Speaking Out of Turn: Implications of partner contributions for patient autonomy during prostate cancer consultations

Simon John Stewart (simon.stewart@staffs.ac.uk)[1] ORCID: 0000-0002-9026-2981

Lisa Roberts (L.C.Roberts@soton.ac.uk)[2,3] ORCID: 0000-0003-2662-6696

Lucy Brindle (L.A.Brindle@soton.ac.uk)[2] ORCID: 0000-0002-8933-3754

[1]Department of Psychology, Faculty of Health, Science, and Wellbeing, Staffordshire University, Stoke-on-Trent, UK

[2]School of Health Sciences, Faculty of Environmental and Life Sciences, University of Southampton, Southampton, UK

[3]Therapy Services, University Hospital Southampton NHS Foundation Trust, Southampton, UK

Corresponding Author:

Lucy Brindle (l.a.brindle@soton.ac.uk) [2]School of Health Sciences, Faculty of Environmental and Life Sciences, University of Southampton, Southampton, UK

Abstract

Objective

This research examines how partners contribute to clinical consultations for people with prostate cancer. It highlights a social practice where a partner responds to talk that addresses a patient.

Methods

A conversation analysis of twenty-eight prostate cancer treatment and diagnostic consultations was carried out using data collected from four clinical sites across England.

Results

The analysis demonstrated that this practice was prosocial and patient enabling. Partners oriented to the patient's primary rights to take their turn as the selected next speaker, only initiating after a substantial delay from the clinician's turn-at-talk. Consequently the partner consistently opened an opportunity space that the patient took to elaborate upon, or collaborate with the partners' turn as they regularly took up a unified stance resisting the individualised configuration of the encounter.

Conclusion

This research highlights the social and clinical utility of partners during these consultations, as they served as important, yet underutilised interactional and informational resources for clinicians and patients.

Practice Implications

This research indicates a need to reconsider the configuration of these consultations and sanction partners as formal participants. Absent of this, partners will continue to have to work to insert their contributions into consultations while resisting the dyadic structure of these interactions.

1   Introduction

Communication in medical care has been examined in relation to its structure, content, and social processes. Research has described these encounters as sites of social action that should encapsulate the patient's lifeworld and the clinician's biomedical concerns [1]. Initially conceptualised as a site for paternalism, granting clinicians authority to make decisions for patients [2], research has underlined how patients can assert agency through negotiation and resistance [3–6]. This has led to the suggestion that patients and clinicians should work collaboratively to negotiate diagnoses and treatment decisions [7,8]. In the UK, this has informed concepts of patient centredness, and Shared Decision Making [9–11]. These concepts serve to protect the patient's autonomy, while encouraging patient-clinician engagement [12,13]. These policies are underpinned by the understanding of the patient as having inherent rights to make decisions about their care [14]. Patient centredness and SDM have informed clinical practice across several medical contexts including oncology [6,15,16]. However, research indicates that the ideals of SDM are difficult to enact, even in contexts where clinicians advocate for SDM [17,18].

The concepts of patient-centredness and SDM have been interpreted largely in relation to a patient-clinician dyad. For example, the key characteristics and elements of patient-centredness take the patient-clinician dyad as the starting point, focusing the need to regard the patient as a person, develop a therapeutic alliance between the patient and the clinician, share power and responsibility, and adopt a biopsychosocial perspective [19]. This is noteworthy as research has shown that patients regularly attend their medical encounters with a companion [20–22]. In the context of oncology, and in particular prostate cancer, patients tend to be accompanied by a partner, distinct from friends, carers, and relatives such as their spouse [23]. When considering the impact that prostate cancer can have on couples, this is not unexpected. The experience of prostate cancer and its treatment have been shown to have physical and psychological morbidities for couples, which in turn, impacts upon their relationship [24,25]. As such, patients largely expect their partners to be involved throughout the cancer experience as they navigate the challenges of living with the consequences of prostate cancer and its treatment [21,26–28].

In the context of prostate cancer, little research has examined partner involvement during clinical consultations, with most studies reliant upon retrospective accounts [23]. Research has yet to examine the communicative practices as they unfold within a prostate cancer consultation comprising a clinician, a patient, and their partner. Accordingly, this study examines the ways that partners contribute to clinical consultations for localised prostate cancer. This study provides a detailed, turn-by-turn conversation analysis of a social practice

where the partner responds to a clinician's turn that explicitly addresses the patient. This practice was identified as noteworthy as earlier research had considered this practice to be problematic [29]. This research on companion involvement in oncology consultations argued that a companion speaking for a patient can inhibit the patient's autonomy. In examining this practice, this research serves to elucidate the interactional consequences of these exchanges.

2 Methods

2.1 Participants and recruitment

This study used audio-recordings of diagnostic and treatment choice consultations collected from four sites in England. The recordings were collected as part of the TrueNTH research project "Understanding Consequences," of which this research is a part. Site selection was informed by the objectives of the wider study, into which all participants were recruited. Participants investigated for possible prostate cancer were initially sent a letter informing them they may be approached during their next visit. On arrival, those with the letter were invited to take part in the study. Researchers provided an information sheet at the time of recruitment. For this study, consultations were selected based upon the patient receiving a diagnosis of low or intermediate risk localised prostate cancer, and the consultation comprising a clinician, the patient, and their partner. This produced a corpus of twenty-eight consultations comprising thirteen clinicians, twenty-six patients, and their partners. Ethical approval for the study was obtained from the Cambridge South NHS Research Ethics Committee (NHS REC No: 12/EE/0132) and permitted only audio recordings of the consultations.

2.2 Method

The data were analysed using conversation analysis (CA). CA was chosen as it draws upon recordings of interactions, offering an empirical, data derived analysis into the social practices enacted and the resultant actions. CA attends to the ways that turns at talk are designed, how recipients orient to these turns, the ways that they respond, and how these responses inform subsequent turns-at-talk [30–32]. As an analytical approach, CA has been applied to clinical communication to make salient the everyday social practices, their interactional consequences, alongside alternative practices [32].

2.3 Analysis

Recordings were transcribed verbatim, with analytically relevant sequences further transcribed to the standards of the Jefferson convention, rendering aspects of talk such as intonation,

emphases, timings, and overlapping talk [33]. During transcription, all participant identifying information was removed. In accordance with the principles of CA, initial analytical work proceeded absent of focused analytical goals [34]. This comprised repeat listening to the recordings, noting key observations. An initial observation was noted relating to the turn-taking practices across all twenty-eight consultations. It was evident that partners were rarely selected as next speaker. This initial observation was examined in greater detail through an analysis based upon the CA concept of next speaker selection as outlined in the seminal paper by Sacks, Schegloff and Jefferson [35]. The primary method for a speaker initiating a turn-at-talk is by way of having been selected as the next speaker. This can be accomplished several ways such as directing gaze to the selected next speaker or using an address term [36]. Additionally, speaker selection can be considered as tacit, only identifiable through an examination of the sequential context of a given turn-at-talk. In a study of questions and responses during multi-party interactions, speakers overwhelmingly selected the next speaker, underlining the primacy in this method of speaker selection [37]. Similar research has shown that, in multi-party interactions, there is a socially organised preference for the selected next speaker to respond, alongside a 'second-order' preference for a response compared to no response, even if this response is not provided by the selected speaker [38].

3   Results

3.1   Partner contributions by speaker selection

Partner turns were initially analysed according to the principles of next speaker selection. In the initial examination, 237 partner turns were identified across all twenty-eight consultations. Partners were selected as next speaker seven times with only three of these selections performed by a clinician. In all other instances, partners overwhelmingly obtained their turn through the process of self-selection, accounting for 90.7% of all contributions [39]

3.2   Partner self-selects after patient selected as next speaker

From the entire corpus, a social practice was identified in fifteen sequences where a partner self-selected to speak after the patient was explicitly selected as next speaker, identifiable through verbal cues and the sequential organisation of the exchanges. This is the interactional feature all these sequences shared. In all fifteen sequences, the practice was prosocial and opened up an opportunity space for the patient to contribute further. In all sequences, the clinician had completed their turn with explicit orientation toward the patient. Notably, partners initiated their turn after a hearable delay from an identifiable transition point of the

clinician's turn-at-talk, projecting orientation to the patient's primary rights to respond [40]. Delays as short as 500 milliseconds can become noticeable by interlocutors [38]. In some cases, the partner initiated their turn after the patient had initiated theirs, elaborating upon, or collaborating with the patient in co-construction of their response. This practice was a prosocial and collaborative exercise that supported the patient and maintained social solidarity between the couple who regularly took up the discourse space to take on a unified stance, referring to their experience in collective terms such as "we" and "us".

This collaboration can be seen in excerpt 1, as the clinician attempts to outline the sexual impact of prostate cancer.

Key: HCP = Clinician; PAT = Patient; PAR = Partner

Excerpt 1: Have you seen the surgeons? (Consultation 16)

```
1   HCP:    A::nd (0.5) #uh# du:hm #up# (0.5) did (0.4) #wuhh# >have
2           you seen the surgins tdeh- are they- (.) eh::m would they
3           s:say thed they ken spare a nu:rve or anything like thad?
4           (2.3)
5   PAR:    .hh we've ony had one meeting with mister ((name)), s:o
6           we,-
7   PAT:    Weh he told us:s [the re]sults.
8   PAR:                     [just  ]
9   HCP:    >Oh ↑okay< °jus tha results then°
```

This sequence takes place early in the consultation with the clinician initiating to request information. They ask two polar questions within a single turn; one to establish if the patient had seen the surgeons, and one to ask if the surgeons said that they can "spare a nerve." This turn is designed with explicit orientation to the patient. Nerve sparing in surgery is intended to minimise loss of erectile function. The two questions, hesitations, and self-repair make the turn fragmented. After a gap of 2.3 seconds, the partner initiates repair on line 5 highlighting a problem with **the** clinician's questions. The problem is elucidated by the patient who picks up from the turn on line 7, noting that "he told us the results". The partner further elaborates in overlap on line 8 with "just", providing both informational and social support to the patient. The clinician orients to the patient's report with a turn indicating receipt of new information by using a change of state token "oh", before reaffirming the patient's informing [41]. This sequence shows how a partner self-selecting after the patient was selected was a prosocial and

collaborative action. This action was not only informative for the clinician, but it also enabled co-construction with the patient. This was a common feature across the collected examples.

The clinician did not always acknowledge this collaboration. In excerpt 2, the clinician is opening the consultation.

Excerpt 2: In shock (Consultation 17)

```
1   HCP:    Howeh you. (.) >alright<?
2   HCP:                 [((mouse click twice))]
3   PAT:    Eh:h (.)  [£↓wehh↓ (.) hah [hahha:hhah£]
4   PAR:                                [↑In↑ shock ]=
5   PAR:    =[HAHAHAHA]=
6   PAT:      [.hhh hah]
7   PAR:    =[£Ahs great-£    ]
8   HCP:      [((mouse clicks))]
9   HCP:     [Ri:igh then     ] let me jus:sah ((clicks))(.) bring
10          up your no:tes (.) sorrih, (.) ((clicks)) °caught >me
11          on< >th' hop,<°
```

The clinician's initial turn in this sequence is a question plus candidate response (How are you, alright?). This is a frequently used practice to solicit presenting concerns that has been shown to have clinical import in the encounter [42]. The patient initiates their response with "Err, well" followed by laughter, indicating a response that departs from the normative expectations of the question [43,44]. The response is produced with a smiling voice, and embedded laughter. The partner latches onto the laughter, and elaborates upon the patient's response, noting that they are "in shock". This is also performed with a smiling voice and is followed with laughter that joins with the patient's laughter in chorus. It is noteworthy that this laughter is only shared by the patient and partner. In this, the partner's contribution is prosocial, offering a socially difficult response that the patient was evidently reluctant to provide [45]. Before the laughter dissipates, the clinician initiates with "Right then," transitioning towards the patient's notes. During the couple's turns, the clinician is heard to click a mouse. They continue this as they initiate their turn, sequentially deleting their question, and a co-produced response that offered an important 'status indicator' of the couple. The turn on line 9 is performed with no orientation to the status update and resultant laughter across lines 4-8 where instead, the clinician is heard to repeatedly click their mouse. This is indicative of a missed opportunity to investigate. Instead, the turn directs the conversation away from the couple's first contributions to the consultation,

transitioning to the patient's notes. This action projects a situation where the lifeworld concern of 'shock' is to all intents and purposes, unattended.

In excerpt 3, the patient provides some information relating to their biopsy experience.

Excerpt 3: Did you have a powdery thing? (Consultation 18)

```
 1  HCP:   You >y'know< last ti:me you had the biopsee
 2         [>y' st]arted< the:e (.) [>antibiotics< the ]night=
 3  PAT:   [Ye:ah.]                 [two hou:ers before]
 4  HCP:   = befo:re.
 5  PAT:   >No I< didn °it° ws two ho:urs (.) #uh# cus I had a
 6         powderee thing?
 7  HCP:   Oh d'yuav po:wdree thing.
 8  PAR:   N-[yeh-]
 9  HCP:     [oh  ] why ws thah (.) >dyou ↑know.<
10         (.)
11  HCP:   dyou [know why tha wuh- ]
12  PAR:        [.hhhhh   is becus ] he said soming tuhdo with the:h
13         [straining uv the (.) muscle (group)  ]?
14  PAT:   [Av I- (.) hhh         hhev I goh tendon]i:tis (.) uh:h
15         >istha< I didn ackshee av [tendonitis but ah do have
16  HCP:                             [arr ohkay].
17  PAT:   brittle (.) tendons,
```

The patient highlights their exceptional circumstances noting that they needed a 'powdery thing'. The clinician responds with a request for confirmation [46]. As this repair initiator addresses the prior turn, it addresses the patient. The partner initiates a turn on line 8 that is hearable as an aborted turn. The clinician pursues further in overlap with the partner's aborted turn. Notably, the clinician's turns are initiated with a news receipt and change of state token demonstrating orientation to the news delivered by the patient across lines 5-6 [41,47]. In doing so, the clinician produces three interrogatives; "oh why was that?" "do you know?" and "do you know why that was?". The partner initiates their turn in overlap with the third interrogative, offering a response fitted to the first interrogative as opposed to the two polar questions that would **mobilise** a yes/no response. While this overlap may suggest that the partner has not oriented to the patient's primary rights as the selected speaker, the timing between the first interrogative "oh why was that?" and the partner initiating their turn illustrates a gap within which the patient could have initiated to respond, despite the clinician's

reformulations. As in excerpt 1, the patient, who did not initially respond, initiates to collaborate with their partner. In this, they offer an account across lines 14 to 17, fitted to the partner's response, leading to the clinician's acknowledgement on line 16.

The ways that partners responded to turns that selected the patient could serve as a form of advocacy that, instead of inhibiting patient contributions, enabled them. This is illustrated in excerpt 4. Here, the clinician works to address the patient's concerns about surgery.

Excerpt 4: No idea (Consultation 10)

```
1   HCP:    .hhh an then the:e (.) the (.) the c:continence (.)
2           what's you:ur (0.6) undestanding >about< how long you'd
3           be leaking urine.
4           (.)
5   PAT:    Uh- >I woud've-< I thought abit three ↑months_
6           (0.4)
7   HCP:    °Tha's right° [So (.)] >on average< (.) three months.=
8   PAT:                  [Mmmm. ]
9   PAT:    =Mmmm.
10  HCP:    #By# #uh:h# >yiknow↓< h:alf the men >will be< dried up by
11          then an the other half=
12  PAT:    =yeah.=
13  HCP:    =>is a< bit longer.
14          (0.3)
15  PAT:    Hm:m=
16  HCP:    =An what's your (.) imagination of how >many people<
17          would still be leaking at one ye:ar.
18          (1.1)
19  PAT:    Uh:h#ih#m#=
20  PAR:    No idea £hhh£=
21  PAT:    =>No uhn< #huh#- (0.3) I >wouldn've< >thought< any:y
21          (.)
22  HCP:    So i-it's lo:w i:is probably[ (.)] uh o:ne in ten wearing
23          pa:d,
```

Here, the clinician asks two questions that can be described as examination questions since the clinician is asking questions to which they know the answer. On lines 16–17, the clinician asks the patient what is their "imagination of how many people would still be leaking at one year".

This turn design, with the lexical item "imagination" allows for the possibility that the patient's response will be inaccurate. After a 1.1 second gap the partner initiates with a response on line 20 "No idea", which is followed by an audible outbreath shown on the same line (£hhh£). This gap indicates that the patient's primary rights as selected speaker were acknowledged. Moreover, the patient latches onto the laughter particles of the partner to offer a turn that aligns with the partner's response before going on to offer an elaborated response, noting that they "wouldn't have thought any" would leak after a year. Like all identified sequences, the partner's initiation after the patient was selected, displayed orientation to the norms of turn-taking and provided space for the patient to collaborate with the partner.

The ways that partners self-selected after the patient was selected was shown to enable patient contributions with as little as a single lexical item as shown in excerpt 5.

<div align="center">Excerpt 5: Brachytherapy is the one we prefer, isn't it? (Consultation 14)</div>

```
1   HCP:    Ok#a:y# .hhh >fine< .hh >so- so< what d'you understand
2           about yo:ur (.) prostate can:cer and about the v- options
3           fuh tre:a'm'n:t.
4           (0.5)
5   PAR:    °W:well°=
6   PAT:    =Well so fa:r (1.0) >I aven< actully:y- #ohh ih#- the
7           ones I- I've >read ohl<- all the (.) paperwork or we've
8           read all the paperwork n:d sortof gone >through it< n:n
9           (.) picked it apa:rt n (.) god [knows what] el-
10  HCP:                                  [ye::ah    ]
11  PAT:    .hh >so far< I ca:an't see a good positive.
12          (.)
13  HCP:    .HHhh
14          (0.6)
15  PAR:    °mmm° Braca the:rapy is the one we prefe:r °i'n it°.
```

```
16          (1.2)
17 HCP:     Do [you euh-]
18 PAT:        [We've lo]oked at thu:h th- operation:n to remo:ve it
19             and I:I thought we- uh- a:t first I thought >well that<
20             probly a good ide:a,
21          (0.6)
22 PAT:     Anen I:I read th- the litri're n I though- f:flipping
23             el:l y'godda be avin a la:ugh is worse [thn (.)] if you
24             ave thu:h,
25 HCP:                                               [ye:ah. ]
26          (0.6)
27 PAT:     thuh actu:l (.) #uh:m# therapy yiknow (.) like [thu:h]
28             thuh br[a- brack, ]
29 HCP:                                                    [yeah ]
30 PAR:          [ra:diothe-]
31 HCP:     >Yeah< (.) brachy[ther:apy]
32 PAT:                      [Yeah which] the:y stick (.) fi- (.)
33          >wiggle uh< (.)
34 HCP:     Ye:ah=
```

Here, the clinician initiates to elicit information from the patient across lines 1 – 3. After a short gap, the partner begins a turn with "well" as a preface to a longer turn. Well-prefaces project an incoming turn that is not in alignment with the prior or has a complex relation to it [44]. In response to this, the patient initiates their own well-prefaced turn, producing an account that does not align with the clinician's question, as the response departs from the pragmatic design of the clinician's question. Instead of offering an understanding, the patient evaluates negatively, all the available options. As the patient completes their evaluation, the partner re-initiates to offer a form of supportive elaboration that picks up from the patient's turn with "mmm" on line 15, followed by an expression of preference on behalf of them both. The partner completes the turn with the tag "isn't it?" which presents this preference to the patient for endorsement. After a 1.2 second gap, the clinician initiates, only to drop out when the patient initiates their turn. On line 18, The patient, from the perspective of the couple, provides a more elaborate account of their understanding, underlining the complexity of their considerations, projected by the initial well-prefaced turns on lines 5 and 6.

Partners' self-selecting after the patient was selected could also take place after the patient had initiated their turn, with partner turns serving as collaborative expansions to the patient's

turn-at-talk. Nevertheless, these turns accomplished the same action, orienting to the patient's primary rights as the selected speaker, and enabling patient contributions. This was shown in excerpt 6 where the clinician outlines the sexual impact of prostate cancer.

Excerpt 6: We have discussed it (Consultation 19)

```
1   HCP:  Thee- uhm- (1.0) the::e (0.8) othe' down side is- (.)
2              #a#changes >t' yo'< sexual function,
3              (0.5)
4   HCP:  >Ah' y'< sexu'y active >at th' moment?<
5              (0.6)
6   PAT:  W- >we ~a:are~< (.) >but ah ↓mean↓< (.) Ahm ↑seventy↓
7              comin' [t' sev]enty.
8   HCP:              [↓yeah↓]
9              (0.6)
10  PAT:  (not to) [((unclear due to overlap from HCP))]
11  HCP:              [Well uh- I- (.) so I think tha' it-] (.)=
12             =[so it's noh-]
13  PAT:    [so it's som]e'ing we'[ve discuss]ed- .hhh ih=
14  PAR:                          [the impo- ]
15             (.)
16  PAR:  =we have discussed it [as something]=
17  PAT:                        [i- in depth]
18  HCP:                        [↓ye:ah↓     ]
19  PAR:  =for for'y seven years (.) and (y'- well °about°) I
20             [(w:ould have) t' say,]
21  PAT:  [°y' 'ow wo' ah mean°]
22  HCP:  [↓ye:ah↓]
23             (.)
24  PAR:  [~>very ] very<~=
25  PAT:  [°↓God↓°]
26  PAR:  =°fort[unate~]°
```

Prior to this sequence, the clinician had been making explicit reference to sexual function as the ability to obtain and maintain an erection, in a series of turns that could only address the patient. The dyadic configuration of this topic was a feature shared across all 28 consultations

[39]**.** The question posed on line 4 is designed with explicit orientation to the patient as it references the patient's sexual function. The question on line 4 is initiated as a direct result of the precursory talk around sexual function across lines 1–3. The patient initiates their response after a delay, offering a mitigating account, indicative of a response out of alignment with the normative expectations of the question [43]. Throughout, the patient produces hearable trouble sources with hitches and re-initiations which are made more problematic as the clinician initiates a turn in overlap with much of the patient's talk on line 10. As the patient continues their turn on line 12, the partner initiates with turns operating in collaboration with the patient's turns from lines 14 – 26. This collaborative effort is elucidated in lines 15 and 16 where the patient elaborates upon the extent to which the couple has discussed the issue (in depth). After this sequence, the clinician further underlines the impact of treatment upon the patient's ability to obtain and maintain an erection. Despite the regular occurrence of overlapping talk in this sequence, the partner's contributions enable the patient to contribute to the conversation while underlining the patient's and partner's stance as a couple.

4   Discussion

This research attends to a social practice where a partner initiates their turn-at-talk after the clinician selected the patient to speak. The use of CA demonstrated that these interactions unfolded in a prosocial manner, with partners displaying orientation to the patient's primary rights to respond [40]. This was evident by the timing between the transition point of clinicians' turns and partners' initiations, where a sufficiently hearable gap was observed in every case in this collection. These gaps could be as little as 500 milliseconds [38]. Despite the patient appearing to initially pass on their option to take their turn, the act of the partner initiating after the patient's interactional move of passing consistently served as an enabler for the patient to elaborate upon or collaborate with their partner. Notably, patients and partners invariably co-produced subsequent turns-at talk, often taking a unified stance of 'we' or 'us,' despite the clinicians' turns orienting exclusively toward the patient as an individual. This pattern was present throughout the collected examples, with no exceptional sequences identified.

These findings are supported by work in other clinical contexts where speaker selection has been examined. Research in the context of the seizure clinic has shown how companions regularly oriented to the patient's primary rights as the selected speaker, prior to initiating their turn-at-talk [48]. Within the same context, research has demonstrated that companions served as facilitative resources to the patient and doctor [49]. The ways that partners initiated after the patient had passed on their rights also follows a similar pattern to that identified by research where companions in the seizure clinic could initiate when patients exhibited interactional

troubles [50]. The finding that partner contributions opened an opportunity space for patients to contribute also bears some similarity to research illustrating how parent contributions in paediatric settings encouraged children to contribute [51]. A similar finding was observed in the context of palliative care consultations where conversation analytic research has established that the practice of companions speaking on behalf of patients can occur without undermining the patient's autonomy [52].

The findings from this study contrast with previous research in the context of oncology, which has considered the ways that partners can speak for the patient may impede the patient's autonomy [29]. While this study offered detailed descriptions of this practice, it did not attend to, nor report on crucial components of these interactions such as the timing of turns, emphases, prosody, and non-word utterances. An inspection of these interactional features enabled this research to show the prosocial and collaborative nature of these exchanges, indicating that the practice of the partner initiating after the patient was selected was an enabling, not inhibiting action.

The data from this study suggest that partners can respond to a clinician's initiating turn, after the addressed patient's response has become hearable as absent. This practice compares well to research on social interaction that has described a preference for the selected speaker to respond, while orienting to the second-order preference for obtaining a response versus no response[35,38]. Following a partner's response, the patient invariably elaborated or collaborated in a series of cocompletions and choral productions where participants produce the same or similar turn-at-talk in overlap[53]. While some research has considered this format of talk akin to 'interrupting' [51], the findings from this research indicate that these overlaps and coproduced turns-at-talk accomplished prosocial actions; a finding supported by research into overlapping speech [54,55]. While the lack of video data meant that an analysis of embodied actions was outside of the scope of this study, the analysis highlighted the value of an analysis of turn-taking and speaker selection using audio-data only, a common practice for CA research in healthcare settings [40,56,57].

These sequences are indicative of the patient and partner acting as the 'cancer couple' as previously conceptualised [24,58]. Furthermore, these actions speak to the expressed preferences of couples for partner involvement in oncology settings [23,26]. In the context of prostate cancer, and several other genitourinary cancers, this is unsurprising as the experience of these cancers, and the impact of treating them is rarely confined to the patient. The decision to treat prostate cancer has particularly powerful implications for people with whom the patient shares an intimate relationship, as they navigate the psychosocial and sexual impact of this condition and its treatment [24,59]. These findings extend those observed in other clinical

settings such as paediatric primary care, neurology, and End of Life care, demonstrating the social and clinical utility of this social practice is evident across clinical settings where companions are not considered as ratified participants in the consultation [40,52]. The current findings highlight incongruities between the understanding of prostate cancer as a shared experience between couples, and the ways that this experience is communicated to couples during consultations. The findings of this study must be juxtaposed against the observation that, across twenty-eight consultations, there were only three instances of a clinician selecting the partner to speak. Moreover, there were only four instances where the patient selected the partner to speak. Based on this study, it is evident that partners' contributions can enable the patient to provide information that was not initially forthcoming, serving as a valuable interactional resource. In considering this incongruity, some explanations might be found in policies relating to patient centeredness and shared decision making (SDM).

SDM is idealised as a practice where clinicians and patients reach decisions by sharing evidence and preferences [10,60]. SDM is designed to encourage collaborative patient-clinician engagement, to promote individual patient autonomy in decision making [12]. Likewise, patient-centredness is intended to promote patient involvement through SDM [13]. It is possible that there exists a tension between the configuration of the consultation where a couple is present, and clinical ideals that are situated within an individualist approach to patient autonomy. Despite the findings in this study demonstrating the social and clinical utility of partner contributions, clinicians exclusively addressed the patient as an individual, distinct from their partner. While this practice may align with patient-centredness, **it is also indicative** of enacting an individualised version of autonomy as conceptualised by Immanuel Kant, where individual decisions are conceptualised as the result of solo cognitions outside of social influences [61]. This can explain the observation that partners were rarely addressed by clinicians and patients, as the participatory framework is arguably informed by the normative primacy of the doctor-patient relationship. The clinical model of patient autonomy places emphasis upon the patient's right to individual determination, while working to isolate them from external influences [14]. By contrast, the ways that couples regularly took up a unified stance indicates that their autonomy within this setting was inherently relational as their responses resisted the individualised configuration of the encounter [62,63]. In this respect, the ways that patients and partners acted in collaboration illustrates that decision-making is never a solo cognitive process, but that it is a fundamentally social process, inextricably connected to social relations and practices [12,64].

5   Conclusion

In these consultations, the ways that the partner responded where the patient had evidently passed on their primary rights to speak were consistently prosocial and patient enabling. Patients regularly took up a unified stance with the partner as a couple, resisting the individualised configuration of the encounter. The findings show that this practice enhanced the relational autonomy of the couple. There are instances where the couple presents as a unified part of a clinician-couple dyad, and others where the encounter might be better considered as triadic. This study argues that there is a need to reconsider what it means to enact patient centeredness in the prostate cancer clinic that is responsive to how the couple presents in the encounter.

6   Practice implications

This research offers evidence for a need to reconsider what it means to enact patient-centred care, especially when the patient attends the consultation as part of a couple. **As decision-making** and patient autonomy can be relational, there is value in reframing the patient as equally relational, connected to a complex network of social relations [65]. One way that this might be accomplished within the context of prostate cancer, would be to sanction and address partners as part of the consultation, akin to the process in the seizure clinic [48,49]. In this context, the formal sanction of a partner does not impact upon the duration or structure of the encounter, and it provides a valuable interactional resource for the patient and the clinician. In the context of prostate cancer, partners are likely to remain as unratified participants unless clinicians proactively engage with couples. Absent of this form of participant ratification, partners will likely continue to have to work to insert their contributions into the consultation, resisting the dyadic structure of the encounter.

Declaration of competing interest

None.

CRediT author statement

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