

Orientations to epistemics and deontics in treatment discussions



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Abstract

An ideological shift to patient-centered health care raises questions about how, in the face of medical authority, patients can assert agency in interactions with doctors. This study uses conversation analysis to explore how epistemic and deontic orientations are raised and made relevant in different types of responses to treatment proposals across two health care settings – New Zealand general practice consultations and Swedish hospital-based physician encounters. By examining responses ranging from acceptance to strong resistance, we show patient practices for deferring to and resisting medical authority, which includes claiming independent access to expert knowledge and raising everyday, experientially based concerns. Doctors rightfully privilege their own epistemic expertise in treatment decisions but they also take patient experiences into consideration. In cases of strong resistance we found doctors raising patients' ultimate right to refuse treatment recommendation. Our analysis further nuances current knowledge by documenting the ways epistemic and deontic domains are observably relevant forces shaping the sequential unfolding of treatment proposals.

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In ancient times, the Hippocratic Oath was introduced to ensure that medicine was practiced honestly and with the patient's well-being in mind (von Staden, 1996). Adherence to the oath requires physicians to base treatment recommendations on scientific evidence. Failure to do so constitutes a breach of the Hippocratic Oath and may lead to accusations of malpractice (Nutton, 2004). This is an incentive for physicians to make explicit the medical reasoning for proposing a particular treatment. Epistemics thus provides an ethical foundation for recommending treatment. In line with the discussion in the introduction to this volume, we use the term epistemics to refer to "the knowledge claims that interactants assert, contest, and defend in and through turns-at-talk and sequences of interaction" (Heritage, 2013:370).

In more recent times, the patient has been afforded an increasingly active role in the medical visit and in many countries around the world today, patient-centeredness is considered another important quality in health care delivery (Kaba and Sooriakumaran, 2007; Stewart, 2001). A patient-centered approach stipulates that the patient should be an active participant in his or her health care. Furthermore, patients should have the right to reject treatments even in cases where they are warranted on bio-medical grounds. Patients' deontic authority thus underpins their rights to accept or reject treatments. Drawing on Searle's (1976) discussion of the two directions of fit between "the words" and "the world", Stevanovic and Peräkylä (2012) differentiate between epistemic and deontic authority in the following way: "epistemic authority is about getting the *words to match the world*, and deontic authority is about getting the *world to match the words*; epistemic authority is about *knowing* how the world 'is'; deontic authority is about *determining* how the world 'ought to be'."

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(p. 298). In this paper we explore joint decision making in medical visits by examining how interactants make the grounds for recommending a particular course of action or treatment available to one another (epistemics) and how the interactants decide on a particular course of action or treatment (deontics).

The tension between the bio-medical expertise of the physician and the personal experiences and preferences of the patient is a long-standing theme in research on clinical practice. The theme emerges in *Mishler's* (1984) microanalysis of the medical interview and is also at the core of research on medical paternalism (cf. *Bremberg*, 2004). Within the medical interview, authority based on medical expertise is especially relevant in the parts of the encounter that involve diagnosis and recommendation of treatment. *Peräkylä's* (1998, 2002) research on the diagnostic phase of medical encounters, nuanced our understanding of medical authority by demonstrating that doctors go to some length to make the general basis of their diagnostic judgments available to patients. Peräkylä showed “that through the coordination of the design and placement of their diagnostic turns, the doctors treat themselves as accountable for the evidential basis of the diagnosis, thereby not claiming unconditional authority vis-a-vis the patients” (*Peräkylä*, 2002:221). The present study explores how bio-medical evidence is recruited (or disputed) in discussions regarding treatment and other courses of action.

The treatment stage of the medical encounter is characterized by a pressure for progressivity (*Costello and Roberts*, 2001; *Koenig*, 2008, 2011; *Robinson*, 2003; *Stivers*, 2005a,b,c; *Stivers and Robinson*, 2006). Physicians will not move on to the next activity until they have secured acceptance from patients and the pursuit of acceptance can result in modifications of proposals for treatment. Prior research has shown that physicians orient to subtle shifts in reciprocity. While tokens like “okay” are treated as accepting, mere acknowledgments like “mm hm” and headnods are treated as manifestations of resistance (*Koenig*, 2008, 2011; *Stivers*, 2005b). Passive resistance thus provides a resource by which patients actively participate in how treatment recommendations emerge as acceptable (cf. *Jefferson*, 1983). That patients can shape treatment recommendations by simply withholding talk highlights that we must pay close attention to how silence is embedded within sequential contexts to capture joint decision making. Patients can also initiate actions that impact treatment outcomes. *Bergen and Stivers* (2013) examined patient-initiated disclosures of medical misdeeds such as taking medication prescribed for someone else or failing to comply with life style recommendations. They found that by reporting these kinds of behaviors as transgressions, patients pay heed to the medical authority of doctors. In sum, previous research shows that medical authority and patient participation is embedded in the structural contingencies of turn and sequence (*Robinson*, 2003).

Outside the medical context, the interactional research on decision making has documented its core interactional features. *Lindström* (1997, in press) examined preferred responses to yes/no formatted remote proposals in everyday telephone conversations (cf. *Houtkoop Steenstra*, 1987). She found that in these sequences simple affirmation was treated as insufficiently aligning with the suggested course of action. Acceptance of a proposal was accomplished by affirmation plus a stance displaying commitment to the relevant course of action. In a study of workplace planning meetings, *Stevanovic* (2012, 2013) also found that more than agreement was needed to achieve a joint decision making about a future course of action. She showed that access to the content of the proposal, agreement and commitment to accomplishing it were necessary elements to a joint decision making process. Other outcomes to remote proposals were non-decisions and unilateral decisions. The features of the latter type of decisions in medical consultations include giving prominence to technical description over individual patient considerations (*Collins et al.*, 2005).

In this paper the sequential unfolding of decision making about treatment recommendations and other suggestions of courses of action are further detailed. A specific focus is on how epistemic and deontic orientations are made relevant in the proposals doctors make and the patients' responses to them. Our analysis aims at providing a better understanding of decision making dynamics in medical interactions by identifying the complex relationships between epistemic and deontic reasoning in treatment proposals and suggestions for other courses of action.

1. Data

Previous research on treatment recommendations has focused on data corpora from uniform clinical settings such as primary care, pediatrics, or oncology. Our research by contrast, mixes data from two different national contexts and includes routine and acute primary care as well as specialized hospital care. Furthermore, two different languages are represented in our materials. The New Zealand English general practice data are drawn from the Applied Research on Communication Health Group (ARCH) Corpus of health interactions at the University of Otago, Wellington, New Zealand.¹ From the larger ARCH corpus a subset of 14 complete, video-recorded, primary-care consultations were examined in detail for this study. The consultations ranged in length from lasting between 15 and 35 min and were selected because the patients were aged 65 years or older.

¹ The ARCH Corpus is a digital archive of video-recorded consultations and related data collected progressively since 2003 by members of the Applied Research on Communication in Health Group (ARCH) for a series of studies funded by the NZ Health Research Council, the NZ Marsden Fund, the NZ Lotteries Health Research Fund and University of Otago (URL: www.otago.ac.nz/wellington/research/arch/).

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