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How surgeons design treatment recommendations in orthopaedic surgery

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ABSTRACT

This paper examines how orthopaedic surgeons skilfully design treatment recommendations to display awareness of what individual patients are anticipating or seeking, and suggests limits to those efforts. It adds leverage to our parallel work by demonstrating that even when surgeons incorporate considerations of recipient design to 'fit' recommendations to patients' displayed orientations, an asymmetry between recommendations *for* vs. *not for* surgery remains: recommendations *for* surgery are generally proposed early, in relatively simple and unmitigated form, and as stand-alone options. In contrast, recommendations *not for* surgery tend to be significantly more complex: they are likely to be delayed, conveyed indirectly, mitigated and justified, and include other possible treatment options. These findings suggest a tension between surgeons' efforts to design recommendations for specific recipients and an overarching institutional bias favoring surgery. Surgeons' efforts to anticipate and respond to resistance to recommendations demonstrate a similar pattern: the methods used to counter patient resistance, and the sequential placement of those efforts, depends on whether the recommendation is for surgery or another treatment option. This work contributes to an understanding of treatment recommendations generally by showing how patients are *co-implicated* in their accomplishment: because surgeons incorporate considerations of recipient design in response to information provided explicitly or tacitly by patients, patients influence the rendering of recommendations from the beginning.

Introduction

In concurrent work (Hudak, Clark & Raymond, in preparation), we describe how orthopaedic surgeons treat surgery as having a special, privileged status relative to other treatment options. This privileged status surfaces in the design and delivery of recommendations as a clear asymmetry: recommendations *for* surgery are generally proposed early, in relatively simple and unmitigated form. In contrast, recommendations *not for* surgery—recommendations against surgery or for a non-surgical treatment—tend to be significantly more complex: they are likely to be delayed, conveyed indirectly and/or elaborated, mitigated and justified, and include other possible treatment options—including surgery, which is often retained as a possible future remedy.

At an early stage of our analyses, the complex character of non-surgical recommendations (relative to surgical ones) gave us reason to pause. We wondered whether this complexity was perhaps related *not* to the type of recommendation per se (*for* vs. *not for* surgery) but rather the result of a misalignment or disjuncture between what the surgeon was offering in terms of treatment, on the one hand, and what the patient was either anticipating or seeking, on the other. In general, affiliative actions (e.g., alignment, agreement, acceptance, etc.) and disaffiliative actions (e.g., misalignment, disagreement, refusal, etc.) are accomplished quite differently in interaction: alignment/agreement is 'preferred', typically being short and to the point, while misalignment/disagreement is 'dispreferred' and typically characterized by delays, mitigation and accompanied by accounts (Pomerantz, 1984; Schegloff, 2007). We reasoned that one might expect a surgeon would need to do significant interactional work to justify *not* recommending surgery to a patient with significant pain and disability who was seeking a solution to their problem (including in the form of surgery). Similarly, the opposite also seemed plausible—that a surgeon would need to do little interactional work to justify a recommendation of surgery if this was what was sought by the patient. As such, we wondered whether the asymmetry between recommendations *for* vs. *not for* surgery was simply attributable to alignment between surgeons' recommendations and patients'

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expectations when surgery was being recommended and misalignment when surgery was not being recommended. To explore this possibility, we undertook to examine systematically the intersection between surgeons' recommendations or offers (*for* vs. *not for* surgery) and patients' displayed orientations to surgery (whether surgery was anticipated or sought vs. not).

Beginning with the answer to our query, we show that the asymmetry between recommendations *for* vs. *not for* surgery is durable, persisting across both different recommendations by surgeons and the distinct orientations displayed by patients: although surgeons clearly evince concern for patients' orientations to surgery—and different orientations by patients are clearly associated with variability in the design of recommendations—this variability does not fully account for the asymmetry we initially observed. These findings suggest that the specialized nature of orthopaedic surgery can be consequential for interactions between these surgeons and patients: treatment recommendations reflect an overarching institutional bias favoring surgery over other treatment options.

What these analyses also show, and what we foreground in this paper, are the skilful ways in which surgeons manage the relationship between patient perspectives on treatment options and the actual treatment recommendations they provide. By calibrating and designing recommendations that take into account the type of treatment or care individual patients appear to be seeking or anticipating, surgeons' recommendations reflect a concern for the manner in which they are designed for the particular recipient they target—that is 'recipient design' (Sacks, Schegloff, & Jefferson, 1974; see also Boyd & Heritage, 2006, for an analysis of the import of recipient design in history taking).

In their paper on the organization of turn-taking, Sacks et al. (1974: 727) describe recipient design as the "multitude of respects in which the talk by a party in a conversation is constructed or designed in ways which display an orientation and sensitivity to the particular other(s) who are the coparticipants." The particularizing function of recipient design operates with regard to word selection, topic selection, admissibility and ordering of sequences, options and obligations for starting and terminating conversations, and so on, and is "a major basis for that variability of actual conversations glossed by the notion 'context-sensitive'" (Sacks et al., 1974: 727). Broadly speaking, it is through the functions of recipient design that a conversation is particularized for the current occasion, with utterances—and thus actions—designed for just these participants.

A small but rich conversation analytic literature draws on detailed analyses of transcripts of actual medical encounters to document how treatment recommendations are structured by physicians and received by patients. In a series of papers describing physician–parent interactions in community-based pediatric clinics in the United States (Stivers, 2002, 2005a, 2005b, 2006, 2007), Stivers shows how physicians and parents arrive at a decision of whether or not to prescribe antibiotics for a child with upper respiratory symptoms. Among the key findings of this work are the following: 1) Recognition that the way a recommendation is designed or formulated makes a difference in terms of parent acceptance. Stivers distinguished between two primary formats for the delivery of non-antibiotic treatment recommendation—recommendations *for* vs. *against* a particular treatment—and showed how specific affirmative recommendations for treatment are less likely to engender parent resistance than recommendations against a particular treatment (Stivers, 2005a); and 2) An appreciation for how patients can exert pressure to influence physician recommendations. For example, explicit or overt parent pressuring for antibiotics, while unusual, can push physicians to prescribe antibiotics even where their appropriateness is questionable (Stivers, 2005b, 2006), and implicit or passive parent pressuring (including through withholding of acceptance of a recommendation) can also lead physicians to alter or reverse their recommendation. Taken as a whole, what becomes evident is that treatment recommendations are not necessarily just 'handed over' for patients to either accept or reject, but rather decisions about treatment are negotiated in and through the interaction.

Using data collected in general medicine and oncology clinics in a Midwestern American city, Costello and Roberts (2001) and Roberts (1999) demonstrate how the negotiation of treatment recommendations (or 'treatment plans' for these authors) is a function of the tendency in routine, everyday talk to minimize disagreement and to maximize agreement. When patients accept (i.e., agree with) a recommendation, no further conversational work is required, the topic can be closed and the participants can move towards completing the visit. However, when patients hesitate, only mildly agree with, or overtly resist (i.e., disagree with) a recommendation, physicians do work to manage this disagreement, including reformulating the recommendation or continuing to present evidence to justify their recommendation. In other words, through their acceptance of, or resistance to, a treatment recommendation, patients play an active part—are agents—in shaping (i.e., negotiating) those recommendations.

These works by Stivers, Roberts and Costello challenge traditional views of physician-patient asymmetry (with physicians as experts who make recommendations which patients then assess, agree with or refuse; but see Heath, 1992). Rather, these authors consider medical recommendations as joint, interactional accomplishments, highlighting in particular how through their *responses* to recommendations, patients ultimately shape those recommendations. Beyond the overarching themes mentioned above, this paper also contributes to the understanding of treatment recommendations by moving the focus of analyses further upstream, to demonstrate how patients contribute to the joint accomplishment of recommending not only once a recommendation is *given*, but also by influencing how recommendations are designed *from the beginning*. Evidence of recipient design considerations in surgeon recommendations display an awareness of what particular patients are anticipating or seeking: because each patient arrives at their orthopaedic surgery consultation with his or her own expectations, presuppositions, concerns and so on of what will transpire as a result of the consultation, and because these pre-existing orientations are displayed with varying degrees of explicitness, the ways in which surgeons can incorporate considerations of recipient design into the design of their treatment recommendations for a given patient also vary. In this manner, these findings provide further evidence of how both the "rendering and reception of the recommendation are conversational achievements" (Roberts, 1999: 108).

Data and method

Our data consisted of audiotapes of office visits between 121 patients and 14 orthopaedic surgeons at 2 academic hospitals in a major Canadian city. These visits were recorded between January 2007 and April 2008. Patients are mixed with respect to sex (59 females, 63 males), ethnic background (73 Caucasian/European, 12 Black, 25 Asian and 12 of other ethnicities) and socioeconomic status (28 with high school education or less, 94 with greater than high school education). All surgeons are male, 8 of Caucasian/European and 4 of Asian background. Research Ethics Board approval was obtained from all participating institutions and patients and surgeons gave informed consent prior to their involvement. All names and identifying references have been changed to protect participants' identities.