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# When the business of sharing treatment decisions is not the same as shared decision making: A discourse analysis of decision sharing in general practice

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## Abstract

Although shared decision making (SDM) in general practice continues to be promoted as a highly desirable means of conducting consultations it is rarely observed in practice. The aim of this study is to identify the discursive features and conversational strategies particular to the negotiation and sharing of treatment decisions in order to understand why SDM is not yet embedded into routine practice. Consultations from Scottish general practices were examined using discourse analysis. Two themes were identified as key components for when the doctor and the patient were intent on sharing decisions: the generation of patient involvement using first-person pronouns, and

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successful and unsuccessful patient requesting practices. This article identifies a number of conversational activities found to be successful in supporting doctors' agendas and reducing their responsibility for decisions made. Doctor's use of 'partnership talk' was found to minimize resistance and worked to invite consensus rather than involvement. The information from this study provides new insight into the consultation process by identifying *how* treatment decisions are arrived at through highlighting the complexities involved. Notably, shared decision making does not happen with the ease implied by current models and appears to work to maintain a biomedical 'GP as expert' approach rather than one in which the patient is truly involved in partnership. We suggest that further research on the impact of conversational activities is likely to benefit our understanding of shared decision making and hence training in and the practice of SDM.

### Keywords

discourse analysis, doctor–patient interaction, general practice, health care communication, shared decision making

### Introduction

There is evidence that most patients want to be offered choices and that doctor–patient collaboration correlates positively with a number of health outcomes (Blenkinsopp et al., 1997; Bradley et al., 2000; Heisler et al., 2002; Little et al., 2001). However, it has been recognized that approaches such as shared decision making are problematic not least because there are difficulties in constructing reliable tools to measure or evaluate it (e.g. Edwards et al., 2003; Mead and Bower, 2000). Although some tools have been developed to examine doctor and patient involvement in decision making e.g. OPTION (Elwyn et al., 2003) and COMRADE (Edwards et al., 2003), the skills needed to share decisions successfully continue to present a major challenge to the clinical consultation process (Edwards et al., 2001; Elwyn et al., 2003). Simon et al. (2007) report that there is not yet a standardized or widely accepted shared decision training model. In spite of innovative approaches towards promoting SDM most of the barriers have not yet been overcome (e.g. Charles et al., 2006; De Haes, 2006; Elwyn, 2006; Gravel et al., 2006). Although the idea that offering patients opportunities to make choices equates with good care has been questioned (Mol, 2008), support for shared decision making continues through government policy, medical education and other organizations (e.g. Makoul and Clayman, 2006; Murray et al., 2006; Towle et al., 2006).

Furthermore, most research into doctor–patient communication focuses predominantly on either an examination of the patient's or the doctor's talk and consequently using findings to inform training and practice is correspondingly fraught with difficulties. This article argues that talk within the consultation needs to be examined as a joint production to understand why SDM is not yet embedded in consultations. Despite an apparent willingness to engage with it, and adopt it as part of 'training for the craft', it remains uncertain whether it is a well-defined concept.

To shed light on why decision sharing appears to be so rarely practised, this study uses discourse analysis to illuminate the conversational features particular to the negotiation

and sharing of treatment decisions. By viewing consultations as relationship-centred discursive events it is possible to regard treatment decisions as joint accomplishments.

## **Methods**

### *Patients*

All adult patients, seeing their doctor for a variety of reasons, were considered eligible. Patients came from a range of general practice sites across Tayside, Scotland. These included both rural and urban settings.

Patients were invited to participate, via a letter from their GP. Included in the letter was a copy of the study background and an information sheet detailing the requirements of the study. Patients unable to provide informed consent and those below 18 years old were excluded. The researcher sought consent when patients reported their arrival at the surgery. Following recommendations set by the Royal College of General Practice consent was sought before and after the consultation to allow a change of mind if the patient so desired.

Ethical approval was granted by Tayside Ethics Committee (reference number 78/01).

### *Doctors*

Six general practitioners (GPs) were invited to participate. All GPs had an interest in consultation skills training with five out of six having undertaken concordance training using 'Therapeutic Alliance Model' (Dowell and Hudson, 1997). This model has been used to assist clinicians in learning how to achieve shared goals and decisions with patients in medicine taking behaviour. Thus, there was a higher probability that the clinicians possessed the skills required for SDM. The GP participants were therefore seeking to demonstrate their own best practice.

Having earlier indicated a willingness to participate, GPs were then formally invited by a letter from the researcher. The letter provided information on the study and participants' involvement and particular requirements. GPs were invited to audiotape two otherwise routine consulting sessions. These took place over a whole day or over two days. No additional time was scheduled for the study.

## **Data collection**

### *Phase I*

The aim of data selection was to target only those consultations where SDM was perceived by the patient to have occurred. The first phase of the sampling process was designed to filter out consultations where other forms of decision making were practised. To assist in this task the COMRADE questionnaire (Edwards et al., 2003) was used. This tool was developed to evaluate the effectiveness of decision making and risk communication in consultations. Therefore, it was expected to be sensitive to particular characteristics of the decision-making process that may be unique to the SDM context. As a result COMRADE provided a practical and efficient sampling technique and a means of focusing on the richest data.

COMRADE was administered to patients after they had consulted with their doctor, along with instructions on how to complete it. A room was provided where patients were

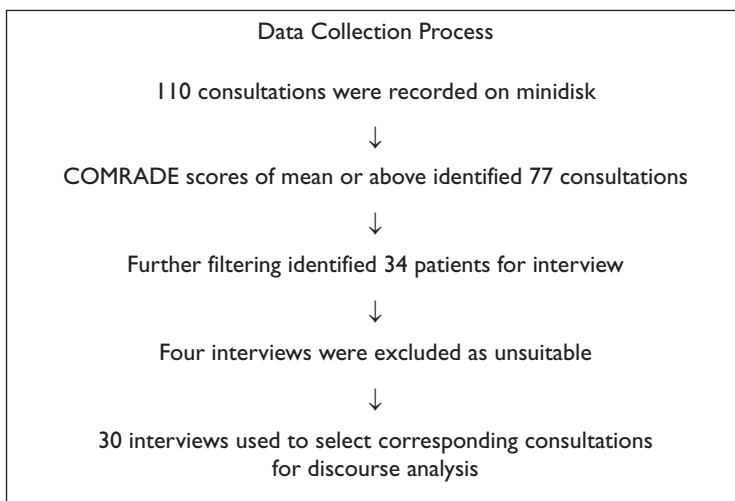
given time and privacy to complete the questionnaire. On two or three occasions, and at the patient's request, the questions and the set of possible responses were read out loud and the patient's responses were recorded for her/him. In total 110 consultations were recorded.

## Phase 2

After each data collection session all of the recorded consultations were listened to, to ensure a decision had actually been reached and to determine whether or not decisions were shared.

As there are times when the situation of equipoise does not arise and treatment choices may not be appropriate or available (Elwyn and Charles, 2001), two actions were taken to reach the decision on consultation selection for final analysis. First, consultations where COMRADE scores fell below the mean ( $n = 33$ ) were excluded. This meant that 77 consultations were regarded as potential examples of SDM consultations. Next, a number of patients had follow-up interviews to explore decision sharing from their perspective. Thirty-four semi-interviews were carried out within four days of the consultation to minimize loss of recall (Cromarty, 1996) to identify the consultations for in-depth analysis.

All patients had indicated their willingness to be interviewed at the beginning of the recruitment process. At the patients' request, interviews were carried out either in patients' homes or at the doctor's surgery. Four interviews were excluded as unsuitable: one patient was a child; a second patient was found to be suffering from confusion during the interview; a further interview had to be abandoned owing to an exceptionally noisy environment; the fourth exclusion arose because the mean COMRADE score for the GP had fallen after the second data collection session. A flowchart summarizing the data collection process is presented in Figure 1 and Table 1 presents data collection details for each GP.



**Figure 1.** Data collection process

**Table 1.** Data collection record for each GP

GP	Sex	Recorded consultations	COMRADE mean score (%)	Refusals	Interviews
1	M	28	82	15	8
2	M	24	86	14	7
3	F	19	89	8	6
5	M	14	96	8	3
4	M	10	86	5	4
6	F	15	86	5	5

**Table 2.** Transcription notation

- Lines are numbered (1 at start of extract)
- Pseudonyms were used in place of all names
- Timing of pause lengths was considered to contribute to this analysis and as data had been recorded on minidisk the lengths of pauses (in seconds) were immediately available from the raw audio data and included within round brackets
- A just noticeable pause is indicated by a full stop between round brackets (.)
- Interruption by another speaker is indicated by a colon: thus marking a restrained utterance
- Overlapping speech is indicated with square brackets
- A colon in the middle of a word indicates an extended or emphasized word

Ultimately 30 consultations were selected for discourse analysis. These were transcribed, loosely based on the Jeffersonian system (as reported in Atkinson and Heritage, 1984: ix–xvi). Highlighting features of the delivery of talk, such as pauses and repairs can illuminate the written talk similar to the way participants hear it. Details of transcription notation are included in Table 2.

## Method of analysis

Discourse analysis (DA) has been described as ideally suited to the study of medically situated encounters as it can illuminate perspectives not yet brought to the fore when researching medical encounters (Elwyn et al., 1999). Its utility can be seen across a number of health care settings (e.g. Barry et al., 2001; Hamilton and Manias, 2006; Nessa and Malterud, 1999; Roberts et al., 2005) and findings have offered insights into central aspects of the interaction (Salmon and Hall, 2003).

The Discursive Action Model (DAM) (Edwards and Potter, 1992) was selected as it provides both a theoretically informed conceptual scheme and an analytic method. Within a discourse analytic framework, language is neither viewed as a neutral medium that is used to describe a pre-existing ‘reality’, nor as bound up with underlying psychological processes. Rather, it is regarded as a social practice through which people actively construct particular versions of reality. Moreover, language is considered to have an ‘action orientation’. That is, when people use language, they do so to perform certain social actions, for example, blamings, requests, mitigations. Thus, people’s language

will exhibit variability depending on what social action they are performing at the time. The focus for the analyst is, therefore, the way in which different linguistic constructions are used to perform different social actions. The use of DA in the current study thus facilitated the identification of the discursive constructions and features particular to the negotiation and sharing of treatment decisions.

### *Preliminary analysis and coding*

A checklist based around the competencies required for and the key stages of shared decision making (Elwyn and Charles, 2001; Towle and Godolphin, 1999) was used to search systematically for features such as references to choices, exploring fears and concerns and other criteria for SDM. As we found little evidence of the key competences or features identified in theoretical frameworks of SDM (e.g. checking patients' understanding, or option portrayal, i.e. there were no examples of a doctor saying 'there's two ways to go here' or 'we have some choices, they are ...') we focused on the discursive features that appeared in the text at points where decisions appeared to be being accomplished.

After initial coding a range of potential analytic themes were identified. Detailed transcription was required to illuminate some of the non-discursive features of the interactions that can have an influence on the interaction such as pauses, hesitations and laughter.

## **Findings**

As it is not possible to present the analysis of each consultation in one article three extracts are presented to illuminate some of the complexity of the consultation. As the discursive features identified within these extracts can be found at work in most consultation behaviours (see Robertson, 2004), those presented here can be regarded as mundane examples.

Two broad themes, viewed as having a clear impact on the decision process were explored. The first of these examined how first-person pronoun deployment can function to help elicit patients' agreement. The second theme explored ways in which patients formulate successful and unsuccessful requests.

### *Practitioners, pronouns and power*

Extract 1 forms part of a discussion between the doctor and the patient over treatment for high blood pressure. The doctor informs the patient that the systolic value remains unchanged in spite of the patient receiving treatment that was aimed at reducing it and so wants to increase the medication.

#### *Extract 1 D5JFM 'Warranting change with trying a wee bit harder'*

1. Dr: Right (.) Right (.5) I mean certainly looking at things for the last you
2. know six months or so it's (.) it's (.) this systolic value's still been high as the

3. first test and em I think if your other risks are good (.) I mean you don't smoke
4. your cholesterol's good um I just wonder if we should be trying a wee bit
5. harder to lower the first value (.5) You're not getting any si:de e::ffects from
6. the tablets you:'re on
7. Pt: No I would have been telling you right away (unclear words)
8. Dr: That's right cos you had problems with the Amlodipine didn't you but the
9. new [one's:]
10. Pt: [The new one's:]
11. Dr: [agreeing with you.] (.5) what would you thi:nk about us increa:sing the
12. dose a wee bit of that and try and get:
13. Pt: Aye (.)Yeah. (.5) I just thought I was doing all right
14. Dr: We:ll you ar::e and you're doing we::ll (.) The thing about it (.5) I could
15. show you some (.5) I've got a computer chart I could show you the difference
16. lowering your blood pressure a wee bit would make if you want to

To warrant a change in the status quo the doctor's talk is constructed in such a way to make apparent a process of 'thinking'. The continuers, repetitions and hesitancy ('ums' and 'it's ... it's'), add to the 'thinking it through' approach where the doctor is almost seen to be verbalizing some sort of thought process in the patient's presence. This works so not to appear as an order or instruction and highlights the doctor's consideration. While this talk may appear to include the patient, it is also rhetorically persuasive and works to invite consensus.

The justification for a change to the dose (lines 2–4) is constructed with a three-part list. This is a persuasive rhetorical device that works to suggest completeness and is designed for recipient uptake (Jefferson, 1990). Here, the three items 'this systolic value's still been high as the first test'; 'you don't smoke' and 'your cholesterol's good' are used to back up the initial claim that a change in treatment is warranted. The listing makes the doctor's suggestion to 'try ... harder to lower the first value' difficult to challenge and works to make a strong case for what follows (lines 4–5).

The words 'I just wonder if ...' work to make the forthcoming proposition. The doctor is heard to suggest rather than instruct. The use of 'we' can be seen to paint a picture of sharing through facilitating patient involvement. However, discursively, these features are conversational techniques that function to build a strong case to invite agreement. All the qualifiers, hesitations and then instances of 'we', are rhetorically persuasive. The patient has listened to the verbalization of a diagnostic process and then right at the end the doctor provides the signal for authority ('we') to act upon it. The 'we' works to have the patient corroborate the doctor's claim by placing the patient in the discursive position of either agreeing or the more difficult position of having to 'knock down' all the previous build up.

It is not clear in lines 11–12 if the doctor means 'you and I' or if the 'us' refers to the doctor and 'not-present others'. While the question appears to provide the patient with an opportunity to provide an opinion (and thus, be involved in the decision making) the minimization of the proposed change with the words 'a wee bit' provides an implicit appeal that it is not an issue of importance either way and is a further attempt to persuade the patient to align and agree with the doctor's suggestion.



The patient's response to the proposed medication change 'Aye, yeah, I just thought I was doing all right' (line 13) does not bring outright agreement; rather, it is an example of active resistance and avoids bringing acceptance (Stivers, 2006). This comment places the doctor in a delicate situation. Not only is this difference of opinion problematic for the interaction, it is also problematic for approaches advocating patient knowledge and experience should be included in the partnership. Peräkylä (2007: 247) argues that some styles of doctor-patient relationships are 'out of touch with the interactional reality of the medical consultation'. Here, the patient's experience has been discounted. Although, the chart could be used to promote patient participation it also provides an external authority, which minimizes any personal interest for the doctor in getting the patient to conform to medical authority.

From this extract the doctor's talk in particular was seen to draw upon strategies such as pronoun deployment, joint remembering and three-part listing. These are persuasive rhetorical devices that work to warrant the treatment suggestions while masking imputation of coercion. The patient was not keen to accept the treatment proposal and the doctor had to work hard to secure an agreement. As a result sharing was not actually visible. Doctors' use of 'we' does not always contribute towards accomplishing a partnership. Rather, the use of 'we' acts to take hold of the decision-making agenda by adopting a collective voice. This appears to add weight to the authority of the decision while masking the 'I', the doctor's agency, in uttering it. On this occasion however, using 'we' did not in fact help to secure agreement.

### *The rhetoric of requests*

Patients are not in the habit of making direct requests for treatment but instead usually only 'suggest' and tend to use covert strategies in taking the initiative or 'hold off their lay diagnosis until the physician has spoken' (Ten Have, 2001: 256). These behaviours have been regarded as markers of an asymmetrical relationship with the doctor. With the change in focus from doctor-centred to patient-centred care, it could be expected that patients will have more confidence in making direct requests. Where patients did make direct requests (11/30), there did appear to be more patient involvement as they took on a more active role. Extract 2 is taken from a consultation where the patient makes a successful request for a referral to dermatology.

#### *Extract 2 D6AR 'Warranting request with attention to a problematic'*

1. Dr: Now what can I do for you?
2. Pt: Em loads of things (laughter) hopefully
3. Dr: Okay.
4. Pt: First of all em could you please refer me to dermatology
5. Dr: [Mh:mm]
6. Pt: [for my] face it looks as though it's okay just now actually (laughter)
7. Dr: Yes
8. Pt: [but e]
9. Dr: [What] problems are you having with your it

10. Pt: Well since I was 11 I think about 11 when I first
11. started just normal
12. Dr: [Yeah]
13. Pt: [teenage] skin and they says 'oh it's just a phase and you'll grow
14. out of it' [and]
15. Dr: [You're sick of it]
16. Pt: I'm 21 and although yeah really like really
17. em it's it's like a main well it seems to be the main thing that the
18. only thing I ever worry about or that bothers me or that don't know
19. it's just always an issue.

The doctor's opener orients to a 'new-concern' (Robinson, 2007) and provides an opportunity for the patient to be specific about what he/she expects from the consultation (line 1). The patient makes a direct request to be referred to dermatology (line 4). However, as there are no visible signs (line 6), the legitimacy of the request could be questioned (Stivers and Heritage, 2001). Normally, visible skin problems would stand alone in countering such issues when making a request for a particular treatment or service (indeed, there would be no legitimacy issues at stake as it would be a case of 'seeing is believing'). By stating that the doctor will not be able to 'see' the skin condition, the patient provides a counter for a potential rejection of the request as unwarranted. This 'getting in there first' strategy and bringing a potential legitimacy issue to the fore, places the patient in a stronger position to ward off challenge and is an example of what Potter (2000) describes as stake inoculation.

In response to the doctor's request for further detail (line 9) the patient provides a chronological history of the present concern (lines 10–19). Potter (2000) has reported it is not the general pattern of events so much as the detail that makes a story credible. By informing the doctor about the 'age of onset' (lines 10–11) and then 'I'm 21' (line 16) the doctor is left to be the judge of the chronicity of the condition as well as an inference that specialist intervention is now required. Furthermore, the detail in the account also works to establish an identity as a legitimate patient (Halkowski, 2007) who is presenting with a 'doctorable' concern (Zimmerman, 1992 cited in Halkowski, 2007).

The patient's request is further supported with 'active voicing' (Potter, 2000). The utterance, 'They say' (lines 13–14), downplays the patient's agency by introducing an external agent, showing that while what was said had been accepted, the 'growing out of it' had not in fact transpired. Words such as 'they' and 'them' can be more rhetorically persuasive than using a specific figure or number as the vagueness reduces the likelihood of the speaker being challenged on the accuracy of the claim made (Potter, 2000). Here it provides ambiguity, leaving the listener to decide on the degree of consensus as well as a claim for the 'truth' of how wrong 'they' were (line 13). The patient does not say who the referents of 'they' actually are so 'they' becomes a reference to a 'general experience of a range of people' (Potter, 2000: 161). Here, the active voicing successfully counters potential dispute over the accuracy of the claim, while strengthening the request. This conversational strategy has been described as basic to lay reasoning when providing consensus and corroboration (Potter, 2000: 60).

This extract shows how the patient has formulated a successful justificatory account to warrant a request. This account is constructed to counter a possible refusal relating

to the doctorability of the condition and so orients to the potential for the request to be viewed as unwarranted or unnecessary. A variety of devices and strategies were deployed to help strengthen the claims underpinning the request, provide warranty for a specialist referral and head off a refusal. These kinds of discursive activities shed light on how requests, being open to a potential ‘no’ response, are rhetorically packaged to accomplish a ‘yes’ response.

Furthermore, the patient had done the diagnostic work via the request for a dermatology referral. The patient’s condition had been unsuccessfully treated before and the patient knew that the treatment now required (i.e. Roaccutane) had to be prescribed by a specialist. This kind of event, where the patient has decided both on the diagnosis and the treatment may be something of an unusual occurrence however, as Stivers (2006) reports that it is far more common for doctors to do the diagnosing work without any negotiation, with patients tending to participate only in the treatment decision discussions.

In this extract the ‘successful’ patient had informed the doctor of his/her expectations in fairly direct and explicit ways. As a result the patient had a more active role in the decision-making process. By contrast, unsuccessful requests were more protracted and complex. Two key features were identified with refusals. The first was that patients were less direct when making the request. Second, doctors never used ‘no’ when refusing.

Strikingly, the ways in which patients introduced and formulated requests was a primary determinant of their subsequent role in the discussion. Extract 3 begins with the patient setting up a dialogue over whether or not the patient’s request referred to the preparation or the delivery device. This sequence has been omitted to aid clarity.

*Extract 3 DIJL ‘Just say no’*

1. Dr: You mentioned before that there were four things you wanted to
  2. talk about
  3. Pt: The second was (.) em I had an asthma attack and I had to go to
  4. Perth Infirmary (.5) on Saturday (.5) it was Carol Smith that I saw
  5. Dr: right
  6. Pt: and I mentioned to her that I was coming to see you on Monday
  7. anyway
  8. Dr: so she thought we should review you
  9. Pt: Aha (1.) I was wondering if it would be possible (.5) to change the
  10. Salbutamol inhaler that I am taking (1.) I am on the AeroBec at the
  11. moment
  12. Dr: Yea:h
  13. Pt: I don’t feel that works for me and I have got an Easy Breathe
  14. inhaler as well at home that I have been using and I’m wondering if
  15. it would be:
  16. Dr: get the Easy Breathe
  17. Pt: all right to change to the Easy Breathe
  18. Dr: Now (1.) (rustle of paper) the AeroBec would be (.) er (.) wouldn’t be
  19. your Salbutamol (.5) it is (.5) is tha:t not your Beta:methas:one
- Text omitted- complex discussion over different preparations and different delivery devices

34. Dr: right (.) right so (3.) o:kay how many doses is that you are taking?  
 35. Pt: (2.) th:e Sal:but:amol?  
 36. Dr: the Aero::Bec  
 37. Pt: the Aero::Bec I'm taking four in the morning and four at night  
 38. Dr: Ri:ght  
 39. Pt: I have upped that be:cause I've been having a bit of (.)  
 40. problems because the field in front of us and the field behind us  
 41. (.5) they're both harvesting  
 42. Dr: they'll be harvesting yes so that is bound to (.5) so that is a  
 43. sen:sible thing to do I'd say (.) during the harvest (.) Em (.) so (.) er your usual  
 44. dose would be two doses twice a day and you have gone up to four twice  
 45. a day which (.5) i:s quite reasonable (.) er (.) I'm no:t convinced there would  
 46. be any (.5) you know (.5) em (.) mileage in switch:ing the preparation (.) em the  
 47. AeroBec at the right dose it might be (.) er (.) if you're getting more er (1.) (tisk  
 48. sound) symptoms we can a:dd in something else (.) but you kn:ow AeroBec (.)  
 49. seems to be the one you are (on)  
 50. Pt: (yeah right) okay (quietly spoken)  
 51. Dr: (It) is a reasonable dose and the way that you are taking it  
 52. the auto-inhaler is a (good:)  
 53. Pt: (Am I) okay to get a repeat prescription for that because I will  
 54. be running out shortly (quietly spoken)

The first thing to note here is that unlike the earlier example of successful requesting, this request is second on a list of four items. As it was the patient who had relegated the request to further down his/her list, this could make the request easier to challenge.

Furthermore, when making requests patients who 'just wondered if ...', did not have all, or any of their agenda met during the consultation. This 'wondering' activity is seen twice in the formulation of this patient's request (line 9 and line 14). As was seen in extract 1, when the doctor did the wondering, it worked to construct a proposition and avoided telling the patient what to do. Here it may have a similar effect, that is, it did not work to present the request as an instruction or an order for the doctor.

Reporting an asthma attack should be enough to grab the doctor's attention but the patient adds further warranty. Lines 3–7 present a justificatory account to warrant the request. Detail and 'name-dropping' work together to provide implicit corroboration for the patient's account (line 4). The doctor does not challenge anything at this point and indeed attempts (erroneously) to anticipate the forthcoming request (line 8). The patient makes a quite different request however (lines 9–17), and although the doctor utters a 'yeah' (line 12) it does not provide an outright agreement. The extended sound indicates some reservation and contains an implicit request for further information and indeed, the patient responds with further justification.

The actions that construct the refusal are visible (lines 18–19). The one-second pause along with the paper rustling is significant. This hesitation can be taken as a refusal (Stivers, 2006). The utterance of 'now' seals it. Although the doctor's initial response implies refusal, some kind of explanation or rationale is called for. Instead the doctor continues by engaging in a long discussion over the delivery devices and the preparations

(text omitted). There did appear to be some misunderstanding between participants over what the patient was actually requesting. It later became apparent that the doctor had established that it was the actual preparation that the patient wanted to change and not the delivery device. Interestingly, if the request for change was medically inappropriate the patient must have held a wrong understanding of what the medications were supposed to do. As this was not stated clearly enough the patient may continue to hold the wrong idea about treatments.

After reviewing the medication the patient has been taking (lines 34–42) the doctor returns to the refusal (lines 46–50). Using a mechanical metaphor to suggest there would be nothing to be gained by changing, the doctor avoids making an outright refusal. Lock et al. (2001: 192) note that this metaphor helps to position doctors as skilled technicians (and patients as damaged parts or malfunctioning machinery). More than this though, using the metaphor at this juncture avoids actually telling the patient how it really is (Potter, 2000: 182) so serves to reduce the doctor's agency for the refusal.

Finally, the doctor suggests that staying on the same drug at the correct dose would be best, making available the inference that the medication is not being used at the correct therapeutic dose. But, by not completing the utterance, the imputation will be more difficult to refute (lines 47–49). The hesitation and repair alongside presents a sensitive and caring doctor who has attempted to soften the blow with a compromise while not dismissing the patient's justifications out of hand. However, any repair is short lived with the words the 'AeroBec seems to be the one you are on' (lines 48–49). This statement carries a suggestion that power to change treatment or grant the patient's request is out of the doctor's hands (lines 49–50) and works to deny the doctor's agency for the decision. The lowered voice (line 50) may indicate resignation in that the patient is not going to pursue the matter any further and the doctor orients to this with a further attempt at persuasion (Stivers, 2006). It is likely that the patient has been unable to adopt an active stance owing to the doctor's ultimate authority (Peräkylä, 2007: 246) and does not want to hear this again and interrupts the doctor and moves on (lines 54–55).

Analysis of this extract has revealed a complex response to a request. This response contains a number of features or components that are characteristic of everyday refusals (Potter, 2000: 60). First, although the request was made very early on a direct response was postponed until much later. Second, the word 'now', although acting as a marker to indicate a refusal was on the cards, only served to increase the delay before the refusal was made. Third, when the doctor did raise the refusal the patient was not given a categorical 'no'; instead the refusal could only be inferred. It is likely however, that direct refusals including a 'no' may be seen to breach everyday rules of good manners (Kitzinger and Frith, 2001).

The ways in which doctors solicit patients' concerns can have quite different consequences and patients and doctors should orient to the appropriateness or inappropriateness of the different question formats (Robinson, 2007). In extract 2 the opener 'Now what can I do for you?' provided the patient with the space needed. In extract 3 the question formation was more complex. The patient had already discussed one concern (perhaps the most important one) so the opportunity to use the open question format had already been used up. Because the doctor did not ask directly what the next concern was this patient did not get enough of an opportunity to make a direct request.

## Discussion

The discourse of the patient as an active agent in managing illness and health care is becoming more visible. Salmon and Hall (2003: 1969) examined how discursive practices can position or frame the patient as an active agent in illness and health care in ways 'that allow clinicians to withdraw from responsibility for certain problematic areas of patient need'. The present study has also identified and explored a number of conversational strategies that appeared to be successful in reducing or absolving the doctor's responsibility or in supporting the doctor's agenda when making decisions.

The examination of pronoun use identified that the deployment of 'we' is a complex business. On the face of it 'we' deployment can present a picture of sharing and patient involvement: however this discursive strategy can also help re-allocate responsibility for the decision. The use of 'I' unequivocally places responsibility and agency with the doctor. 'We' can function therefore to reduce the doctor's responsibility, or even to remove it and place it on the patient. It was clear that doctors' use of 'we' seldom contributed towards partnership in treatment decision making. Similar findings from doctor-patient interactions have been reported elsewhere. Skelton et al. (2002) found that in patient-centred consultations doctors use 'we' significantly more than patients. However, these authors found that, using 'we' to involve patients may be undermined because the doctor's 'we' may or may not be aiming to be inclusive and patients may or may not view 'we' in partnership terms either.

First-person pronoun deployment, such as 'we' and 'us' was also used to help the patient 'remember' in a particular way. Potter has shown that when people recount events from the past they are not simply telling a story as if automatically downloading from a memory store due to some trigger. The account or description will be constructed in such a way as to perform particular actions or in Potter's (2000: 24) words, 'the past is reconstructed according to the functional concerns of the present'. Facts are 'remembered' and constructed in such a way as to prevent undermining. So, in order for a claim to achieve success agreement needs to be reached about what the case *was* and what its relevance *is* in the here and now. Joint remembering can be used to help to tidy up matters. In the extract presented the joint remembering was used to help persuade the patient to align with the doctor's wishes by undermining a possible potential representation of the doctor as agent (i.e. solely responsible for the claim), while presenting a face of inclusion and partnership. Although the conversational activities may at times suggest something of a process of co-opting patients to act 'responsibly' and through their own choice, the deployment of other discursive strategies makes it is hard not to view the doctor's contributions as medical paternalism. The use of this pronoun has been found in other settings to achieve similar effects. For example, Edwards and Mercer (1987) found that pedagogic discourse used by teachers in the classroom often made use of 'we' in summarizing lessons and drawing attention to what pupils *should* have understood. This had the effect of directing and controlling the learning agenda for pupils. Time-constrained doctors may have developed discursive strategies using 'partnership talk' that aims to counter resistance or invites consensus to get the job done quickly. It is therefore safe to suggest that the use of 'we', for the most part, is a means of discursive control over the trajectory of the consultation.

The second theme examined successful and unsuccessful patient requests. Successful requests were formulated to undermine or counter the possibility that they might be refused. When granting the request, doctors tended to be brief and direct in their response. Successful requests were constructed from a number of discursive resources and strategies, and in such ways as to prevent refusal. One of the key strategies used was for the patient to be confident and direct. Where doctors did refuse, both the request and refusal were formulated indirectly. In functional grammar, direct commands such as 'Come here!' shade into tentative suggestions when formulated in the following way 'I wonder if you might find it more convenient to step this way' (Leech and Svartvik, 1975). Thus, a phrase introduced with 'I wonder ...' is normally assumed to be relatively indirect. Refusals were also protracted and usually followed with palliative gestures. It is also apparent that making and negotiating requests or tactfully declining them derive from everyday conversational skills.

What is clear is that the business of refusing is much more complex than the granting of a request. It is also notable from other work that these discursive features are not specific to medical consultations but derive from people's everyday skills in making and negotiating requests and refusals.

## Conclusion

This study provides new insights into the consultation process and points towards a re-evaluation of existing models of shared decision making with implications for health care practice and communication skills training. Notably, decision sharing does not happen with the ease implied by current models and may work to maintain a biomedical 'GP as expert' approach rather than one in which the patient is truly involved in partnership. Collaboration with patients, as a result, continued to be limited.

Although GPs have to maintain their biomedical expertise they still need to make a space for the patients' expertise to achieve partnership and sharing. Treating shared decision making as an outcome that is imposed as a gloss on the interaction through a script gives it a superficial coherence and legitimacy that we do not find when we look at how the consultations actually are.

Shared decision making does not consist of a list of phrases to use: applying a script at what seems to be appropriate times is not a guarantee of proper sharing, merely of something which bears a passing resemblance. This resemblance is likely to vanish under scrutiny. This makes DA the appropriate route to explore, both for research and in education.

Courses labelled 'communication skills' rarely offer discourse-based teaching or advice, and few practising doctors have an awareness of DA as a concept. Although emphasizing the implications for practice is not a priority for this article it does seem possible that to incorporate explicit teaching about the various ways the consultation can be articulated would offer doctors another way of thinking and reflecting upon their practice. This study suggests that better ways of identifying, and reflecting upon, how participants' talk contributes to the complex process of the consultation would be useful in communication skills training for health professionals.

However, as with any methodological approach DA can only offer a partial view of how the SDM model works in practice. There are aspects of the model that DA cannot

access, for example, the context of the relationship between the GP and patient. That may be more suited to an ethnographic study.

The main theoretical conclusion to this work is in enhancing our understanding of the complex conversational processes at work between doctors and their patient. GPs and patients can be considered as colluding with one another in order to maintain sequences of talk that constitute a medical consultation. However, there are tensions here in terms of the stated aim of shared decision making. The nature of conversational preference structure gives GPs more power over the conversational agenda and trajectory. Patients are likely to conform with a summary or assessment given by a doctor, even if this may lead the consultation in a direction that the patient does not understand or intend. It is therefore clear that many of the conversational features of ordinary everyday talk are present in the surgery and that while shared decision making may be desirable it cannot be simply imposed upon what are deeply seated forms of talk-in-interaction. In other words, if we are to seek to find ways of encouraging shared decision making then we must first understand the conversational processes at work in the surgery and how these can pull in the opposite direction. This normative barrier to SDM is something that could be tackled through collaborative work between discursive researchers and medical practitioners.

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