



## Negotiating relevance in pre-operative assessments

Bethan Benwell<sup>a</sup>, Catrin S. Rhys<sup>b,\*</sup>

<sup>a</sup> University of Stirling, United Kingdom

<sup>b</sup> Ulster University, United Kingdom

### ARTICLE INFO

#### Keywords:

UK  
Conversation analysis  
Troubles-telling  
Nurse-patient interaction

### ABSTRACT

Preoperative assessments provide an essential clinical risk assessment aimed at identifying patient risks and requirements prior to surgery. As such they require effective and sensitive information-gathering skills. In addition to physical examination, the preoperative assessment includes a series of routine questions assessing a patient's fitness for surgery. These questions are typically designed to elicit minimal, 'no problem' responses, but patients sometimes produce expanded responses that extend beyond the projected information. Our analysis reveals that troubles-telling is often invoked by both nurses and patients as an effective, patient-centred resource for negotiating the medical relevance of patients' concerns in these contexts.

### 1. Introduction

The preoperative assessment (POA) exists in most healthcare systems and is completed prior to planned surgery to ensure that the patient is fully informed about the upcoming procedure and that potential risks for surgery are properly assessed. The POA is part of a perioperative system of care aimed at monitoring and mitigating the associated health and mortality risks as well as reducing cancellations, shortening 'patient pathways' to treatment and speeding up post-surgery recovery, all of which in turn improve resource efficiencies (Findlay et al., 2011; Malley et al., 2015).

A range of healthcare professionals may carry out the POA, though in the UK, the role is increasingly allocated to specially trained nurses (Abraham, 2013), who are particularly suited to the communicative/therapeutic demands of the role (Bramhall, 2002; Mottram, 2009).

The POA involves a medical examination and assessment of the patient's suitability for surgery approximately three weeks before an operation. It comprises routine procedures such as measuring blood pressure and carrying out ECGs, as well as questions about the history of the patient's health (especially previous surgery/anaesthetics), and about current medication and conditions. Determining fitness for surgery is crucial for patients at risk of adverse outcomes, hence communication is key for the efficacy of POAs (Chan et al., 2011). Poor communication can contribute to, or cause, adverse events in treatment (Lingard et al., 2008) and can exacerbate patient anxiety (Carr et al., 2006; Gilmartin and Wright, 2008). Good communication can reduce patient anxiety prior to surgery (Mottram, 2009; Chan et al., 2011), help manage patient expectations and identify their needs (Malley

et al., 2015).

The studies above focus on the communicative role of nurse practitioners in POAs, and often identify their success in providing a 'holistic' service of care (Hines et al., 2013: 74), preparing patients psychologically, and identifying potential risks through the gathering of accurate and full data. However, very little existing research on communication in the POA addresses actual interactional data (though see Benwell & McCreddie (2016); also Jones, (e.g. 2007) on similar hospital admissions processes). The current study opens up this interactional 'black box' to closer analytical scrutiny by using conversation analysis to examine exchanges between nurses and patients in the UK health system. Our analysis reveals strategies for efficiently and empathically gathering relevant information from potentially anxious patients. We focus specifically on sequences in which patients give expanded responses to the checklist questions posed by the nurses. Our analysis examines how nurse and patient collaboratively negotiate the relevance of the patient's expanded response to the immediate institutional agenda of assessing fitness for surgery.

#### 1.1. Questioning in medical interaction

Interaction in POAs shares with other medical interactions the property of being a highly question-driven form of interaction (Roter and Hall, 2006; Stivers and Majid, 2007). Questions set the agenda for the patient in relation to both the topical domain and the type of action expected in the response (Stivers and Heritage, 2001). In their design, questions also embody the medical professional's presuppositions vis-à-vis the patient and their epistemic stance towards the information

\* Corresponding author. School of Communication & Media, Institute for Research in Social Sciences, Ulster University, Shore Road, Newtownabbey, Co. Antrim BT37 0QB, United Kingdom.

E-mail address: [cs.rhys@ulster.ac.uk](mailto:cs.rhys@ulster.ac.uk) (C.S. Rhys).

<https://doi.org/10.1016/j.socscimed.2018.01.034>

Received 25 April 2017; Received in revised form 17 January 2018; Accepted 23 January 2018  
0277-9536/ Crown Copyright © 2018 Published by Elsevier Ltd. All rights reserved.

solicited in the question, as well as setting a preference for the polarity of the response (Heritage, 2010). For example, a question about asthma designed as “you don’t have asthma do you” (Heritage, 2010: 57) seeks confirmation (through the tag question) of a relatively confident assumption about the patient not having asthma (the epistemic stance displayed by the declarative formatting).

These issues of question design are also influenced by the *type* of medical encounter (e.g. ‘well visits’ vs ‘acute visits’) and the *stage* of the medical encounter (e.g. history taking vs diagnosis). Heritage (2010) explains how they are differently influenced by two key principles: *optimisation* (Heritage, 2002) and *problem attentiveness* (Stivers, 2007). *Optimisation* refers to the observation that unless a physician has reason to believe otherwise, they typically formulate their questions to favour “‘no problem’ responses” (Boyd and Heritage, 2006: 162). This is illustrated in the example above, in which the doctor’s question is grammatically designed to favour a ‘no asthma’ response. Boyd and Heritage (2006) show that this is the default principle of medical questioning, evident during medical history taking and routine information gathering appointments (with the notable exception of lifestyle questions relating to smoking and drinking, which are rarely optimised (Heritage, 2010)). In contrast, in acute visits, patients present with a problem for which diagnosis/treatment is sought. In these contexts, *problem attentiveness* dictates that questions relating to the patient’s primary symptoms are designed to presuppose a problem. In the POA, diagnosis/treatment has already been addressed; the function of the POA is to determine that there are no *additional* concerns that might prevent surgery taking place. In other words, the patient’s current health problem is not the focus of the questioning. Thus, the design of the nurses’ questions is not typically problem-attentive but rather is oriented to optimised information gathering.

An additional factor in information gathering/medical history taking is orientation to the routine, ‘checklist’ nature of the interactional task where the *content* of the questions is governed by a procedure or even an actual form to be filled in. This has consequences for the design of the questions and also for the opening sequence. Specifically, health visitors (Heritage and Sefi, 1992; Raymond, 2010) and nurses (Jones, 2007) are observed to preface the questioning with reference to the bureaucratic, imposed nature of the task. In addition, successive questions are often linked through *and*-prefacing (Heritage and Sorjonen, 1994) or a reduced grammatical form that is anaphorically dependent on the preceding question (Stivers and Heritage, 2001) and marks the question as one in a ‘checklist series’ of questions.

In all this, Heritage (2010: 46) observes that ‘physicians and patients both cooperate and struggle with one another over “what matters” in a given medical context’. In other words, whilst the health professional ultimately decides what information will be recorded on the form, in designing and responding to the questions, both parties are involved in negotiating the value of the information exchanged in relation to the institutional goals of the medical encounter.

Our analysis shows that POA questioning involves a routinized, checklist style of optimised questioning but with some important departures in the patterns of sequence organisation and action-orientation that bear directly on the ‘negotiation of what matters’.

### 1.2. Activities and the institutional agenda

While questions in medical encounters set the agenda for the ongoing talk, patient responses sometimes extend beyond the restrictions imposed by the professional’s optimised first position turn. Stivers and Heritage (2001) suggest that these extended responses are either *expanded answers*, which are nonetheless aligned to the checklist agenda, or *narrative expansions*, which fully depart from the checklist agenda and are oriented to the patients’ ‘lifeworld’ (Mishler, 1984) concerns.

Expanded answers are oriented to difficulties in responding that prompt additional details but still address the agenda of the question, whereas narrative expansions introduce aspects of the patient’s own agenda into the interaction (cf. Nishizaka, 2011; Bonnin, 2014). However, both types of extended response may introduce elements of the patients’ lifeworld and both are oriented to as accountable, so the distinction is perhaps one of degree rather than discrete categories of response. Our analysis shows that, in the POA, the alignment or otherwise of a patient’s response to the agenda of the nurse’s question emerges as a collaborative outcome of the interaction between nurse and patient.

Stivers and Heritage (2001) suggest that narrative expansion displays a progressive transition from formulaic history-taking into interaction that is more conversational in form. Ten Have (1989) discusses a similar mixing of interactional frameworks during GP consultations. However, rather than a transition from one interactional framework to another, he suggests that doctor-patient interaction systematically involves ongoing convergence (Jefferson and Lee, 1981) between two distinct activities (consultation and troubles-telling). Both Stivers & Heritage and ten Have thus demonstrate that participants in medical settings shift between the institutional/medical agenda (history-taking/consultation) and the patient’s agenda (narrative/troubles-telling). Our own data shows a similar shifting between the checklist agenda of the pre-operative assessment and the patient’s agenda, observable in shifts between the type of checklist oriented Q-A sequences described above and troubles telling, but we argue that the distinction emerges as a *product of negotiation* rather than an a priori property of any particular turn at talk.

### 1.3. Troubles-telling in medical encounters

‘Troubles-talk’ refers to a particular kind of extended sequence involving personal disclosure of difficult, intimate or embarrassing episodes or problems (Jefferson, 2015). Crucially, Jefferson and Lee (1981) argue that it is not the content of the talk per se that makes it a troubles-telling but the projected trajectory of the talk and the locally invoked categories for the participants (e.g. troubles-recipient). This is particularly relevant to our analysis as we focus on patients’ extended responses introducing potential health problems. In other words, the content of these responses ‘might be pre-classified as a trouble’ (p.403) but its actual status is a matter of interactional negotiation.

In other medical settings, troubles-telling has been examined as a central activity of the problem attentive phase of the encounter, leading to diagnosis/treatment (Ruusuvuori, 2005, 2007; ten Have, 1989). Questioning in the POA, however, is not typically problem attentive, nor is diagnosis/treatment relevant, as the focus is on ‘fitness for surgery’. Troubles-oriented talk nonetheless occasionally emerges in the context of patients’ expanded responses which potentially challenge their fitness for surgery. In these contexts, the nurses observably orient to the institutional goal of probing for and recording potentially relevant information.

In the analysis that follows we demonstrate how routine pre-operative sequences normatively orient to an ‘optimised’ design involving ‘no-problem’ or minimally expanded answers to checklist questions, but that where responses are expanded and dispreferred, troubles-oriented talk may be deployed as a resource for negotiating ‘what matters’ to this local agenda in the context of the epistemic and institutional asymmetries of this particular setting.

## 2. Data and methods

Data from fifteen POAs with six different nurses were audio-recorded from an NHS hospital in Scotland. Ethical permission to audio-record (but not video-record) and transcribe was obtained from the

Download English Version:

<https://daneshyari.com/en/article/7328475>

Download Persian Version:

<https://daneshyari.com/article/7328475>

[Daneshyari.com](https://daneshyari.com)