Chapter 1: When neurologists solicit patients’ treatment preferences: The relevance of talk as action for understanding why shared decision-making is so limited in practice

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# Abstract

Shared decision-making (SDM) is now accepted as an ideal within many healthcare systems, but research repeatedly shows that it is often not implemented as proposed by models of SDM – if at all. This is true also of soliciting patients’ preferences, which is a key element of SDM. As part of a wider, conversation analytic study of 223 recordings of UK neurology outpatient consultations, my team identified a collection of 149 turns that we called patient view elicitors (PVEs). In this chapter, I demonstrate two recurrent sequential positions in which these occurred: after the neurologist had made a recommendation or as a preliminary to doing so. Taking the view that to talk is to do something, I argue that we can see how, in both locations, the PVEs and their responses are being used in the service of other social actions. We are not, then, seeing the kind of ‘pure’ exchange of views assumed by SDM models. Rather, PVEs may work against the ideal of SDM even as they enact the requirement to solicit patients’ preferences. I argue that, by understanding talk as social action, rather than information exchange, we see why there’s such a tenacious gap between the SDM ideal and decision-making in practice.

# Introduction

Shared decision-making (SDM) is now accepted as an ideal within many healthcare systems around the world – including the UK’s National Health Service (NHS), where the present study was conducted. Although there is a range of definitions (for reviews, see Bomhof-Roordink et al., 2019; Makoul & Clayman, 2006; Moumjid et al., 2007), SDM can be described, most simply, as patients and clinicians working together to decide on the best care plan for the individual (Rake et al., 2022). Core to this process is eliciting the patient’s “personal perspective on their health, based on the individual’s context, values, and preferences” (Rake et al., 2022, p. 2860). Although this may sound straightforward, a recent systematic review found low levels of “personal perspective elicitation” across almost 100 empirical studies of decision-making in clinical practice (Rake et al., 2022, p. 2860). Such studies are important for highlighting the gap between SDM as an ideal and what happens in real decision-making interactions. However, this entails largely a focus on failure. We can read this focus – in line with the theme of this edited collection – as a concern about the failure of long-standing attempts to (re)socialise clinicians from a more ‘paternalistic’ approach to a more ‘collaborative’ one. This concern is significant, given the moral case for SDM (see Stiggelbout et al., 2015). However, the focus on failure leaves us with a very important question: what happens, interactionally, when clinicians *do* enact one or more of the elements of SDM? In this chapter, I address this question with respect to eliciting patients’ views. I argue that, by seeing what talk about patients’ views is used to do, ‘in the wild’, we gain a much better understanding of why the ideal of SDM is so difficult to implement consistently in practice.

I take a conversation analytic (CA) approach, which means that I start from the understanding of talk as social action; in other words, talk is a means to do things. This contrasts starkly with the widespread model of talk as a mechanism for information exchange (see Drew, 2005; Schegloff, 1996). The latter perspective maintains a focus on *what* gets said. For instance, Rake et al.’s (2022) systematic review also found that, on the rare occasions when patients’ perspectives were elicited, clinicians asked only about physical health, leaving social or psychological matters unaddressed. Moreover, they seldom went on to integrate what was discussed into the patient’s care plan. Again, then, we have some important insights into failures to enact the ideal of SDM. What we do not know, is what clinicians and patients are *doing* when they do talk about the patient’s views.

The analysis presented in this chapter builds on a rare exception in the literature. Using CA, Landmark et al. (2017) investigated how clinicians in a Norwegian teaching hospital talked about patients’ treatment preferences. They identified an interactional practice that involves the clinician formulating a hypothesis about the patient’s preference and then making a treatment option contingent on that preference (i.e., “If you think X + we/you can do Y”) (p. 2081). These hypotheses could be framed in different ways, but, in all cases, the hypotheses were used in a sequential context where the patient had already indicated some resistance to a recommended option. The practice was thus typically used to try to secure acceptance of what the clinician thought was best. Positively framed hypotheses were used to promote the clinician’s already stated recommendation, e.g., “If you have a bit of patience and could wait…” (p. 2084), followed by another version of the original recommendation. Negative framing was used to present an alternative to the recommended treatment, but in such a way as to discourage the patient from choosing it, e.g., “If you are very impatient then…” (p. 2084), followed by an option that was presented as less optimal than the recommended option. Even the more neutrally framed hypotheses could be embedded in a complex turn that was tilted towards acceptance of the clinician’s recommendation. “The effect”, Landmark et al. argue, “is a communicative ‘double bind’” (p. 2086): even as the clinicians were ostensibly offering a choice, they were simultaneously presenting the patient’s (resistant) position as sub-optimal relative to their own.

Landmark et al.’s (2017) study exemplifies what’s to be gained by studying decision-making ‘in the wild’. By focusing on the situated practice of talk about patients’ perspectives, they go beyond the binary question of whether or not such talk occurs. By understanding talk as action, they show how, even when it does occur, such talk may not have the effect of truly enacting the SDM ideal. In this chapter, I take up their call for more fine-grained analysis of how patients’ views are discussed in practice. Also using conversation analysis – but with a much larger dataset – I show that patients’ views may be elicited in two recurrent sequential locations: i) in post-recommendation position (i.e., after a treatment recommendation has already been made); and ii) in pre-recommendation position (i.e., just prior to a recommendation that is projected to be forthcoming). The first of these accords with Landmark et al.’s findings: I show how a patient view elicitor (PVE), when it comes after a recommendation, may be heard as pursuing the *clinician’s* preferred option. The second of these offers some novel insights: I show how, by seeking to establish the patient’s preferences as a first step in the decision-making, clinicians can avoid the double bind that Landmark et al. highlighted. However, I also show how PVEs used in pre-recommendation position have their own limitations with respect to enacting the SDM ideal. I conclude by discussing an evidence-based solution to these challenges and by reflecting on what the idea of talk as action can contribute to our understanding of why SDM is so hard to enact in practice.

# Data, Methods, and defining ‘patient view elicitors’

The analysis reported in this chapter arises out of a wider, collaborative study, funded by a grant from the UK’s National Institute for Health Research. Our team recorded 223 neurology consultations in two large neuroscience centres in the UK in 2012. The primary aim of the study was inductive: we employed conversation analysis to identify the practices used by neurologists to offer patients choice and the interactional consequences thereof. Following our foundational CA work, we coded for the interactional practices we had identified. This allowed for statistical claims about their relative use across our dataset (for our project reports, see Reuber et al., 2015; Reuber et al., 2018).

Our team included conversation analysts and neurologists, working in close collaboration. Thus, although our starting point was always the recorded interactions, our focus was guided, from the start, by what practitioners themselves experienced as challenging in their day-to-day encounters with patients. This drew our attention to their experience of dual demands, which are not always easy to reconcile: on the one hand, neurologists are expected to use their expertise to make patients better (or at least better able to cope with chronic conditions); on the other hand, they are also expected to empower patients to make their own decisions about their care. Our focus on how ‘patient choice’ plays out in real decision-making sequences thus arises out of the lived experience of practitioners, rather than an abstract interest. At the same time, our specific findings have emerged from what’s observably happening in the give-and-take of real decision-making sequences, captured ‘in the wild’ (see Ikeya, 2020, for more on this ‘hybrid’ approach to ethnomethodological work).

The neurologists in our dataset oriented to patients’ right to choose in a variety of ways. We coined the umbrella term ‘patient view elicitor’ (PVE) to capture a range of turn designs that we identified, inductively, within our recordings. What holds them together is that they serve to *explicitly invite* the patient to express a preference, their thoughts or feelings about a treatment, medical investigation, or referral option. These include open formats (e.g., “What do you think of that”) and closed formats (e.g., “D’you want to try some steroids”). The term PVE is akin to what Rake et al. (2022) call “personal perspective elicitation”, which they define as:

The disclosure (either elicited by the clinician or spontaneously expressed by the patient) of information related to the patient’s preferences, values, and/or context, that are potentially relevant to the process of decision-making (p. 2861).

Like Rake et al. (2022), I recognise that patients’ perspectives can be woven into the decision-making in a host of subtle ways, not all of which depend on the clinician’s active solicitation. For instance, in their CA study of how clinicians broach whether to undertake cardiopulmonary resuscitation (CPR) with older patients admitted to a Swiss-francophone hospital, Sterie et al. (2022) showed how even pronouncements (Stivers et al., 2017), strongly in favour of CPR, can be done in a way that “highlight[s] the role of the patient in the decision process” (p. 889). This accords with a long-standing line of research in CA showing how patients can influence decision-making even through passive resistance (see Stivers, 2005; Koenig, 2011). I agree entirely with these important observations. However, if we are to understand what happens when clinicians demonstrably enact elements of SDM, then there’s value in distinguishing between *recommending* and *patient view eliciting* as approaches to decision-making. While different recommendation formats will certainly encode varying degrees of pressure for the patient to accept what the clinician thinks is best, recommendations set up a slot in which acceptance of the clinician’s treatment preference is the interactionally preferred response. By contrast, patient view elicitors set up a slot in which the decision is explicitly made contingent on the patient’s preference (Toerien, 2021). Thus, I would not code pronouncements like “so uh… if there’s a problem with uh: the heart or something general… we resuscitate you” (Sterie et al., 2022, p. 998) as a patient view elicitor, even though I agree with Sterie et al.’s (2022) analysis that such a turn requires the patient’s validation. Similarly, this chapter will retain our term – ‘patient view elicitor’ – to avoid broadening our focus to the spontaneous disclosure of a preference by the patient, as captured by Rake et al.’s (2022) term. Our focus, in other words, is firmly on what happens when clinicians actively seek to solicit patients’ views.

In line with studies using other methodologies, we found that the neurologists in our dataset were far more likely to recommend a treatment than to offer the patient a choice. Nevertheless, from 623 instances that we coded as decision-points about a treatment, referral or investigation, we were able to build a collection of 149 turns that met our definition for a patient view elicitor (Chappell et al., 2018). It is this collection that I draw on in the present chapter. In the two analytic sections, below, I focus on two recurrent locations where these PVEs occurred: in post-recommendation and pre-recommendation position.

# Analysis

## Soliciting the patient’s treatment preference in post-recommendation position: a means to pursue acceptance

One recurrent position in which neurologists sought patients’ treatment preferences in my dataset was *after* they had made a recommendation. Unavoidably, due to their sequential placement, PVEs in post-recommendation position can only be understood by reference to the (often extensive) decision-making sequence that comes before them. It is thus only practical to work through a single, illustrative case in this section. For clarity, I have divided the example into three consecutive parts (shown in Extracts 1a-c[[1]](#footnote-1)). These map onto three key moments in how the neurologist directs the decision-making, which can be summarised as follows:

1. The neurologist initiates the decision with an option-list, laying out a choice between two alternatives (Extract 1a);
2. He then shifts to a recommendation, indicating his preference for the first option (Extract 1b);
3. Having failed to secure the patient’s acceptance of his recommended treatment, he pursues with another recommendation (Extract 1c).

In the rest of this analytic section, I will track through these key moments, showing that the patient does reveal her treatment preference and the neurologist does explicitly seek her views. Thus, some of the ‘machinery’ of shared decision-making can be seen in operation in this example. However, by examining how this ‘machinery’ works in practice, we can see how the discussion of the patient’s preferences is being done in the service of other social actions: resisting the neurologist’s recommended option and pursuing the patient’s acceptance of that option.

The patient in our example has possible multiple sclerosis (MS) and has described some difficulty with climbing stairs. Just before Extract 1a, the neurologist has reminded the patient of some recent test results, sent to her by post. These suggest she is at risk of further inflammation, but the diagnosis is not yet definite. The test results thus lay the groundwork for decision-making, but do not indicate a definitive next step with respect to treatment. We join the consultation as the neurologist indicates that there is, rather, a choice: “two ways of dealing with this” (l. 1). Using an approach that we have called option-listing (Toerien et al., 2013; Toerien et al., 2018), he lays out two possibilities: she can take a short-term course of oral steroids, which can help MS patients to recover more quickly following a period when their symptoms have worsened; or she can be referred to an MS specialist who may be able to recommend other forms of treatment. By setting up the decision with an option-list, the neurologist appears to be opening a slot for the patient to consider which of these alternatives she may prefer. This is evident also in how he makes the steroid option contingent on her *self*-assessment of her current condition (l. 2-6), using the same format identified by Landmark et al. (2017): “If you think X + we/you can do Y” (p. 2081). By the end of Extract 1a, then, the neurologist has laid a foundation for discussing the patient’s preferences, as many SDM models suggest should occur.

Please note that, in all the transcripts, ‘Neu’ refers to the Neurologist and ‘Pat’ to the Patient. The code for each extract indicates the location of recording (‘S’ for site 1, ‘G’ for site 2), the unique patient ID (first three digits) and the unique neurologist ID (last two digits).

Extract 1a (G01805)

01 Neu: And there’s two: ways of dealing with this,

02 (0.2) If you: don’t feel that things are (1.2)

03 absolutely back to normal,=if you still feel

04 that you’re inhibited a wee bit (0.2) in this:.

05 .hh then I can (0.3) give you some (0.3)

06 steroid treatment for a short while,

07 Pat: **Mhm,**

08 (0.9)

09 Neu: .tchhh and we could see how you (1.0) do after tha:t,

10 Pat: **Yeah.**

11 (0.7)

12 Neu: Alternatively I could arrange for you to be seen by one

13 of our (0.5) MS specialists.

14 Pat: **Uhuh,**

15 (0.4)

16 Neu: Er get them to see you and see if they think that the

17 (2.1) inflammation=the cha::nge in the signal. (.)

18 would benefit from some (0.5) other forms of treatment.

19 (0.4)

20 Pat: **Mhm.**

Throughout Extract 1a, the patient only produces minimal responses (see turns in boldface). There is good evidence from the prior literature that minimal responses are typically understood as a form of passive resistance in response to treatment recommendations (Koenig, 2011; Stivers, 2005). However, I would caution against assuming that the same applies in response to option-lists. Not only would it be premature for the patient to accept the first option before hearing the second (e.g., at l. 7), but we found that, when options were listed, patients generally waited for an explicit slot to voice their views – even when they went on to choose without any interactional trouble (Reuber et al., 2018). This slot was created with a patient view elicitor. In Extract 1a, this could have come at line 19 or after the minimal turn at line 20. However, as Extract 1b shows, this neurologist changes tack. Having started with an option-list, he now makes a recommendation for the first option: steroids (l. 21-24). He justifies this based on the patient’s prior report of a symptom: “having difficulty with the< stai::rs,” (l. 23-24). This recasts the optionality introduced in Extract 1a (l. 2-6) as something that hehas already assessed: she is not “absolutely back to normal” and thus treatment “make[s] sense” to *him* (l. 24). There is, then, a shift from foregrounding the relevance of the patient’s preference (in Extract 1a) to foregrounding his own (in Extract 1b).

Extract 1b (G01805)

21 Neu: Rec 🡪 .Hhhh Now no matter what happens (0.3) I think

22 🡪 a short course of steroids may well be helpful=

23 🡪 >If you’re having difficulty with the< stai::rs,

24 🡪 .hh that would make sense to me.

25 (0.5)

26 Neu: Pur 🡪 Is that absolutely essential, no it’s not.

27 (0.5)

28 🡪 But I think if you’re tellin’ me that you

29 🡪 h’ve problems on the stai::rs,=

30 Pat: **=It’s j’s:t (.) you fee:l the tingles more**

31 **(0.1) [doctor.**

32 Neu: [(Mm)

33 Neu: °Oka[y,°

34 Pat: **[Um: (0.5) and obviously if I’m carrying=**

35 **which I always am carrying heavy bags ‘cos**

36 **(of-) (.) I work security so .hh I’ve also**

37 **got the horses .hh so I’ve always got a big**

38 **bag with me with either my uniform in it,**

39 **(0.2) or my,**

40 Neu: Mhm,

41 Pat: **horsey clothes in it, .hhh so if I’m carrying**

42 **bags of shoppin’ I just (0.2) by the time I get**

43 **up (0.2) to (the top) flight of stairs I’m startin’**

44 **to (0.4) feel the pre:ssure a wee bit, (0.2) but**

45 **I mean it’s no: (1.0) cripplin’ or sto:ppin’ me or**

46 **anything but-**

47 Neu: °Right.°

48 Pat: **I’m awa:re of it, put it that way.**

49 Neu: °Okay.° .h[hh

50 Pat: **[I’m aware of it.**

The patient makes no immediate vocal response to the recommendation (l. 25). Since she declined permission to video record, we cannot tell if there was a non-vocal response. However, we can see the neurologist treating this as passive resistance through his pursuit of acceptance (Stivers & Timmermans, 2020). Although he retains the optionality of treatment (l. 26), he works to persuade the patient, again drawing on her reported symptom (l. 28-29). The patient now responds, resisting the treatment recommendation in two ways. First, she minimises the symptom, both with the use of “j’s:t” and by formulating the symptom as one of “fee:l[ing] the tingles more” (l. 30). This downgrades the trouble from a practical limitation (struggling to climb stairs) to a sensory experience – and a mild one at that (suggested by the word “tingles”). Second, she normalises her experience: the stairs present challenges because she’s “carrying heavy bags” (l. 35), implying that the problem is one that anybody might experience and thus is not treatment-relevant. She also further minimises the symptom: it is only when she “get((s)) up (0.2) to (the top) flight of stairs” that she feels anything untoward; even then, she’s only “startin’ to (0.4) feel the pre:ssure a wee bit” (l. 43-44). Like “tingles”, “pressure” does not index pain. Finally, she explicates the lack of impact on her daily routine: “it’s no: (1.0) cripplin’ or sto:ppin’ me or anything” (l. 45-46) (see Toerien, 2021).

Here, then, we have evidence of an exchange of preferences: the neurologist is in favour of steroids while the patient appears not to be. However, to think of this only as an exchange of *information* is to neuter it of its interactional import. The neurologist’s preference has been articulated as a recommendation for treatment, with persuasive work done to tilt the recommendation quite strongly in favour of acceptance (l. 21-29). The patient, likewise, is doing interactional work across her extended telling at lines 30-50. By detailing her experience of climbing stairs, she is countering the neurologist’s assessment that steroids are indicated. Subtly, without any outright disagreement, she is resisting the neurologist’s recommendation. What we have here is not a ‘pure’ exchange of views. This is better understood as a pair of social actions: recommending and resisting treatment (see Stivers, 2005).

Extract 1c shows how the neurologist handles this resistance. At first it seems as if he’s going to seek the patient’s view of some proposed plan (projected by the “How about” at the start of his turn). However, he self-repairs (note the use of “>I mean” on line 51), the effect of which is to shift back into doing recommending: again, where he first seemed set on foregrounding the relevance of the patient’s view, he instead shifts to foreground his own. While he continues to orient to the option of doing nothing (l. 56), thereby implicitly acknowledging the patient’s apparent preference, he counters this with a repeated justification for steroids. He also tilts this second recommendation in favour of acceptance by further minimising what’s involved: the option of “some (0.3) steroid treatment for a short while” (l. 5-6, Extract 1a) is transformed into merely “*a wee trial* of a >short course of steroids<” (l. 57-58, Extract 1c, emphasis added). He self-labels his action as providing his “take on this” (l. 55) – as opposed, say, to issuing a directive to the patient (Enfield & Sidnell, 2017). While this suggests an openness to the patient’s ‘take’, in its sequential context, this contrasts with what the patient has already said (l. 30-50). He is, then, voicing a contrastive position with the patient’s normalising of her experience on the stairs. The work being done here is thus to (further) pursue acceptance of his prior recommendation for steroids. What’s relevant at line 59, then, is the acceptance that has thus far been absent. When the patient does produce a response (l. 60), it is only to make a minimal acknowledgement. In this sequential context – where a treatment recommendation has been pursued with persuasive work by the neurologist – such a response is inadequate for acceptance and is thus understood as a form of passive resistance (Koenig, 2011; Stivers, 2005).

Extract 1c (G01805).

51 Neu: How about (0.9) (uh-)/(I-) >I mean I< (m-)

52 think that whether or not you’re seen by the

53 Rec🡪 MS specialist,=I think if that, (.) if the- if

54 🡪 these are affecting you, if these are affecting

55 🡪 what you’re doing:. my take on this would be:

56 🡪 (0.2) could we leave it alone, yeah we could.

57 🡪 .hh But I think a wee trial of a >short course

58 🡪 of steroids< would >make a bit of< sense to me:.

59 (0.4)

60 Pat: Mhm,

61 (0.4)

62 Neu: PVE🡪 How d’you feel about that,

63 (1.0)

64 Pat: **Yeah,**

65 (0.2)

66 Pat: (mhh.)

67 (0.3)

68 Neu: °Okay.°

69 Pat: **I think,**

And so, we finally come to our target turn: the patient view elicitor (PVE) at line 62. A binary, check-list appraisal of the neurologist’s practice might simply note that he has indeed sought her preferences; he has even done so with an open-ended question: “How d’you feel about that,”. However, the work being done here would be misconstrued without taking account of the longer decision-making sequence that has come before: the option-list and recommendation, the patient’s resistant narrative (about the stairs), and the neurologist’s pursuit with another version of his recommendation. It is against this backdrop that we must understand the work that the patient view elicitor is doing: further pursuit of the patient’s still missing acceptance. The neurologist is creating another slot for her to respond in the context of a prior response that was too minimal to allow him to treat the decision-making as closed (see Stivers, 2005). In overtly seeking the patient’s feelings about steroids, the neurologist is not neutrally creating a slot for her to voice an as-yet not known in common treatment preference. He has already displayed an understanding that she’d prefer not to take steroids and has sought to persuade her otherwise. What he is seeking, then, is a *change* in her stated preference.

This helps us to understand the patient’s apparently unfitted response to the PVE (l. 64).

The delayed “yeah” does not align with the action agenda conveyed by the question’s design (Boyd & Heritage, 2006); she does not (now) reveal her feelings about treatment. Instead, what this turn does is to (finally) grant the neurologist his pursued acceptance. Thus, the patient displays her understanding that, in this sequential position, the PVE is no ‘neutral’ question, designed purely to solicit her treatment preferences. Following the lengthy delay (l. 63), her acceptance is hearably reluctant, and is further cast as uncertain, with the increment “I think,” (l. 69). Nevertheless, the neurologist treats this as adequate, going on to explain that he will write to the patient’s GP, who will then prescribe a specific tablet (data not shown). This reflects the system in the UK’s NHS, where the GP typically manages the patient’s treatment, even if they are receiving input from a secondary care consultant (such as a neurologist). It is worth noting that they also agree that she will be referred to a specialist (data not shown) – thus, what began as an apparently either/or choice between steroids or a referral becomes a yes/no decision with respect to each of the two options.

This was a lengthy case to work through; I hope that the way I have broken it down has helped to clarify what we gain from understanding both parties’ interactional moves in their wider sequential context. To sum up, I have tried to show how talk about patients’ treatment preferences – a key element of many models of shared decision making – may be done in the service of other social actions. If we think of the patient view elicitor from this interactional perspective, then we see how it can sometimes serve less as a mechanism for sharing a decision, and more as a tool for pursuing the neurologist’s preferred option.

This is not meant to imply that the neurologist is doing anything wrong. While the patient may be seeking to avoid a treatment she does not want, the neurologist has a duty of care to ensure she understands its potential value. This is part of his institutional role – arguably, even more prominently so than the expectation that he enact SDM (see Pilnick & Dingwall, 2011). My point is not that the neurologist necessarily ought to have done otherwise. Rather, this kind of analysis highlights why it may be profoundly *difficult* to do otherwise, even after decades of clear guidance on the principles of SDM. There is a mismatch between the inevitable abstraction of such guidance and the doing of real interactional work. When seeking patients’ preferences ‘in the wild’, clinicians are not doing so in the abstract; they are doing so in the service of trying to accomplish the project of medicine: treating the patient (see also Pilnick, 2022). As our example illustrates, the PVE can work, in post-recommendation position, to secure acceptance of a treatment option that has been previously resisted. The PVE can be understood, then, as an effective tool for pursuing the neurologist’s duty of care even if it is not so effective, in this context, for enacting SDM.

# Soliciting the patient’s treatment preference in pre-recommendation position: ‘testing the water’

One implication of the prior section is that sequence really matters. As we saw, a patient view elicitor may be heard as a pursuit of acceptance if it is positioned *after* a recommendation. So, what happens if it is used *before* any recommendation is uttered? In this section, I explore examples from our dataset where neurologists initiated the decision-making sequence by seeking patients’ preferences – as a first step.

Extract 2[[2]](#footnote-2) provides a clear example. This patient has already been seen by another neurologist for her headaches, which they believe to be migraines. However, because she has another neurological condition, the two neurologists have consulted each other. As the neurologist explains to the patient near the start of the recorded appointment: “we had a chat and I said ‘well just in case something’s brewing, one of us ought to see her again’”. In other words, this consultation is at the neurologist’s invitation rather than the patient’s request, and the main priority is diagnostic: to ensure that her headaches are only migraines, rather than an indication of something more serious.

As it turns out, the neurologist agrees with her colleague that the patient experiences migraines. The question then arises of what to do about them. Although preventative treatments are available, whether they’re worth taking is generally deemed to be a preference-sensitive decision because they can have side effects and typically only reduce the number of migraines experienced, rather than controlling them entirely. In my dataset, it was thus usual for neurologists to offer patients a range of possible migraine treatments – often using extensive option-lists. What distinguishes the decision in Extract 2, is that the neurologist launches the entire decision with a patient view elicitor. Before introducing any treatment information, she asks a question that seeks the patient’s treatment preference (l. 9-11). The question also gives a basis for deciding: symptom frequency (l. 9-10). This is akin to the first offer of steroids in Extract 1a (l. 2-6) in that the option is made contingent on the patient’s self-assessment. However, it differs both in its design and sequential placement. As we have seen, the offer of steroids was initially part of an option-list, making it reasonable for the patient to wait for the second option before expressing a view. The offer of steroids was also designed using an ‘if-then’ declarative format (i.e., more like an informing than a request for her views). In Extract 2, by contrast, the patient is asked to consider just one option, and this is presented using an interrogative format. There is, then, substantially more interactional pressure on the patient in Extract 2 to produce an immediate response regarding whether she wants to try treatment (see Stivers & Rossano, 2010). Although displaying some hesitancy, she indicates a preference for treatment at line 13.

Extract 2 (S08504)

01 Neu: Um a::nd you know e:::r some people find it’s:: (.)

02 certain (mex-) .hh if they’re in that sort of (0.3) f::::

03 I’m gonna get (0.1) a bit of a migraine and then you eat

04 choc[olate then you get one=or

05 Pat: [Mm:

06 Neu: cheese:=um .hh but other people it- it- not true at a:ll

07 but certainly that sounds very typical

08 Pat: Nyuh::

09 Neu: PVE🡪 for a migraine aura, .hhhh A:re these >kind of< often

10 🡪 enough that you would be wanting to try:: (0.6) a drug

11 🡪 to try and redu:ce how (.) often it’s happening.

12 (0.3)

13 Pat: **.thhh U:m:: (1.1) .t (0.4) yes: I (sp-) <yeah.**

14 Neu: Yeah.

15 (0.1)

16 Neu: U::m how did=you get on with Amitriptyline before?

17 Pat: .thhh I lost the feeling in: e::r (0.1) my arms and

18 my le:gs:.

19 Neu: So it didn’t suit you at all did it,=

20 Pat: =No:. [I wasn’t- I wasn’t on it for very lon::g.

21 Neu: [Okay

In contrast to the case in Extracts 1a-c, this patient’s treatment preference has been sought *before* the neurologist has articulated a recommendation. Thus, instead of reaching back across the sequence – to try to secure the patient’s acceptance of a treatment that the neurologist has already endorsed – here the PVE is prospective in nature. It projects a forthcoming recommendation but makes this contingent on the patient’s perspective. It is thus hearable as a preliminary (Schegloff, 2007). Barnes (2018) has shown how GPs’ requests for information about patients’ prior use of medications (e.g., “what’ve you tried taking”, p. 1366) are understood as pre-recommendations when they occur after a diagnosis has been made. In Extract 2, we see an example of this at line 16. Rather than directly recommending Amitriptyline, the neurologist seeks the patient’s experience of using that drug in the past. As Barnes notes, this more cautious approach enables clinicians to “test the water” (p. 1367) before making a recommendation. They can then deal with any barriers to acceptance that the pre-sequence may reveal (such as seen in lines 17-21). The query about the patient’s treatment preference (l. 9-11) functions in the same way. It projects the possibility of a recommendation for “a drug to try and redu:ce how (.) often it’s happening” (l. 10-11) but makes this dependent on the patient’s response.

Broadly, recipients of preliminaries have three options when responding: they can give the go-ahead, block or hedge (Barnes, 2018; Schegloff, 2007). If we recognise the turn as a preliminary, we know that this has implications for what’s to come next. To take a familiar example, a friend may ask if I’m driving past her house the next morning. At face value, this is a request for information. However, if we think of this in action terms, it is understandable as a pre-request – as preliminary to a projected request for a lift. I am thus well advised to respond with that projected request in mind. If I say ‘yes’ but do not wish to grant the request, it becomes harder to then decline it (most of us have experience of doing things we wish not to do because we could not come up with an ‘excuse’ in time!). Thus, just as a response to a post-recommendation PVE is made in light of what has already occurred, a response to a pre-recommendation PVE is made in light of what is projected to be coming.

This is well illustrated by cases in which patients hedge in response to a pre-recommendation.

Extracts 3 and 4 show examples of this. Structurally, they are akin to Extract 2. In all three extracts, the PVEs (see arrowed lines) follow a discussion about a symptom the patient is experiencing. In Extract 3, we see the tail-end of a history-taking sequence about the patient’s memory problems, which could affect her work (l. 1-5), although thus far she’s benefited from her employers being “understanding” (l. 1-2). Just prior to Extract 4, the patient has reported “getting like an electric shock”, which an MS nurse has explained to her as being “li:ke mixed- mixed messages” from the brain (l. 1). Just like in Extract 2, then, here we see PVEs being used to *initiate* the treatment decision-making.

Extract 3 (S08304)

01 Pat: … and I just think I’ve been right lucky with

02 that, I thi[nk they’re (right) understanding.

03 Neu: [Okay, s o t h a t ’ s-

04 that’s- that’s >good<.

05 Pat: (.hhhh) But yeah i- it [could- it could.

06 Neu: PVE🡪 [Is- is it enough that

07 🡪 you would like (e) to see:: a psychologist.

08 (0.9)

09 Pat: **hh. U:::m well if it’d (0.1) help, I suppose**

10 **cos:: I- (1.1) I** **don’t know=would i::t.**

11 (0.1)

12 Pat: **Wh- what [would that**

13 Neu: [Well >I- I- I-< I think there’re two

14 ways of (.) helping with kind of memory problems

Extract 4 (S06204)

01 Pat: It’s probably just li:ke mixed- mixed messages.

02 (0.4)

03 Neu: Ye[ah.

04 Pat: [(You kno:[:w)

05 Neu: Pre🡪 [Ba:d enough to want to take tablets,

05 (0.[7)

06 Pat: [((Visible in-breath during this silence))

07 Pat: **Phhhhh.hhu. E:r what kind of tablets.**

08 (0.5)

09 Neu: Well (.) the sorts of drugs that work for this

10 sort of cross-wiring thing are often drugs that

11 we use fo:r >epilepsy=things like< Gabapen[tin.

Just like in Extract 2, the PVEs in Extracts 3 and 4 seek the patient’s treatment preference, making treatment contingent on their self-assessment. Coming after the expression of a trouble, these questions are hearably done in the service of another action: recommending a solution (see Shaw et al., 2015 on advice-implicative interrogatives). If they indicate a preference for treatment, then, the patients are giving the go-ahead for a more specific recommendation to be made. The patients are clearly alert to the implications of where these sequences are headed. They each respond with a hedge, which makes their go-ahead contingent on further information (see boldface turns, above). In Extract 3, the patient produces a conditional acceptance: “if it’d (0.1) help,” (l. 9). She thereby displays herself to understand what is meant by “see:: a psychologist” (l. 7), that she is willing to do so, but is uncertain about the *efficacy* of such treatment. She seeks further information as a basis for producing a fully fitted response, first countering (see Schegloff, 2007) the neurologist’s yes/no question with her own (l. 10). In the absence of an immediate answer (l. 11), she reformulates her question to an open-ended one. This seems to be seeking information, either about what the treatment would achieve or what it would involve (l. 12). In response, the neurologist starts to provide further information about treatment options. Extract 4 shows a more extreme hedge in that the patient does not express even tentative acceptance (l. 7). Rather, she produces a repair initiator, targeting the neurologist’s general reference to “tablets” (l. 5). The patient treats this as inadequate for expressing a preference. Like in Extract 3, she shows herself to require more information in order to produce the response made relevant by the PVE (Schegloff, 2007).

These examples indicate a challenge for patients in articulating their treatment preferences so early in a decision-making sequence. If they say ‘yes’, they know that a recommendation is almost certainly going to be forthcoming. However, with such limited information about what the neurologist may be offering them, it can be difficult to know whether they want the treatment. Moreover, because the neurologist has also sought their self-assessment of whether treatment is warranted by their lived experience of the symptom, if they give the go-ahead, subsequent refusal of a recommended treatment risks seeming perverse. Thus, giving the go-ahead sets up a trajectory in which refusal may be particularly hard to do. Hedging addresses this challenge and has the advantage of opening up discussion by seeking further information from the neurologist. This can lead to (a more informed) acceptance or refusal of treatment (as it does in Extracts 3 and 4, respectively, data not shown due to space constraints).

The risk, however, is that the patient might block the relevance of such a discussion. Extract 5 shows an example. The patient has been referred to the neurologist because she’s planning a gap year trip to Peru. Her GP wants a specialist opinion about the patient’s headaches before writing a letter for her insurance provider (l. 21-25). There is, then, a similarity here with Extract 2: in both cases the primary goal is to rule out a more worrying underlying explanation for the headaches; treatment is a secondary consideration. The neurologist decides to order a scan but makes it clear that this is for reassurance – he strongly suspects that she has nothing more serious than migraines (data not shown). We join the consultation immediately after the neurologist has told the patient about his own experience in Peru. At line 1, he brings them back to the business of the consultation, initiating decision-making about treatment. Like we have seen in Extracts 2-4, he uses a PVE to seek the patient’s preference (l. 4) – as a very first step in the decision-making. In this case, the relevance of the projected treatment recommendation is soundly blocked (see patient’s extended response, in boldface).

Extract 5 (G08704)

01 Neu: Erm Okay (0.4) Er right what do we do

02 about this.

03 (0.7)

04 Neu: PVE🡪 D’you want this treated,

05 (1.1)

06 Pat: **.HHH (0.2) If (it /er) I mean it does**

07 **sound like it’s probably just a migraine**

08 **I get in the night I mean I know that I**

09 **can um generally ways of (‘s) like staving**

10 **off (m-) migraines is just make sure that I**

11 **stay calm,**

12 Neu: [Mm.

13 Pat: **[Um (0.5) with my exams right now it’s a**

14 **wee bit stressful ‘cos like uni depends on**

15 **them right now but- um I know how to deal**

16 **with migraines but I didn’t know what these**

17 **were, so if I know that these- th- pretty much**

18 **are migraines (in the night), I, I know how I**

19 **can then counteract th[at.**

20 Neu: [Yeah.

21 Pat: **We were just checking that it wasn’t, she**

22 **seemed to think, w- there is, like (I) said**

23 **“if it is something more serious then I**

24 **can’t obviously write you this**

25 **[letter. So we just need to [check it out”**

26 Neu: [Mm. [Mm.

27 Pat: **But if- (1.4) the pl: most plausible thing**

28 **is, is a migraine in the night, I think I**

29 **know how can I deal with that. [Pretty much.**

30 Neu: [Alright.

31 Neu: (Now) that’s up to you.

32 (0.5)

33 Neu: Okay. (C- there-) I mean you don’t have to

34 treat this. You [can you know (you) can

35 Pat: [Yeah

36 Neu: tolerate it if you- if you must

37 Pat: Yeah.

The patient’s block is produced in three ways: first, by indicating that she already knows how to deal with her migraines (l. 8-11 and l. 18-19), second, by orienting to her current situation as exceptional (l. 13-15), and third, by indicating that the reason for the consultation was primarily diagnostic (l. 16-17). She expands on the third point after the neurologist’s minimal response (l. 20), formulating the consultation as “just [to] check” that her symptom was not “something more serious” (l. 21-25) and primarily for bureaucratic purposes. Since the ‘check’ has already been handled by the neurologist’s recommendation to scan, the purpose of the visit, from the patient’s perspective, has been fulfilled. She completes her turn with a version of how she began: if the diagnosis is migraines, then she already knows how to handle her condition (l. 27-29).

Having tested the water with a turn that made the decision entirely contingent on the patient’s treatment preference (“D’you want this treated,” l. 4), the neurologist now has no interactional basis for making a recommendation. As Landmark et al. (2017) note, clinicians may make recommendations even in such inauspicious sequential environments. However, in this case, he does not. He maintains the preference-sensitive nature of the decision – “that’s up to you.” (l. 31) – and only hints at an alternative view through the way he formulates the option of not treating (l. 33-36). This is suggestive of the advantages of treatment (not having to “tolerate” the headaches) and the use of “must” seems to imply a kind of perversity to the patient’s stance, given that treatment is available. However, he does not produce a recommendation for treatment. It seems likely that this approach to the decision is (subtly) oriented to the unsolicited revelation, during the history-taking, that the patient “doesn’t like taking medication” (data not shown). This was announced by the accompanying other (possibly, the patient’s mum), as an account for the patient’s use only of paracetamol, which the neurologist characterises as “not taking anything for it really”. Explaining that this is due to a bad experience in hospital, the patient uses an extreme case formulation (Pomerantz, 1986): “I don’t like taking pills unless it’s absolutely necessary. And I’m like dying or something”. Thus, the patient’s preference against treatment has been ‘in the air’ since before the possibility of prescribing was broached by the neurologist (see also Britten et al., 2004). The PVE, used in pre-recommendation position, is thus well fitted to handling the treatment decision-making in this case; it offers a means to approach the decision cautiously, demonstrating that the neurologist has paid attention to the patient’s general preference against medication.

The neurologist goes on to remind the patient that she can see him again if she changes her mind (data not shown). However, no further treatment information is provided. The absence of any attempt to persuade the patient to consider treatment is in line with her right to decline treatment, with the preference-sensitive nature of this decision (there is no research evidence to suggest that migraines are associated with damage to the brain), and with the primary, diagnostic purpose of this consultation. However, since her block has effectively shut down the discussion, it remains unclear as to whether the patient is aware of the wide range of treatment options available for migraines. While she may have made a more autonomous decision than the patient in Extracts 1a-c – since she is not revealing her preference *in response* to the neurologist’s – here it is not possible to judge whether the decision is an informed one (see also Sterie et al., 2022).

To sum up, this section has explored what happens when patient view elicitors are used to initiate a decision-making sequence. Just as we saw with respect to post-recommendation PVEs, these pre-recommendation PVEs are being used in the service of another social action. In this preliminary position – like Barnes’s (2018) preliminary questions about the prior use of medicines – they can serve to ‘test the water’ for a potential recommendation. This overcomes one possible barrier to shared decision-making. Since clinicians are typically oriented to as having greater knowledge in the medical domain (Heritage, 2005; Landmark et al., 2017), clinician and patient do not exchange views from a level ‘playing field’. Thus, if a patient’s views are sought after a treatment recommendation, they are in a particularly challenging position if they wish to refuse treatment: not only is it generally interactionally delicate to disagree (Clayman, 2002), but this is compounded by their respective institutional roles. To disagree in post-recommendation position, the (lay) patient must go against an expert’s opinion. PVEs in pre-recommendation position give the patient a slot to indicate their preference at the very first opportunity. They may be seen, therefore, as a tool to support shared decision-making (see also Barnes, 2018). As this section has shown, however, the use of PVEs in this pre-recommendation position also carries risks. Not only is the patient having to voice a view at a point where they may know little about the treatment option(s), but if they block the relevance of a recommendation, they may leave without really knowing what it is they have turned down.

# Discussion

Addressing the recurrent finding of a gap between practice and the widespread ideal of shared decision-making, this chapter has argued for the value of examining decision-making ‘in the wild’. Taking a conversation analytic (CA) approach, we go beyond the binary question of whether or not some element of SDM has been enacted in a consultation, to the interactional question of what happens when it is enacted. In this chapter, I showed that the neurologists in my dataset actively elicited patients’ views in two sequential locations: following a recommendation and as a preliminary to making a recommendation. In line with Landmark et al. (2017), I showed how clinicians’ recommendations may “interfere with the SDM process” (p. 2086). Even as they appeared to be enacting a core principle of SDM – by discussing patients’ treatment preferences – they were actually doing other interactional work: they were trying to secure acceptance of their own preferred option. Thus, post-recommendation PVEs may achieve a goal that is important for doing medicine: securing the patient’s acceptance of a recommended treatment. However, this may come at the expense of doing SDM. Using a PVE prior to making any recommendation offers a solution to this problem as the patient’s views are sought right from the start of the decision-making sequence. As I have shown, this approach is not trouble-free either, as the patient may lack the resources needed to formulate an informed view.

My analysis of PVEs in these two naturally-occurring locations thus raises a dilemma for communication training in how to seek patients’ treatment preferences. If we advise clinicians to provide information about the option(s) first (as in Extracts 1a-c), the risk is that they do so in a way that conveys their own view. Patients will then be responding in a sequential slot where they must take account of that view. If their views differ, they will have to handle the delicate task of disagreeing with an expert. If we propose – as the solution to this – that the clinician should seek the patient’s views first (as in Extracts 2-5), then patients may not be able to engage in informed decision-making (see also Reuber et al., 2015).

Grappling with this dilemma, I came to see full-form option-listing as a good solution. This is an approach to decision-making that also occurred naturally in our dataset – although rarely (Chappell et al., 2018). It involves three key steps, which I have summarised in our training for clinicians using the acronym ALF:

Announce that there’s a decision to be made

List the options and relevant information about each (e.g., pros and cons)

Find out what the patient thinks about the options (to access the training, see NICE, 2021).

These steps address the pitfalls, for achieving SDM, identified in the present chapter with respect to using PVEs. The initial announcement that there are legitimate options not only indicates that the decision has yet to be made (thus holding choice open), but also creates space for doing information provision in its own right. For instance, in one of our clearest cases, the neurologist initiates an option-list as follows: “Possibilities. (0.9) .tch Okay let me talk through these.” (Toerien et al., 2018, p. 1254). In so doing, he not only projects a list of options, but explicitly formulates what is to come *as informing* rather than recommending. Having set up the activity in this way, the list of options then allows the clinician to give the patient information. In so doing, the patient gains an evidence base for formulating a treatment preference – the very thing that may be lacking if a clinician seeks the patient’s views first. By following the list immediately with a patient view elicitor, clinicians can explicitly seek the patient’s views *before* articulating their own. In this way, they can decrease the pressure on the patient to align with an expert opinion, the problem that we saw so clearly illustrated in Extracts 1a-c. Full-form option-listing, then, has the potential to resolve the dilemma outlined above (Reuber et al., 2015).

My initial plan for writing this chapter was simply to set up the dilemma and then propose full-form option-listing as the solution. However, as I engaged more closely with the theoretical SDM literature on patients’ preferences, I was troubled by just how similar this solution is to Stiggelbout et al.’s (2015) four-step model of SDM:

1. The professional informs the patient that a decision is to be made and that the patient’s opinion is important;

2. The professional explains the options and the pros and cons of each relevant option;

3. The professional and patient discuss the patient’s preferences; the professional supports the patient in deliberation;

4. The professional and patient discuss patient’s decisional role preference, make or defer the decision, and discuss possible follow-up (p. 1173).

Although some elements of their model were largely absent from our dataset (e.g., the neurologists seldom explained the importance of the patient’s opinion or discussed whether they wished to make the decision), our inductive discovery of full-form option-listing accords closely with their four steps. Also in line with our findings, Stiggelbout et al. (2015) concluded that there is only limited evidence of their model occurring in practice. Thus, they provide detailed explanation of the steps, along with suggested phrases that may be used to implement them. The intended audience is practitioners themselves, the aim being to reduce the gap between the SDM ideal and observed practice.

As a conversation analyst, I have been socialised to be sceptical about “communication propositions” (Stiggelbout et al., 2015, p. 1174) that arise out of models rather than close analysis of how interaction works in practice. Thus, Stiggelbout et al.’s (excellent) paper made uncomfortable reading for me. While, by definition, any model must be ‘abstracted’ from the nitty-gritty of specific moments of talk-in-interaction, SDM theorists tend to take account of two crucial features of how interaction works: that precisely *how* and *when* a turn is produced in a sequence of talk really matters. It matters for how the turn is understood (e.g., as a choice or not, see Toerien et al., 2018); and it matters for what subsequently happens in the interaction, including, for instance, whether the patient ultimately leaves with a prescription despite indicating that they do not want one (Toerien, 2021). This twin recognition is built into Stiggelbout et al.’s model, not only in their detailed examples, but in their insistence on a particular conversational sequence for achieving SDM – hence a set of numbered steps. They also offer more fine-grained advice on sequencing. For instance, they tell clinicians to “*first* mention the options explicitly” (p. 1175, emphasis added) before discussing patients’ preferences.

In effect, we had reached similar conclusions by different routes. My team started with what actually happened in a set of clinical encounters and then derived training implications from our analysis of how ‘choice’ played out. Stiggelbout et al. (2015) started with a model of SDM and then assessed the extent to which it is implemented. That we came to similar conclusions about how to advise clinicians is perhaps cause for celebration – at least, we achieved triangulation! However, I had spent long hours figuring out, inductively, that neurologists were (sometimes) enacting a kind of reduced version of SDM in their interactions with patients. I was left wondering: what (if anything) is the added value of our approach? The answer, I think, lies in CA’s understanding of talk as action.

If we think about patient view elicitors (PVEs) in terms of *social action*, then we can see these as functional for engaging in a larger activity that is central to clinical practice: deciding on treatment. This activity is integral to achieving the overarching project of many medical consultations: addressing the patient’s presenting problem (Robinson, 2003). In a nutshell, that is what the doctor is typically there to do. When clinicians seek patients’ preferences, they are not doing so in order to achieve some sort of ‘pure’ exchange of views. They are doing so in the service of accomplishing that project. If they have a clear opinion on what is best for the patient – but the patient thinks otherwise – they might use a PVE to pursue acceptance, while maintaining an orientation to the patient’s (legal and moral) right to choose. If they have reason to approach a recommendation cautiously, they might use a PVE to test the water, a practice which can help avoid resistance altogether (Barnes, 2018). In short, these uses of PVEs make sense as part of doing the work of doctoring (see also Pilnick, 2022).

Likewise, in both sequential locations, patients are also doing interactional work when they reveal a preference. Following a recommendation, they may be working to secure some alternative or compromise. Before a projected recommendation, they may be working to avoid an unwanted recommendation altogether. Again, these make sense in the context of doing the work of being a (reasonable) patient. As we have seen, patients are observably balancing an orientation to the clinician’s expertise with any wish they may have not to receive a particular prescription or referral. Revealing a preference that contra-indicates a treatment option can allow the patient to resist (either retrospectively or prospectively) based on “knowledge to which they are entitled” (Gill et al., 2010, p. 16) – their own lived experience of symptoms and prior treatments.

This understanding of the interactional work that talk about patients’ views is being used to do helps explain, I would argue, why SDM is so difficult to implement routinely. It is not just that clinicians fail to remember to enact a particular set of guidelines. As this chapter has shown, even when they do enact them – e.g., by eliciting patients’ views – this is not done in some sort of abstract way. To talk is always to do something. When doctors elicit patients’ views, and patients reveal their views, they are doing so in the service of (sometimes conflicting) interactional goals, and the goal may sometimes be at odds with SDM; for instance, the clinician may be prioritising a duty of care (by pursuing acceptance of a recommended option) over the ideal of patient choice (Reuber et al., 2015). Models of SDM, however sophisticated, fail to recognise this. They assume a kind of ‘pure’ exchange of information between clinician and patient. From that perspective, it is impossible to understand why clinicians – after decades of effort to try to (re)socialise them into taking a shared approach to decision-making – are still failing to do so (Pilnick, 2022). After all, asking patients about their preferences sounds like such a simple thing to do. If we understand talk as action, however, we see that it is far from simple. To get clinicians to *do* SDM on a regular basis, they do not just need to believe it is a good thing and know how to do it. They need to fully reconceptualise what they are *doing* in the activity of treatment decision-making: shifting the emphasis from delivering on what they think is best to facilitating the patient’s ability to make up their own mind.

Pilnick and Dingwall (2011) have drawn similar conclusions in relation to the notion of ‘patient-centered’ care. In their controversial, and compelling, critical review of CA studies of doctor-patient interaction, they argue that “asymmetry lies at the heart of the medical enterprise” (p. 1374). Thus, they propose, while communication training may enable doctors to exercise their authority “in more civil ways,” it is misguided to think that patient-led medical practice can be achieved “without some major shift in the social function of officially sanctioned medical practice” (p. 1374). I find myself somewhat more optimistic about the implementation of SDM than Pilnick and Dingwall (2011) were about reforming medical authority more broadly. This is because, while the latter is diffuse, SDM models articulate a set of defined, skills-based interactional practices; and these are already occurring in clinical practice to some extent (as our inductive identification of option-listing shows). I believe, then, that it is viable for SDM to occur more regularly, at least. However, for it to become *routine*, I think Pilnick and Dingwall are right: we would need to see a shift in the institutional goals of medicine. At present, the evidence strongly suggests that clinicians are prioritising the goal of trying to ‘fix’ the patient – even if that conflicts with the patient’s preferences. For SDM to become routine, it would need to become the over-riding goal instead. Whether that is in our collective best interests, however, is the real question. As Pilnick (2022) rightly concludes, the careful study of real medical interaction reveals that we need a broader rethink of what we – as a society – want from the institution of medicine.

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1. Extracts 1a-c have been presented and discussed, for different analytic purposes, in Reuber et al. (2018, pp.26-28) and in Toerien (2021, pp.19-21). [↑](#footnote-ref-1)
2. Extract 1.2 has been presented and discussed, for different analytic purposes, in Reuber et al. (2015, p.101). [↑](#footnote-ref-2)