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# 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 subtle 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.



## 1. 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 and Roberts, 2001; Quirk et al., 2012; Stivers, 2006; Toerien et al., 2011, 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 authentic 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

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patient's preference or views towards treatment. The influence these formulations have on the interaction is the topic of this paper.

### 1.1. 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 and 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 and Clayman, 2006). Moreover, it is a central communication skill in medical curricula (e.g. Frankel and 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 and 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 and Spranz-Fogasy, 2011; Hayano, 2013; Weiste and 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.

### 1.2. 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 and 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, while maintaining, on the surface, a neutral stance by appearing to merely summarize what the other has said (Heritage, 1985). 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 and Peräkylä, 2013).

### 1.3. 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 and 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 and 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.

## 2. Data and method

Our data set consists of 380 video-recordings of authentic 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 and 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