented as
‘to be made’, i.e. with potential of co-decision (Collins et al., 2005). The further analysis
sought to identify instances of what we initially described as physicians’ treatment questions,
understood as inquiries seeking to reveal the patient’s stance towards treatment. This broad
category resembles what Reuber et al. (2015) recently has described as ‘patient view
elicitors’. In 17 of the 140 encounters, physicians explicitly oriented to patients’ preferences and views through various forms of treatment questions. These encounters form the primary data for this study and were distributed on the branches of gynecology/obstetrics (6), gastroenterology (4), orthopedics (2), infectious disease (2), oncology (1), urology (1) and anesthesia (1). In 14 encounters, the discussion was focused on choosing invasive procedures, such as surgery (12) or biopsy (2). In the remaining 3 medications, additional tests or watchful waiting (Elwyn et al., 2000) were the options of discussion. In other encounters, patients’ preferences were not elicited explicitly, but could be oriented to indirectly through e.g. physicians seeking acceptance to treatment recommendations (see e.g. Koenig, 2011; Stivers, 2006).

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

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

Findings

We identified formulations of patients’ stance to be a practice physicians use in order to elicit, check, and establish patients’ stances towards treatment. As we will show, the formulations function as more than neutral summaries in that they in subtle ways assess the legitimacy of the patients’ treatment preference. Patients’ stances framed as less than fully legitimate work to elicit a rationale for the preference that in turn can be challenged or attempted altered, as illustrated in trajectory (a) in Table 1. In one case only, indicated with dashed arrows in trajectory (b), the patient’s stance is framed as legitimate and given implicit support by the physician. This case differs in several respects, both regarding turn design features of the formulation and the physician’s subsequent actions. Thus, in addition to merely bringing up and making patients’ perspectives relevant, the physicians’ formulations of patients’ stance
may function as a device for assessing the legitimacy of patient stances and for negotiating other treatment options. We have not found any cases in our data where treatment options are presented as completely equipoised.

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

Table 1. Trajectories in formulations of patients’ stance

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

Formulating patient’s stance as less than fully legitimate

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

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

1 D: .hh og så har han ((clears throat)) snakket med deg om e: .hh and then he has talked to you about e: 

2 (0.3) .h e: hormonespiral? 

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

3 P: ((micro head nod))
4  D:  .hh men du vil (.)(lateral head shake)) ikke prøve det?  

      .hh but you don’t (.) want to try that?  

5  P:  ne:i? ((lateral head shake))  

      no:?  

6  D:  du vil gjerne fjerne livmoren.  

      you would like to remove the uterus.  

7  P:  °mm,° ((small head nods))  

8  D:  .hh får jeg lov å spørre hvorfor?  

      .hh may I ask why?  

9  P:  .h fordi jeg er e: verldig s:liten og lei av å være et  

      .h because I am e: very sick and tired of being a  

10  .(.) menstruelt menneske? .h[h] det har vært pla:gsomt  

      (..) menstrual person? .h[h] it has been bo:thersome  

11  D:  [*m°*] ((small nod))  

12  P:  fra jeg var fjorten år? ((narrative follows))  

      since I was fourteen years old?  

The summary is constructed as a series of declaratives about the patient’s wishes and experiences. Such statements about matters about which the interlocutor has the primary epistemic authority (‘statements about B-events’) are recurrently treated as requests for confirmation (Heritage, 2012), and indeed the patient provides such confirmations at lines 3, 5, and 7. The declaratives thus contribute to establishing common ground and continuity from a previous encounter by getting first hand from the patient what is only reported second hand by another physician. Furthermore, it introduces talk about treatment by mentioning a specific treatment (hormonal coil) proposed by the referring physician (lines 1-2). The target lines are the two formulations of the patient’s stance in lines 4 and 6. In line 4 the physician
first formulates that the patient does not want to “try that”. The adversative conjunction “but” marks the patient’s stance as somewhat problematic by contrasting it with the referring physician’s proposal, while highlighting her stance as *active*; that is, she has actively turned down a treatment recommendation (“you don’t want to”). The subsequent formulation (line 6) articulates what the patient *does* want: “you would like to remove the uterus”.

The physician’s formulations manage to check his understanding of previous events and establish common ground. However, the formulations perform additional actions: First, they get the patient’s stance ‘on the record’ (Heritage, 1985) as an active wish, thus framing the patient as a responsible agent. Second, the patient’s stance is conveyed in opposition to the referring physician’s proposal. Furthermore, after the patient has confirmed the formulations (lines 5, 7), the physician inquires about her reason for this wish: “may I ask why?” (line 8).

Such why-interrogatives treat the accountable event and responsible agent as not in accord with common sense, conveying a challenging stance (Bolden & Robinson, 2011). Besides framing the patient’s stance as not in accord with another medical professional, the physician prefices the interrogative with a request for permission (“may I”), which frames the question as delicate (Schegloff, 1980). The patient responds with a long narrative built to justify her wish for radical treatment by highlighting her endurance (lines 10, 12), referring to herself as a “menstrual person” (line 10), indicating that this is a dominant feature of her identity, and pointing to major negative effects on her everyday life (data not shown).

Extract (2) does not contain additional formulations of the patient’s stance, but illustrates how the physician builds on the positions established by his previous formulations, further challenging and negotiating the patient’s position. The extract begins with the end of the patient’s long response, initiated in line 10 in the previous extract (29 lines of transcript is omitted).
and then I have become forty eight years old

and think that HH[hh]h

I don't need [the] uterus anymore,

we [no-] one can understand how bothered you are by it?

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

other methods? that can help you get rid of

without removing uterus?

(0.3) do you want to do that?
In lines 49-50, the physician first acknowledges her bothersome situation, before he indicates his opposing position ("but my point is", line 51). He follows with a rhetorical inquiry about her willingness to try “other methods” if they are available and if they would resolve her problem effectively (lines 51-54). By providing a potential solution, the inquiry is framed as a reasonable proposal designed to achieve acceptance. Rejections of proposals are dispreferred actions that usually generate accounts that explain or excuse the non-compliance (Pomerantz, 1984). The patient’s minimal rejection in line 56 is therefore noticeable as openly disaffiliative or uncooperative. This negative stance may be considered as oriented to by the
physician in that he upgrades his challenge in lines 57-58: “why should one shoot a fly with a cannon”. This rhetorical question characterizes her position as in conflict with the common sense expressed in the idiomatic expression, thus further weakening the legitimacy of her position. The patient subsequently modifies her stance by opening up for considering “very concrete and good alternatives” (line 60). However, the preparatory gesture of crossing her arms (line 59), emphatic stress on “Very” and “Good”, and her subsequent account in line 62 all serve to maintain her oppositional stance.

In (1) and (2) the physician’s formulations contribute to establishing the patient as a responsible agent with an active wish in opposition to a proposed treatment recommendation. In the subsequent talk, this is used as a basis for pursuing an account and challenging the patient’s position. This delegitimates the patient’s position by constructing it as diverging from common sense, and in (2) the physician succeeds in opening up an opportunity for negotiating other treatment options. Throughout, the patient works to justify her position, and in the remainder of the encounter the negotiation continues, eventually ending up with a less invasive procedure recommended by the physician, deferring the option of surgery.

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

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

1 P: nei? [merkə'ke det da,]
2 no? [didn’t feel that then,]
[nei. nei.] [no. no.]

but e: so you are satisfied with that

coil you have had for six months.

yeah, I think so, that it [has been] okay,

but should a young healthy woman

like you use such pessary in the vagina?

I don’t know?

[du har jo takket nei til operasjon-
[you have said no to surgery-

[have operert] og der har
[I have a friend who] got surgery? and there it has

after a year descended again?

.hh is that why: you said no to surgery?

=ne:i, det va’ke no snakk om jeg kunne velge her da?
=no:, there wasn’t any talk about me having a choice then?

{{(turn continues)}}
The physician initiates his response to the patient’s description with an adversative conjunction “but”, indicating from the outset that there is something problematic with the patient’s talk, and possibly starting a challenge right away, before he continues to formulate the gist of the patient’s stance, with the inference marker “so”: “so you are satisfied with that coil you have had for six months” (lines 3-4). Note that at this point, the patient had not expressed any stance, nor had she used the word “satisfied.” The physician transforms her symptom description (“didn’t feel that”) to a stance of being “satisfied” with the coil (Antaki, 2008). After the patient’s confirmation in line 5, the physician moves on with a kind of polar question that Heinemann (2008) has described as challenges that are unanswerable: “but should a young healthy woman like you use such a pessary in the vagina?” (lines 7-8). The reduced legitimacy of this option and the physician’s opposing stance is reinforced by the Norwegian “en sånn” (lit. “a such”), a modal determiner marking psychological distance to the object referred to (Johannessen, 2012) and the turn initial “but”. The question either invites the patient to defend her stance (going against the physician’s opinion) or to affiliate with the physician’s position (giving up her own stance). The patient resists the question by neither confirming nor disconfirming (“I don’t know”, line 9). In response, the physician pursues an account in line 10 with a stronger and revised version of her stance from being satisfied with the coil to having actively turned down surgery, indicating stronger agency on her behalf. Simultaneously, in overlapping talk (indicated with square brackets), the patient provides a delayed account; referring to her friend’s negative experience with surgery (lines 11-12). However, unlike the patient in (1) and (2), the patient here, in line 14, resists the physician’s framing of her stance as an active decision.
In extract (3), the physician works to elicit and establish, in his own terms, the patient’s stance towards treatment, before challenging it and pursuing an account based on her ascribed agency. In the further talk, not shown here (but see Landmark et al., 2014), the physician introduces and advocates surgery as a viable option.

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

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

1  D: men det var godt at det har gått bra da:
   but it’s good that it went well

2  P: j[a.hh]

3  P: y[ea.h]

3 D: [ikke] sant på tross av alt det der.=men du har litt tak nå?:
   [right] in spite of all that.=but you have some cramping no:w?

4  (.)

5  P: .h[hh (    )]

6  D: [.h og så er] du redd.=
   [.h and you] are scared.=
=ja. ikke akkurat nå: nå har jeg'ke tak,
=Yes. not right now: right now I don't have any cramps,
((14 lines omitted, P elaborates on condition and they establish that P is
21 weeks pregnant))

22 D:  [s:]å da: tenkte du at det er greit å ha
[s:]o the:n you thought that it is okay to have
an ekstra undersøkelse?

23 en ekstra undersøkelse?
an extra examination?

24 (0.7)

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

28 D:  [((nods))]
After the physician’s empathic acknowledgement (line 1), he formulates her condition by referring to a physical symptom (“some cramping now”) and an emotional state (“scared”) (lines 3, 6). In line 7, the patient gives a turn-initial agreement, but disconfirms any cramping right now. In the following (the 14 lines omitted), she continues to elaborate on her physical condition, while ignoring the reference to her emotional condition (Deppermann & Spranz-Fogasy, 2011). After this elaboration, the physician formulates the patient’s stance as a wish for “an extra examination” (lines 22-23). Similarly to the formulations in (3) the patient’s talk is transformed to a candidate conclusion (indicated by “so”) about what she wants, inferred from her symptom description, and perhaps from notes in the referral, whereas constructing it as something she merely “thought” mitigates the strength of her wish expression. Nevertheless, the adjective “extra” foregrounds the extraordinary status of the option, turning it into an accountable action. Together with rising intonation, this invites the patient to agree and to explicate her rationale for wanting the examination. After a delay indicating a dispreferred response (line 24), the patient indeed provides a multi-unit account where she
subtly rejects two presuppositions in the formulation (lines 25-29): first, she rejects full agency by distributing part of the responsibility to the midwife, who is a legitimate and medically authoritative third party (Gill, 1998); second, she indirectly counters the extraordinary status of the option by pointing out that she received the same follow-up during her last pregnancy at a different hospital (i.e. yet another legitimate medical authority). The final part of her account states a medical objective, namely to monitor a previous experienced high risk factor for preterm birth (cervical incompetence). In addition to providing a relevant motivation for the option, she portrays herself as medically knowledgeable by referring to a technical measurement level (lines 32-33), thus strengthening her epistemic authority. In sum, the formulation subtly indicates the patient’s wish as “out of ordinary”, seeking out the patient’s underlying reasons.

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

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

P: livmor[halsen ja.]
the cervix yes.

D: [riktig.] okay. så det er e: ja. jeg skjønne.
[right.] okay. so it is e: yes. I understand.

. hh okey. (0.8) ((hand palms meet)) det kan vi:
.hh okay. (0.8) we: can

. da vet jeg hva du ↑vi:l, e hva du forventer av ↑meg, .h
then I know what you ↑wa:nt, e what you expect from ↑me, .h

o:g du er enogtyve uker og med den forhistorie
and you are twenty-one weeks and with that prehistory
så vil du ath h vi måler livmorhalsen selvom you wan't to have the cervix measured even though
det er (.) fortsatt veldig tidlig? it is (.) still very early?

P: mm, ((nods))

D: .hh men at vi gjør det slik at vi har en utgangspunkt? .hh but that we do: it so that we have a starting point?
P: mm, ((nods))

D: for å kunne sammenligne? (0.7) Om (0.4) situasjonen to be able to compare? (0.7) If (0.4) the situation

skulle tilsi det. should indicate it.

P: mm,

D: ikkesant? det er det tenker, right? that is what you think,

P: ja, yes,

ja. .hh (.) >okay. jeg skal gjøre det, < .h (.) Me:n jeg yes. .hh (.)>okay. I will do it, < .h (.) Bu:t I

har lyst til å understreke en ting for deg, want to emphasize one thing to you,

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

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

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

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

**Formulating patient’s stance as legitimate**

Extract (6) is drawn from orthopedics, where surgery may have a particularly privileged status relative to other treatment options, affecting both parties’ expectations of surgery as a potential treatment option (Hudak et al., 2011). Extract (6) is the only case in our data in which a formulation of the patient’s stance is found without any signs of conflicting treatment preferences. Instead, the physician formulates the patient’s stance as legitimate, thereby consolidating their congruent positions.
The male patient has had a meniscus injury for ten years that has gradually worsened. During the three minutes before the extract starts, the patient provided a vivid description of physical restraints on work and everyday life, with long and painful periods every time the knee cap slips out. During this narrative, the physician complimented the patient for being “extremely patient” (data not shown), after which the patient replied that his spouse, a health care worker, had expressed lack of patience on this matter. The physician refers to this previous talk in the formulation of the patient’s stance in lines 3-4:

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

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

1 D: ja,
yes,

2 P: .hh [men-]

3 D: [så nå] er'e egentlig ikke bare samboeren som er [so now] it's not only your spouse that is lei detta?=du er [litt lei det sjøl og?] tired of this?=you are [a bit tired yourself as well?]

4 P: [(er Møkka lei)]

5 P: [(am Fed up]

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

7 D: [ja,]

[yeah,]
P: (så) ta så hensyn te det?
(so) take it into consideration so much?

D: ja,

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

D: [nei,] ((nods))

P: og spille fotball med dattra mi men .h[h]
and play football with my daughter but .h[h]

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

P: det jeg mørker
what I f eel ((turn continues before D initiates physical examination a few seconds later))

The physician’s formulation of the patient’s stance (lines 3-4) offers his version of the patient’s previous talk (initiated with “so”), by adding the emotionally loaded word “tired,” which the patient had not used (Weiste & Peräkylä, 2013). Unlike the previous cases, this stance is not framed as a wish for a specific treatment option, and thus ascribes less agency to the patient. Instead it orients to the patient’s motivation for active treatment, based on his experience of the problem. The orthopedic setting and the patient’s history might be enough to invoke the underlying options of surgery vs. watchful waiting at this point (Hudak et al., 2011), and the two options are made explicit later in the encounter. Several features contribute to framing this stance as legitimate: First, it refers to a significant third party (spouse and health care worker) capable of assessing the patient’s situation. Second, it downgrades the description of the patient’s emotional state as being “a bit tired” (line 4), a
relatively moderate position compared to his major complaint. Finally, the patient’s stance is not conveyed as opposing the physician’s stance. Rather, the physician has indicated support to the presented problem in the previously mentioned characterization of the patient as “extremely patient”. In subtle ways, the formulation seems to acknowledge, and maybe also indirectly suggest, that this situation warrants intervention, thus preparing the ground for proposing (invasive) treatment (Hudak et al., 2011). The patient’s response in line 5 (a collaborative completion) with the upgraded stance from “a bit tired” to “fed up” (line 5-6) signals eager, unproblematic agreement (Lerner, 2002). This differs from the previous cases, in which the patients’ responses are delayed or in other ways delivered in dispreferred turn shapes (Pomerantz, 1984). Nevertheless, the patient provides an account for his expressed strong stance (lines 6, 8) and, by pointing to the bright side, that is, what activities he does manage (lines 10, 12), displays ‘troubles resistance’ (Jefferson, 1984).

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

Summary of findings

This article scrutinize how physicians formulate patients’ stance for more than merely checking and establishing common ground and bringing up patients’ preferences and views as a relevant topic in medical decision making. Extract (1)-(5) illustrate how the physicians’ formulations of patients’ stance bring the patient’s stance ‘on the record’ as less than fully legitimate and portray them as responsible agents with a treatment wish. This may function as
a starting point for challenging and/or (re)negotiating opposing treatment preferences. The patients on the other hand work to justify (1)-(2), (4)-(5) or reject (3) the ascribed stance and agency, for instance by providing accounts or distributing the responsibility to third parties (Gill, 1998). That the formulation of the patient’s stance in extract (6) is neither designed nor pursued in similar ways, might be related to the lack of opposing stances in this case, where it instead seem to establish agreement and prepare the grounds for proposing invasive treatment. This single example suggests that formulations of patients’ stance may also be used for achieving other objectives than the ones described in extract (1)-(5). Further inquiry is needed to explore other potential functions achieved by formulations of patients’ stance than those documented in our analysis, and to investigate to what extent patient stances portrayed as active treatment wishes are associated with being challenged.

**Discussion**

We have identified formulations of patients’ stance as one conversational practice physicians use for eliciting and checking patients’ preferences and views in relation to treatment. This is in line with central objectives in the process of making shared decisions (C. Charles, Gafni, A. and Whelan, T., 1997; Elwyn et al., 2012; Makoul & Clayman, 2006). However, this practice may be potentially Janus-faced compared to these objectives; By allowing the physician to transform and edit the patient’s previous contributions (Antaki, 2008), they can contribute to delegitimizing the patient’s stance and implicitly convey the physician’s opposing stance. This suggests that physicians and patients also orient to and negotiate normative aspects of decision making, that is, what is a legitimate and appropriate treatment wish and what is treated as not in accordance with common sense or the physician’s expertise. This is an aspect that has received little attention in SDM models, which rather tend to describe discussion of preferences as a neutral and straightforward sharing process (Coylewright et al., 2012). According to Eilon (1969) the crux of a rational decision (or free choice) is not to be
found at the stage of the final resolution, but in the ranking of alternatives based on some criterion. So “[i]f the decision-maker behaves rationally, he must resolve to select this superior alternative” (178). By indicating what stances are more or less legitimate, formulations of patients’ stance might be used as a resource for the physician to direct the patient towards a decision that is congruent with the physician’s stance in situations with potential disagreement, whilst (ostensibly) avoiding a more authoritarian or paternalistic approach. Keeping in mind that our examples are encounters with high score on patient involvement, our findings indicate that there is still some way to go from current ‘best practice’ to the ideal ‘best practice’ described in guidelines.

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

Partnership is another established concept in SDM models, encompassing some degree of shared responsibility for the decisions (C. Charles et al., 1999; Da Silva, 2012). Formulations of patients’ stance that ascribe the patients as responsible agents can be seen to accommodate that requirement by involving patients as more active partners or agents in the decision. However, a potential disadvantage of increased agency is that it also makes one accountable and challengeable. After the patient’s stance has come ‘on the record’ as an active wish, the
physician can pursue and challenge the patient’s rationale, and as Bolden and Robinson (2011, 115) point out, such actions are frequently accompanied by “negatively valenced actions”. Again, an on-the-surface practice in accordance with a core concept in SDM models may also conceal competing physician objectives, such as well-intended persuasion of the patient to commit to the physician’s opinion by delegitimizing the patient’s stance. The accountability that seems to follow increased agency might contribute to understanding a well-established barrier to shared decision making, namely that many patients are reluctant to take more agency in the medical encounter (de Haes, 2006; Elwyn et al., 2012; Guadagnoli & Ward, 1998).

Implications

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

References


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

word Stress or emphasis of underlined item, the more underlining, the greater emphasis

WORD Markedly loader 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
Aspiration within speech, usually laughter

Creaky voice

Transcriber’s comments on preceding talk, e.g. description of non-verbal activities

Transcriber's best guess of an unclear fragment

Inaudible talk