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Simon John Stewart, Lisa Roberts, Lucy Brindle



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Shared decision-making during prostate cancer consultations: Implications of clinician misalignment with patient and partner preferences

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

Lisa Roberts (l.c.roberts@soton.ac.uk)² ORCID: 0000-0003-2662-6696

Lucy Brindle (l.a.brindle@soton.ac.uk)² ORCID: 0000-0002-8933-3754

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

²School of Health Sciences, Faculty of Environment and Life Sciences, University of Southampton, Southampton, UK

Corresponding Author:

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

Abstract

Concepts of patient-centredness and shared decision-making inform expectations that clinicians should display sensitivity to patients' expressed preferences. This study examines the organisation of treatment-related preferences expressed by patients and their partners during clinical consultations for people with localised prostate cancer. A conversation analysis of twenty-eight diagnosis and treatment consultations was conducted with data recorded from four clinical sites across England. When clinicians disaligned from expressions of preference such as directing talk away from expressions, or moving to redress perceived misunderstandings, it caused discordance in the unfolding interaction. This led to couples silencing themselves. Two deviant cases were identified that did not feature the misalignment found in all other collected cases. In these two cases, the interaction remained collaborative. These findings highlight the immediate consequences of expressions of preference being resisted, rejected, and dismissed in a context where clinicians are expected to explore expressed preferences in service of SDM. The deviant case analysis offers an alternative practice to the pattern observed across the collection, offering a comparison between misaligned sequences, and cases where social solidarity was maintained. By acknowledging couple's expressions as valid contributions, rather than acting to inform or correct them, clinicians can create opportunity spaces for discussion around treatment preferences.

Keywords

Prostate Cancer, Partners, Conversation Analysis, Conflict, Treatment Decision Making, Shared Decision Making

Introduction

In healthcare, patients typically seek medical attention to gain an explanation and solution for an illness. During clinical consultations, the explanation and potential solutions are usually discussed during consecutive phases (Robinson, 2003; Stivers, 2006). Research into these phases has shown how clinicians can communicate diagnoses and make treatment recommendations in ways that convey varying degrees of authority (Peräkylä, 2006; Stivers et al., 2018). For example, the ways that diagnoses are presented has been shown to draw upon authoritarian practices such as doctor-centred communication (Byrne and Long, 1976; Heath, 1992). In treatment recommendations during primary care consultations in the UK and USA, the most common form of treatment recommendation is the use of a pronouncement, such as “I’m going to start you on X”, regarded as the most authoritative form of treatment recommendation (Stivers et al., 2018).

Research into the interactional processes of treatment recommendations has highlighted how patients orient toward authoritative actions. This work has shown how patients producing minimal responses to authoritative deliveries can indicate resistance (Heath, 1992; Koenig, 2011; Stivers et al., 2018). Research in the context of primary care has also identified how patient silence can be produced as patients orient to particular consultation phases in which they are not normatively entitled to contradict clinicians (Heritage, 2017). These studies suggest that resistance should be treated as an important interactional resource, enabling patients to assert agency and engage during the consultation (Koenig, 2011). The medical encounter has also been regarded as a site where the patient and clinician should be treated as agents in the negotiation of diagnoses and treatment decisions (Lindström and Weatherall, 2015; Peräkylä, 2006). This relates to the concept of Shared Decision Making (SDM). As a clinical model, SDM is designed to encourage clinicians and patients to share information, achieve consensus, and to promote informed, shared decisions (Charles et al., 1997; Elwyn et al., 2012; NICE, 2021). Research has explored the interactional strategies available to, and employed by clinicians to encourage affiliation and SDM. In a systematic review, Kiesler and colleagues highlighted how physicians can employ several interactional strategies to encourage affiliation (Kiesler and Auerbach, 2006). Strategies included work to match and reciprocate patient’s behaviours through verbal and non-verbal strategies to align with patient preferences for information. Strategies included matching and reciprocation of gaze, body orientation, frequency of overlapping talk, and length of clinician speaking turns. However, research has also illustrated some of the challenges faced by patients in expressing their own experiential expertise and preferences relative to treatment decisions (Weiste et al., 2022). In this study of

social and healthcare services in Finland, when clients sought to promote their experiential knowledge as a resource for decision-making, these contributions were disregarded by professionals. The research underlined how client engagement in self-dismissal of their own epistemic status led to professionals offering appreciation of the client's knowledge, leading to a paradox of clients having to dismiss their own experiences to have their views made relevant. In the context of palliative care, research has examined the dilemma of affiliation faced by healthcare professionals if the views of the patient and their companion are seen to diverge (Pino et al., 2021). The analysis characterised strategies where HCPs effectively set aside their position relative to a divergence, only to return to it later in the consultation without siding with one party over the other. This body of work indicates that the implementation of SDM is a complex practice that requires tailoring to the clinical context.

SDM has been described as both a philosophical principle and a practical process as clinicians are expected to engage in partnership with patients to make choices about their care, driven by evidence and the patient's expressed preferences (Coulter and Collins, 2011). SDM can be applied in settings where multiple treatment choices are available, and the right choice might be expected to balance benefits, risks, and the expressed preferences, needs, and orientations of the patient (Elwyn and Charles, 2001). Low and intermediate risk localised prostate cancer is a context where there is an expectation of SDM, and explicit sensitivity to expressed preferences regarding treatment choices (NICE, 2014). Current guidelines recommend that SDM should be embedded at an organisational level and individual level so that it becomes part of the culture of healthcare delivery (NICE, 2021). From high-level leadership to individual training and continued professional development, embedding SDM across all levels has been recommended to ensure that clinicians have the capabilities and confidence to support SDM in the delivery of healthcare in practice.

SDM has informed healthcare policies across several medical contexts, including neurology and oncology (Cohen and Britten, 2003; Toerien et al., 2018; Toerien and Jackson, 2019). However, research indicates that the ideals of SDM are rarely enacted, even in contexts where clinicians advocate for SDM (Driever et al., 2020; Lipstein et al., 2014). In the context of gastroenterology and rheumatology, Lipstein and colleagues (2014) observed limited use of SDM noting minimal elicitation of preferences, treatment goals, and patient knowledge. Additional work in the context of back pain consultations has highlighted limited evidence of SDM during consultations, noting that the clinician's desire to treat served to inhibit SDM (Jones et al., 2014). Likewise, Driever and colleagues (2020) noted that, while most primary care physicians in their research advocated for SDM, they often reverted to a paternalistic delivery during primary care consultations.

Low and intermediate risk, localised prostate cancer is a noteworthy medical context for several reasons. Firstly, there are multiple treatment choices available which pose different risks and benefits. Broadly, treatment choices include surgery, radiotherapy, and active surveillance which, distinct from “wait and see”, includes regular blood tests and biopsies along with the option to move to a treatment with curative intent (TCI) later. Secondly, prostate cancer is often slow growing and research to date indicates that there is no clear benefit from selecting one treatment option over any other at 10 years following diagnosis (Hamdy et al., 2016). In the UK, this has informed a policy of SDM and preference-sensitive treatment decision-making during clinical consultations, although active treatment, rather than active surveillance is recommended for many patients with intermediate risk localised prostate cancer (NICE, 2014). Thirdly, the experience of prostate cancer has been shown to affect both patients and their partners, as its treatment-related side-effects have profound implications for what has been described as the ‘cancer couple’ (Bullen and Tod, 2013; Soloway et al., 2005). Treatment-related side-effects such as incontinence, impotence, fertility issues, and fear of cancer progression can all lead to the cancer couple experiencing physical and psychological morbidities that inevitably impact upon their relationship (Bullen and Tod, 2013; Wootten et al., 2014). Accordingly, patients largely expect their partners to be involved throughout the cancer experience (Beisecker et al., 1996; Davison et al., 2002; Stewart et al., 2021; Zeliadt et al., 2011). Finally, unlike other contexts such as primary care where there is an institutionalised expectation of an explicit treatment recommendation (Stivers et al., 2018), in these consultations, clinicians are expected to adhere to the principles of SDM where clinicians outline available treatment options, the benefits and risks of each option, while acknowledging and respecting expressed orientations and preferences.

To date, research into the expression of treatment-related preferences, has mainly taken place in contexts where the clinicians’ authority to treat patients is grounded in the clinician’s expertise as they offer biomedical reasoning to patients as justification (Koenig, 2011; Lindström and Weatherall, 2015). Nevertheless, in these settings, clinicians were found to orient toward the patient’s right to accept or refuse treatment recommendations. Additionally, research in the context of paediatric primary care has explored the ways that parent companions may orient to clinicians’ recommendations, indicating that they can resist recommendations as an interactive resource for negotiation on behalf of a child patient (Stivers, 2005; Toerien and Jackson, 2019). While research has investigated practices relating to patient’s preferences in prostate cancer consultations (Wade et al., 2009), research has yet to examine these practices relating to a couple’s treatment-related preferences as expressed in this context. Accordingly, this research examines the ways that treatment-related preferences are

expressed by patients and their partners during clinical consultations for localised prostate cancer. This study offers an analysis into the structural organisation of these interactions, exploring how SDM is conducted, and how the exploration of treatment preferences unfolds. The analysis elucidates the ways that talk is organised around expressed treatment preferences by examining how patients and partners express their preferences, and in turn, how clinicians respond to these expressions. In doing so, this study identifies the implications of clinicians' responses for the extent to which expressed preferences are explored, and the extent to which SDM is being enacted.

Methods

Participants and Recruitment

This study used audio-recordings of consultations collected as part of the xxxx research study "xxxx", an aim of which was to investigate partner involvement in prostate cancer consultations. Four sites spanning South and Central England were recruited to a study exploring communication about low and intermediate risk prostate cancer and support for preference-sensitive decision-making. Clinicians were invited to take part in a study that would involve audio-recording their consultations to either inform development of a complex intervention to improve preference-sensitive decision making or to provide baseline consultation data prior to the intervention's implementation. Potential patient participants being investigated for possible prostate cancer were initially sent a letter to inform them that they may be approached about the study during their next hospital visit. On arrival at the clinic, those in receipt of the letter were invited to take part in the study. Researchers provided an information sheet to all participants prior to, or at the time of recruitment. For the purpose of exploring partner involvement, 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 co-present partner defined as a romantic partner or spouse distinct from a friend or relative. This selection process produced a corpus of twenty-eight consultations comprising thirteen clinicians, twenty-six patients, and their co-present partners. Consultations included appointments at which biopsy results and treatment options were first presented to patients, and subsequent appointments which might provide further information about multiple, or a single treatment. Ethical approval for this study was obtained from the Cambridge South NHS Research Ethics Committee (NHS REC No: 15/EE/0132). Approvals restricted recording of consultations to audio only.

Method

Data were analysed using conversation analysis (CA). CA was chosen as it draws upon data collected from recordings of interactions, offering an empirical, data-driven analysis into the situated social practices enacted and actions accomplished (Sacks et al., 1974). This is made possible by situating analyses within the broad context of the clinical encounter, as well as the narrow context of the turn-by-turn organisation of interactional moments. CA considers how turns at talk are designed, how interlocutors orient to these turns, the ways that they respond, and how this relates to subsequent exchanges (Clayman, 2013; Drew, 2013; Stivers, 2012). CA has been applied to clinical communication to highlight the everyday social practices and their interactional consequences, alongside viable alternatives (Drew et al., 2000).

Analysis

Recordings were transcribed verbatim, with all analytically relevant sequences further transcribed according to Jeffersonian conventions (Jefferson, 2004), rendering details of talk such as intonation, emphases, gaps, and overlapping talk (Table 1). In accordance with the fundamental principles of CA, initial analyses proceeded absent of focussed analytic goals (Hoey and Kendrick, 2017). This involved repeat-listening to the recordings, with notes made about key observations. One observation was that patients and partners regularly expressed preferences relating to decisions about treatment, with or without invitation from the clinician, such as the production of a patient view elicitor (PVE) (Toerien et al., 2018). All sequences containing such expressions were collected for a detailed, line-by-line analysis. The analysis considered how the configuration of these sequences informed contribution opportunities for the patient and partner, attending to details such as turn design (Drew, 2013), and sequential organisation (Stivers, 2012). The analysis produced an illustration of how clinicians oriented to patients' and partners' expressions of treatment preferences.

Results

Sample

Twenty-eight prostate cancer consultations were analysed where a patient attended with their partner, and diagnosis was discussed alongside available treatment choices. The patients were diagnosed with low or intermediate risk, localised prostate cancer, and consultations involved the clinician outlining several available treatment options. Although encouraged to make a treatment decision, patients also had the opportunity to take some time after the consultation before making this decision. Contextual information (prostate cancer NICE risk categorisation, treatments options, and type of consultation) is provided for the excerpts, in Table 2. In

accordance with NICE guidelines, clinicians are expected to present these treatment choices while remaining sensitive to expressed preferences and orientations (NICE, 2021, 2014).

Nonalignment with expressions of preference

A social practice was identified in eighteen sequences where patients and partners expressed treatment-related preferences. In all but two of the eighteen sequences, the ways that clinicians oriented to these expressions of preference were found to be out of alignment with the ongoing activity (Heritage, 2011; Whalen et al., 1988). This action of nonalignment stands distinct from non-affiliation as it relates to how the clinicians responses did not support the structural organisation of the unfolding sequence whereas affiliation refers to the support and endorsement of a person's point of view (Stivers, 2008). Sequential misalignments became apparent as clinicians moved to dismiss expressions of preference, sought to inform patients and partners, or change the topic. By doing so, they organised the unfolding interaction as a series of turns that failed to acknowledge and respect expressions of preference.

For each excerpt, HCP: indicates the clinician (healthcare professional), PAT: indicates the patient, and PAR: indicates the partner.

Nonalignment, with patient-initiated preferences

This sequential misalignment takes place over a protracted sequence in Excerpt 1. Prior to this sequence, the clinician had been informing the patient about the treatment choices and their side-effects which included a lengthy explanation about the expected duration of treatment-related complications.

Excerpt 1: What's your imagination? (Consultation 10)

- 1 PAT: Yeah (.) 'eah [°>bu- bu-<
- 2 HCP: [Wha- wha-] what >soddo< things are
- 3 attractive to yo:u in choosing a treatment,
- 4 (.)
- 5 PAT: Weuh↓ (.) #Ah# Ah wa- I wasn't keen on thee eh:m (0.5) eh
- 6 removal.
- 7 (0.5)
- 8 HCP: Mhm, =
- 9 PAT: =Th- that's uh:m (1.0) first'v all >an' en'< I b- wa'dn
- 10 keen on tha- o- option,
- 11 (0.7)
- 12 PAT: [Uh:m]

- 13 HCP: [>What wa-<] What was driving that decision o:ut of
 14 interest.
 15 PAT: We:ll uh- thee:e thee ongoin:n uhm (.) #ihh# havin' a
 16 cathete:h 'n uh:h nappies 'n all that foruh- fo' months
 17 'n' (0.3) yiknow=
 18 HCP: =So:o so let's >just make< su:re >that your<
 19 understanding is (.) #uh# >correct< on that >so the<
 20 catheteh stays in foruh (.) ten:n ↓days?=
 21 PAT: =Righ [ye:ah]
 22 HCP: [.h h h h] >Then it's< removed [s:so] the's no
 23 catheter a:fter=
 24 PAT: [mmhm↓]
 25 HCP: =tha:at,
 26 (0.4)
 27 PAT: °no°=
 28 HCP: =.hhh (.) Uh:hm (.) an:n s:so that's (.) yiknow sh:hort
 29 period time,
 30 (.)
 31 HCP: .hhh an then thee:e (.) the (.) the c:continence (.)
 32 what's you:ur (0.6) understanding >about< how long you'd
 33 be leaking urine.
 34 (.)
 35 PAT: Uh- >I woud've-< I thought abit three ↑months_
 36 (0.4)
 37 HCP: °Tha's right° [So (.)] >on average< (.) three months.=
 38 PAT: [Mmmm.]
 39 PAT: =Mmmm.
 40 HCP: #By# #uh:h# >yiknow↓< h:alf the men >will be< dried up by
 41 then an the other half=
 42 PAT: =yeah.=
 43 HCP: =>is a< bit longer.
 44 (0.3)
 45 PAT: Hm:m=
 46 HCP: =An what's your (.) imagination of how >many people<

47 would still be leaking at one ye:ar.
48 (1.1)
49 PAT: Uh:h#ih#m#=
50 PAR: No idea fhhhf=
51 PAT: =>No uhn< #huh#- (0.3) I >wouldn'tve< >thought< any:y
52 (.)
53 HCP: So i-it's lo:w i:is probably[(.)] uh o:ne in ten wearing
54 pa:d
55 PAT: [Hmm]
56 (.)
57 HCP: Ana handful (0.3) s:o that's many (.) swf- safety:y
58 [o:r] just a fe- few=
59 PAT: [yeah.]
60 HCP: =drips here n the:re >nothing<
61 (.)
62 PAT: °Yeah.°=

At line 2, the clinician initiates a patient view elicitor (PVE). The patient's response from lines 5 – 9 is performed with a well-preface, hitches, and re-initiations, all indicative of a turn performed against the normative expectations to respond positively to a treatment offer conveyed by the clinician (Pomerantz and Heritage, 2013). After expressing their preference there is a gap long enough for the patient to initiate a further turn on line 12. At the same time, the clinician initiates a turn on line 13. This turn treats the patient's expression as insufficient and is a repair initiator insofar as it is an explicit request for an explanatory account (Kitzinger, 2013). The repair initiator places a hold on the progressivity by cutting short the patient's turn on line 12, but does not alter the collaborative organisation of the unfolding interaction; that is to say, the patient goes on to describe the reasons for their preference. The patient initiates their turn on line 14 with a well-preface, projecting a formulation from 'my side' as they offer their account (Heritage, 2015).

The clinician, instead of acknowledging this account, launches a new sequence beginning on line 18. This sequence is designed to inform the patient as the clinician signals their intent to make sure the patient's understanding is "correct." While this informing adheres with the principles of SDM, this is where the sequential misalignment becomes explicit. The patient orients to a shift in consultation phase which effectively limits their participation. From lines 19 – 47, the clinician launches a sequence of probing questions. During this sequence, the clinician is not acting to understand the patient's preference but is instead delivering a sequence in which they

inform and check the patient's understanding. The first informing action takes place on lines 18 – 29, where the clinician rhetorically describes the duration of catheter use as a “short period”. The second action to check the patient's understanding takes place when the clinician asks the first probing question on lines 31 – 33, asking the patient for their understanding of how long they will leak urine. This information was explicitly provided by the clinician just prior to this sequence. The patient's response is hearable as distressed as they abort and re-initiate their turn, answering with the information provided earlier. The patient orients to the organisation of this sequence, downgrading their answer to what they “thought” it was. After a notable gap, the clinician provides a more elaborate version of the answer from lines 37 – 43, with only minimum acknowledgement that the patient answered correctly on line 36. The third informing action takes place on lines 46 – 47, where the clinician asks, “what's your imagination of how many people would still be leaking at one year?”. The turn design, and the lexical item “imagination” is distinct from the earlier action that solicits the patient's understanding. This provides an opportunity space for the patient to produce an incorrect response that the clinician can correct, as signalled at the beginning of the informing sequence on line 18. The 1.1 second gap after this question is noteworthy as it is followed by an extended discourse particle “uhm” on line 49, to which the partner orients as a trouble source as they provide the repair solution in support of the patient on line 50 with “no idea”. The laughter particle produced after this is noteworthy as, taken in combination with the patient's turn, and the lengthy 1.1 second gap, it indicates that the question was considered as inappropriate within the organisation of this sequence (Potter and Hepburn, 2010).

The patient then attempts to answer on line 51 (I wouldn't have thought any). The clinician concludes that “one in ten” will still be leaking, and around “one or two in a hundred” might need surgery, described rhetorically as “low” and a “handful” respectively. It is therefore of critical importance to note how the patient orients to these assessments, as their contributions are reduced to negligible; with the patient reducing their responses to near silence from lines 52 – 62, in orientation to a protracted informing sequence and nonalignment with an expressed preference.

In Excerpt 2, the expression of preference and the subsequent misalignment takes place after the clinician pronounces what they describe as the ‘best option’.

Excerpt 2: That's the one I didn't want (Consultation 5)

- 1 HCP: So we've discussed it >in one of our< meetings, and
 2 everyones agreed re:ally that the bes:t (.) option >for
 3 you< would be something we ca:ll active surveillance,=
 4 PAT: =°Oh n:o° £aHAHHAH£ [>no I-<] £ca:hhn't£ s:s-that's the=
 5 HCP: [S::o]
 6 =one I didn' want.
 7 HCP: ↓N::aw↓ s:so I mean (.) active surveillance is like PS
 8 A:A surveillance which is >what youve< ba:sically been on
 9 (0.4) for the last (.) ye:ar or two
 10 (0.3)
 11 HCP: ((lip smack)) okay?
 12 (0.3)
 13 HCP: Bec'se we have been watching your PSA:A, haven't we.
 14 PAT: Mmmm.

The clinician's turn projects a high level of paternal entitlement based upon the epistemic and deontic authority of "everyone" from the meeting, taking a unilateral stance of "us" relative to the patient. The patient latches onto this recommendation to resist it. The laughter particles, turn design, and the re-initiation during the turn project an expression that is performed in orientation to the high entitlement of the recommendation. The sequential misalignment with the patient's expression occurs on line 7. Prior to this turn, the clinician attempted to initiate their next turn, only to then reorient toward the patient's resistance. In doing so, the initiating lexical item of "Naaw" on line 7 fails to align with the patient's resistance, evidenced by the ways that the clinician performs a persuasive elaboration and clarification across lines 7 – 9. There is no uptake by the patient or partner, which prompts the clinician to pursue a response on line 11. After a brief gap, the clinician elaborates further still on line 13, with an evaluation and an explicit additional pursuit for acknowledgement and consent. The minimal response token on line 14 "mmm" demonstrates that the patient and partner have silenced themselves in this exchange (Koenig, 2011). By not providing conditionally relevant next turns, their silence can be seen as an interactional move to keep their disagreement 'beneath the surface' (Toerien and Jackson, 2019).

The critical aspect of the observed sequential misalignment is the ways that clinicians failed to align with expressed preferences. Whether elicited by the clinician (Excerpt 1) or produced without elicitation (Excerpt 2) the misalignment was observed. The importance of this relates to

the ways that clinicians inadvertently close opportunities to explore preferences during a time where it would be of benefit to acknowledge and respect these preferences. This is of significance as clinical interactions are typically organised around the normative relationship between a doctor and a patient, in which the doctor takes up the epistemic rights and privileges of the ‘expert’ (otherwise known as a K+ status) relative to the patient who typically expects advice and guidance from the doctor (otherwise known as K- status) (Heritage, 2012; Lindström and Weatherall, 2015). While the prioritising of the clinician’s epistemic position would typically be expected, within the context of SDM, the failure to acknowledge expressed preferences is arguably counterproductive as it is a context where clinicians would be expected to acknowledge, respect, and explore these preferences (NICE, 2021, 2014).

Nonalignment with partner-initiated preferences

Sequential misalignments were more pronounced when partners expressed preferences. In Excerpt 3, the clinician just completed an extensive informing sequence, describing some elements of treatment options and their side effects. In the previous turns, the clinician had described a “deterioration of sexual function”, stopping short of delivering a treatment recommendation.

Excerpt 3: The cancer’s the main thing (Consultation 20)

- 1 HCP: [S:O-]
- 2 PAR: [>As far<] as I’m concerned the sexual side (.) I mean:n
- 3 the cancer’s the main thing=
- 4 PAT: =It is[:s.] °it is°
- 5 HCP: [yeah. (.) Bu]ddin [TERMS OF]
- 6 PAR: [From the] othe’ si[de th-]
- 7 HCP: [BUDDIN]
- 8 TERMS OF (.) thee (.) phhackage of the two treatments,
- 9 (0.6) Uhm (1.3) Yiknow (0.7) is depends whethe’ on:e
- 10 seems >to be< more attractive to you than another.
- 11 (0.7)
- 12 HCP: [Uh::m]
- 13 PAR: [Hhhh]

The opening line is hearable as a transition to a new project within the consultation. As the clinician initiates their turn, the partner self-selects in overlap, expressing their preference for a curative intervention over the preservation of their sexual relationship, noting that the cancer is their priority, not the “sexual side”. The turn is designed with emphasis on the start of the word

cancer, conveying this priority. Notably, the patient initiates their turn on line 4, latching onto the partner's expression with the supportive expansion, "it is". Instead of acknowledging, accepting this expression, for example, with a news receipt (Maynard, 2010), the clinician initiates in overlap with the patient, taking a stance of nonalignment that fails to acknowledge the co-constructed expression of the partner and patient. The partner then initiates an elaboration on line 6. The turn is hearable as incomplete as the clinician re-initiates their turn from line 5 by way of an interjacent overlap. They initiate with their voice raised above the surrounding talk, with the partner dropping out. The clinician acknowledges briefly to the way that they have taken the floor from an active turn-in-progress through the re-initiation of the turn, repeating "in your case" at a lower volume. The 0.7 seconds of silence combined by an audible outbreath indicates that the partner has chosen not to speak where a conditionally relevant next turn was warranted. This absence is indicative of an interactional move of conflict avoidance or minimising (Toerien and Jackson, 2019).

Sequential misalignment with the partner's expressed preference is evident in Excerpt 4.

Excerpt 4: Obviously, you must have an opinion (Consultation 21)

- 1 HCP: Ra:rely [(.) one particular] treatment,
 2 PAT: [((clears throat))]
 3 (0.4)
 4 HCP: =the treatment that you should have (.) okay? (.) >there
 5 a< number of options >for you< to consider >so< re:ally
 6 (0.4) toda:y is more about (.) giving you (0.7) >the<
 7 diagnosis, (.) >telling you< about the diagno>sis< a:nd
 8 (.) then giving yo:u (.) some information (0.4) °okay°,
 9 =>so th't< >you c'n then< go awa:y, (0.3) reflect on that
 10 information, (0.4) star' to absorb it (0.3) =and then
 11 come ↑ba:ck (1.2) M:ore informed (.) >tuh then< (0.6)
 12 talk (.) >a bit< more about (.) wha' you think (0.5)
 13 >w'be the best< treatment for yor- (0.3) #your
 14 >disease< (.) =>and we< can guide you through that
 15 (.) >with the< help of myself, (0.7) >uthe membis
 16 uthe< team (.) >dealing< ((name[na::ame)) `n' pro-]
 17 PAR: [>b'd obviously< y:ou]
 18 must h:ave (0.3) an opinion,
 19 (0.7)

- 20 HCP: ↑↑Yeah we D:O↑↑ HAVE OPINIONS (.)=
 21 =BU- (.) [BU- (.) BU- (.) BUT] IN YO:UR CASE,
 22 PAR: [>fwith more experience th'n usf.<]=
 23 (0.3)
 24 HCP: in your case (.) ther:re a:a number uv options.
 25 (0.6)
 26 HCP: Okay?
 27 (0.5)
 28 HCP: No:w (0.6) if yo:u (.) >if you< have very aggressive
 29 prostate cancuh,

As the clinician introduces the treatment choices, the partner self-initiates with a turn on lines 16 and 17 to express a preference for some form of expert guidance relating to treatment, noting that the clinician “obviously must have an opinion”. While the clinician was outlining the process of listing options, the partner has conveyed an expressed preference that they do not want a list of options, but instead they want an expert opinion. While the partner’s turn was hearable as incomplete on line 17, the gap of 0.7 seconds provides affordance for the clinician to respond to this expression. It is therefore on line 19 that the interaction shifts, with the turn on line 20 hearable as out of alignment with the partner’s expression. The pitch of the turn-initial “yeah we do” is significantly higher, with the turn escalating in both volume and pace. As they initiate the next unit of their turn a total of four times, this turn actively inhibits the partner’s attempted elaborative account for their expression on line 21. The clinician continues at the same high volume on line 22, after which they take a micropause before reinitiating the turn, noting “in your case, there are a number of options”. The 0.6 second silence demonstrates that the partner has silenced themselves where a conditionally relevant acknowledgment was warranted. Notably, the clinician orients to this, producing a response pursuit on line 26, which receives no take-up. From line 28, the clinician transitions to a topic that is not relevant for the couple as they are not faced with an aggressive form of cancer. The clinician instead introduces this hypothetical scenario where there would be a treatment recommendation by the clinician, to justify the currently proposed method of treatment choice in which the patient decides between options. This action occurs instead of acknowledging and exploring the partner’s view that the clinician might be expected to have an opinion regarding the best treatment.

Nonalignment with expressed preferences could also be performed by failing to respond to the previous turn, as if the turn was not produced at all (Lerner, 1989). In Excerpt 5, the clinician notes that ahead of any decision about treatment with curative intent, the patient will be

monitored until they make a treatment decision. The misalignment in this sequence relates to the failure to acknowledge an expressed preference for a particular treatment. The patient and partner are not expressing a preference for a moratorium on their treatment decision, but instead, they have stated that Active Surveillance is the treatment that “we want”. They have expressed this preference at several points prior to this sequence in the consultation.

Excerpt 5: So there’s no harm (Consultation 3)

- 1 HCP: Uh:m (.) an:nd (0.8) >in the< mean time we >gonna be<
 2 monitoring yo:u an a:ble to give you othe’ (0.7) [non:n-]
 3 PAT: [Ye::s]
 4 (.)
 5 PAR: Ahs- That’s what we want=
 6 PAT: =[Ye::s-]
 7 HCP: [yiknow↓]
 8 (.)
 9 PAT: [ye:ah- °yeh°-]
 10 HCP: [So #i#- SO #i#- S:O] I think there’s ↑no↑ harm (0.7)
 11 >Well< (0.3) >sorry< >ther is< harm ↓treating↓ you,
 12 (.)
 13 PAR: °Mmm.°
 14 (0.6)
 15 HCP: Uh- (0.3) >but the< ha:rm is something tht we cn
 16 expres:s.
 17 (0.6)
 18 HCP: In percentages n >so on< >[n you] can appreciate [that.]<
 19 PAR: [Yes.]
 20 PAT: [Mhm.]

On line 5, the partner self-selects to express a joint preference for active surveillance as their treatment decision, stating “that’s what we want”. The expression is endorsed by the patient on line 6. In overlap, the clinician initiates a triple so-initiated turn that is hearable in its sequential deletion of the partner’s expression, with the extensive use of “so” projecting a turn that has arisen from incipency, absent of orientation to the prior (Bolden, 2009). Moreover, the clinician fails to align with this expression by returning to the concept of potentially curative treatment. Instead, the clinician produces a pairing of bad news and good news. This can be seen as utilising the pairing phenomenon to make salient reasons to consider a curative treatment

(Leydon, 2008). The impact of the misalignment is evident in the minimal contributions of the couple from lines 12 – 17. The clinician's turn on lines 10-11 was hearable as complete, but with the silence and minimal uptake (lines 12 – 14), they pick up their turn where they left off, offering an elaboration, which also receives no take up (line 17), leading to a third elaboration which receives acknowledgement by the couple as the response. The continued pursuit of talk around curative treatment as one of several options aligns with some of the key principles of SDM, but in doing so, fails to acknowledge an expressed preference for Active Surveillance.

Alternative practices

Two cases were identified in which the sequential organisation differed remarkably. Both cases featured the same clinician whose consultations are distinct insofar as the purpose is to discuss one treatment option rather than the entire suite of available choices. In these cases, the patient had already been informed about the range of treatment options in a previous appointment. The difference between these and the previous sequences relates to how the clinician orients to expressed preferences for treatment.

Excerpt 6: Brachytherapy's the one we prefer, isn't it? (Consultation 14)

- 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 (.)
 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: [radiotthe-]
31 HCP: >Yeah< (.) brachy[ther:apy]
32 PAT: [Yeah which] the:y stick (.) fi- (.)
33 >wiggle uh< (.)
34 HCP: Ye:ah=
35 PAT: =needl[es in o:r >suh-think< an:n,]
36 HCP: [needles into your prostate]
37 PAT: >anen< fippi:n (.) [whackit] with som:e (.) pellets or
38 >some'ing<.
39 HCP: [ye:ah.]
40 (.)
41 HCP: Yih- #y-# y:yeah yeah ↑wha- so- so- what- what-↑ did
42 mister ((name)) ex:plain to abo:ut w:wha=
43 =[what w's found on the s:can n the- (.) the bi]opsy
44 PAT: [Hes::::::::::::::::::s (.) euhhhh]

In Excerpt 6, the clinician initiates with a topic transition on line 2, followed by an open format patient view elicitor (PVE). The turn design of the PVE solicits neither preference nor decision, but instead, it makes a request for the patient to inform the clinician of their own understanding.

This strategy enables the patient to launch a storytelling sequence in response to the elicitor (Mandelbaum, 2012). The well-prefaced turns in lines 6 and 7 indicate the ways that both patient and partner oriented to this request, with the well-preface projecting a response requiring an extended turn-at-talk, while simultaneously indicating a departure from the normative expectations projected by the clinician's turn (Heritage, 2015). The design of the

patient's turn initiation in line 6 indicates the production of a dispreferred action, as it is performed with delay, hitches, and self-repair (Pomerantz and Heritage, 2013). The inclusion of the well-preface and the lexical item "actually" further project this dispreferred action. In its entirety, the turn on lines 7-9 is hearable as an account that foregrounds the evaluation of the treatment options on line 11. The organisation of this sequence is underlined by the clinician, whose turn at line 10 can be heard to serve as both aligning and affiliative, encouraging progressivity. Although the evaluation in turn 11 projects resistance toward the selection of any treatment option, the clinician does not move to address this resistance, and instead they pass up on their opportunity to speak. The partner then self-initiates to offer a form of supportive elaboration, that notably selects the patient to speak next. The resulting gap after this turn is sufficiently long for the clinician to initiate a turn. The clinician drops out when the patient initiates their turn. From lines 18 – 37, the patient then elaborates upon their evaluation. During this sequence, the clinician both acknowledges receipt of turns, supporting story progression through continuers in lines 25, 29, 31, 34, and 39, encouraging progressivity, while demonstrating alignment with the teller's project (Stivers and Robinson, 2006). The distinction between this and the previous excerpts takes place at the end of this sequence. Once it is apparent that the patient, in conjunction with their partner, has completed their account, the clinician acknowledges this contribution, and in this moment, treats it as sufficient to warrant a topic transition. The sequence continues with the clinician soliciting further information from the patient.

Excerpt 7 illustrates a similar pattern, featuring the same clinician in a different case.

Excerpt 7: Radiology was the best for me (Consultation 22)

- 1 HCP: ° ° right (.) oka:y° ° (.) ° f:fine° hhh ↑Uhm >So- So< ↑
 2 What >do you< understand about your (.) prostate ↓cancer
 3 and about the- (.) options for treatment.=
 3 PAT: =I re- (.) I ↑listened↑ >to the ma:n< (.) >That I< sa:w
 5 (0.7) ↓ladies↓ colleague on (.)
 6 HCP: On >mi- o- [Monday<] (.) Yes:s
 7 PAT: [↑Mon↓day]
 8 (.)
 9 PAT: I' d ↑already ↑heard >some of it< (.) I' d (0.4) Of
 10 course I (.) >live in a< block where ↓>there are<↓ a lot
 11 of sick fpeople as wellf
 12 (.)

- 12 HCP: O:h ↑>okay<.=
- 13 PAT: =>And I' d-< (.) end up doing shopping >for things< and >
- 14 ↑everybody< tells me their ↑prob↓lems=
- 15 HCP: =Ri:ght=
- 16 PAT: =So I' ve ↑heard different (.) s:tories different things.
- 17 (.)
- 18 HCP: Ye:ah.
- 19 PAT: I looked at >all the< (.) options I h:had anyway↑
- 20 (.)
- 21 HCP: #Yeah↓#=
- 22 PAT: =Then (.) ↑((name))↑ told me on ↓Monday↓ (.) ° >the
- 23 options<° >and I< worked out (.) re:ally what >was< best
- 24 for m:e?
- 25 (.)
- 26 HCP: Ye:ah,
- 27 PAT: What would ↓work↓ for ↑me↑=
- 28 =[(.) With lookin' after th:e ((relative))]
- 29 HCP: [Yes (.) Ye:s:s (.)] °yes°.
- 29 PAT: U:hm (0.4) My way of life which would suit me (.) >the
- 30 best< and it ↑seemed [>to be<] that radiology ↓was >the
- 31 best↓<
- 32 (.)
- 33 HCP: [Ye:ah↓]
- 34 PAT: [>For me<=
- 35 HCP: =Right] (.) Yeah (.) yeah good (.) [↑Okay↓]
- 36 PAT: [°you know°]
- 37 HCP: So- ↑So (.) They- >so there' s< ↑two↑ different ways
- 38 actually of ha`vi- having (.) radiotherapy ↓tre:atment↓=
- 39 PAT: =Yeah.

Like the previous excerpt, the clinician produces a topic transition before initiating the next sequence with an open format PVE (lines 1-3). Likewise, the patient launches a story from second position in lines 4 – 38. During this story, the clinician orients to their responsibilities as a story recipient, producing responses that both acknowledge turns while enabling story

progression, including a turn on line 6 that serves to facilitate progression (Mandelbaum, 2012). The story culminates in the patient offering an account ahead of their expression of preference. The expression is acknowledged by the clinician on lines 35 and 37, after which the clinician initiates topic closure on line 37 before initiating a topic transition.

When compared to the pattern observed across all other collected cases, the differences are remarkable. The clinician invites the patient to take an extended turn at talk, and rather than intervening to inform, they cede the floor to the patient. While the elicitation of ‘understanding’ leads to an expression of preference in both cases, this preference is elicited neither implicitly nor explicitly. Instead, in both instances, the story culminates in an expression of preference. Critically, after the exploration of, and production of this preference, the clinician acknowledges this preference, closes the sequence, and moves onto the next project in the consultation, proceeding in alignment with the expressed preference. These exceptional interactions do not contain the sequential nonalignment found in the other cases in this collection (Heritage, 2011).

Discussion

This research examines the sequential organisation of treatment-related preferences expressed by patients and partners during consultations for localised prostate cancer; a consultation where clinicians are expected to be sensitive to treatment-related preferences (Bullen and Tod, 2013; Hutting et al., 2022; NICE, 2014; Soloway et al., 2005). The analysis of these consultations illustrates a contradiction in the sequential organisation relating to the ways that clinicians orient to expressions of preference. Clinicians failed to align with patient-initiated expressions of preference (Excerpts 1 and 2), and they disaligned from partner-initiated preferences in particularly robust terms (Excerpts 3 – 5). It is arguable that the approach of the clinicians in all but two of these consultations (Excerpts 6 and 7) is problematic for the purpose of exploring treatment preferences in accordance with this key principle of SDM (NICE, 2021). It is noteworthy that, in the alternative practice case where the partner expressed a joint preference, this turn was not addressed by the clinician, albeit without the sequential misalignment observed in the main analysis (Excerpt 6). In failing to align with couples’ expressed preferences, where preference-sensitivity is expected, the clinician is drawing upon the typical epistemic gradient between a doctor and a patient and the normative expectations that inform relations between this pairing of a doctor with an inherent K+ status relative to the patient’s and their partner’s K- status (Kendrick et al., 2020; Ruane and Ramcharan, 2006; Sacks, 1972). By not acknowledging expressed preferences, the clinicians’ actions are inadvertently privileging their own epistemic status whilst attempting to inform patients, correct misunderstandings, or communicate a stance of adhering to the principles of SDM. However,

this misalignment invokes a shift away from cooperative action at a time where treatment preferences should be acknowledged and respected in a manner that affords all parties a position as resourceful agents within the encounter (Lindström and Weatherall, 2015; NICE, 2021; Peräkylä, 2006). Accordingly, responses that fail to acknowledge expressed preferences, serve to undermine cooperation in interaction.

In Excerpt 4, when the partner's expressions imply or assert an expectation of expert guidance, the clinician was seen to disalign from these expectations, drawing upon the concept of patient choice. These sequential misalignments are doubly hearable through patient and partner silences where conditionally relevant responses were warranted, and clinician pursuits for acknowledgement. While the clinician's actions can be seen to orient to a model of SDM, they are having an unintended effect of misalignment. This is evident where expressions of preference for or against a treatment choice, and requests for expert guidance, were neither acknowledged nor respected.

Clinical implications

The importance of these findings is best illustrated by comparison with the alternative practice. The most salient difference is that, in these exceptional sequences, the clinician acts to be informed, instead of acting to inform. It is important to recognise that clinicians have a duty to provide clinically relevant information about treatments and their side effects. However, our analysis identifies how this practice can be accomplished in ways that support the exploration of expressed preferences; in the alternative practice, the patient's views are solicited through communication practices that encourage the production of a narrative account, with expressions of preference for and against treatment choices treated as valid. There is potential to incorporate these observations into medical education relating to SDM. This might serve to support clinicians to identify ways to inform patients about available treatment options and their consequences without inadvertently preventing the acknowledgement and exploration of couples' expressed preferences.

Previous research has examined the importance of partner involvement in prostate cancer treatment decision-making, with patients expressing a preference for their partners to have an active or collaborative role in treatment-decisions (Davison et al., 2002). Likewise, the contributions of partners are typically expected and valued by patients across multiple clinical settings as they facilitate information provision and decision-making (Shin et al., 2013; Wolff et al., 2017). Accordingly, it is reasonable to expect a partner's expressed preferences to be acknowledged and accepted, particularly when endorsed by the patient. Other studies have examined the conflict inherent in the ideals of SDM, describing tension between clinicians'

established expertise and the affordance of patient autonomy (Bishop and Yardley, 2004). Related studies indicate that patients want to be informed by clinicians, but do not necessarily want to make decisions based solely upon clinician's information (Beaver et al., 2005). As such, it has been argued that resistance to clinician information provision should be accepted as an interactional resource that projects autonomy (Koenig, 2011; Lindström and Weatherall, 2015; Stivers, 2005). The present analysis highlights the ways that patient and partner expressions of preference were treated as dispreferred, 'blocking' actions that impeded the progress of the clinicians' information delivery (Stivers and Robinson, 2006). This is underlined by the ways that clinicians inserted repair initiations after expressions of preference, as well as how they treated expressed preferences as inapposite through disalignment from them (Sacks, 1992; Stivers and Robinson, 2006).

The importance of these findings relates to both the clinical context of prostate cancer, and broader structures of social action. The clinical encounter is understood to be a site of social action, encapsulating the biomedical and lifeworld concerns of the patient (Mishler, 1985). It is evident that it is a setting, like many in everyday interaction, in which there is a preference for the maintenance of social solidarity, and the minimisation of conflict (Heritage and Clayman, 2010). Accordingly, the sequential misalignments highlighted by this analysis are arguably dysfunctional within both their sequential and situational context as they represent a threat to ongoing collaborative activity (Heritage, 2011). This is evident in the ways that patients and partners were observed to silence themselves, following the sequential misalignment, with such silences hearable as an interactional move to avoid conflict escalation, and instead keep it 'below the surface' (Heritage, 1984, p. 265; Toerien and Jackson, 2019).

Strengths, limitations, future research

While this study demonstrates the immediate consequences of these sequential misalignments for verbal interaction, an analysis of non-verbal data may have provided further insights into the organisation of these sequences. Additionally, our analysis cannot speak to the broader implications relating to patient outcomes, such as satisfaction with the encounter, or satisfaction with the treatment decision (Cohen and Britten, 2003). This is an area worthy of further investigation. However, these findings do offer a detailed comparison between a dysfunctional practice, and a contrasting practice. Such data can be valuable for making salient the social practices in clinical communication, which can in turn, inform clinical communication skills training.

Conclusion

This research highlights that patients and partners regularly expressed treatment-related preferences in the context of treatment discussions during prostate cancer consultations. This collection illustrates how clinicians treated expressed preferences of patients and their partners as blocking actions to their information delivery that subsequently required repair to enable a return to information delivery. Moreover, when clinicians failed to align with expressions of preference, this inhibited the exploration of expressed preferences, leading to couples silencing themselves. The alternative practice offers a comparison between misaligned sequences, and cases where social solidarity was maintained. By acknowledging couple's expressions as valid contributions, rather than acting to inform or correct them, clinicians can create opportunity spaces for exploring treatment preferences.

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Table 1: Jefferson transcription convention

Symbol	Definition and use
[yeah] [okay]	Overlapping talk.
=	End of one TCU and beginning of next begin with no gap/pause in between (sometimes a slight overlap if there is speaker change).
(.)	Brief interval, usually between 0.08 and 0.2 seconds
(1.4)	Time (in absolute seconds) between end of a word and beginning of next.
<u>Word</u>	Underlining indicates emphasis. Placement indicates which syllable(s) are emphasised.
wo::rd	Colon indicates prolonged vowel or consonant. One or two colons common, three or more colons only. in extreme cases.
↑word ↓word	Marked shift in pitch, up (↑) or down (↓). Double arrows can be used with extreme pitch shifts.
.,-¿?	Markers of final pitch direction at TCU boundary: Final falling intonation (.). Slight rising intonation (,). Level/flat intonation (-). Medium (falling-)rising intonation (¿). Sharp rising intonation (?).
WORD	Upper case indicates syllables or words louder than surrounding speech by the same speaker.
°word°	Degree sign indicates syllables or words distinctly quieter than surrounding speech by the same speaker.
<word	Pre-positioned left carat indicates a hurried start of a word, typically at TCU beginning.
word-	A dash indicates a cut-off.
>word<	Right/left carats indicate increased speaking rate (speeding up).
<word>	Left/right carats indicate decreased speaking rate (slowing down).
.hhh	Inbreath. Three letters indicate 'normal' duration. Longer or shorter inbreaths indicated with fewer or more letters.
hhh	Outbreath. Three letters indicate 'normal' duration. Longer or shorter inbreaths indicated with fewer or more letters.
whhord	Can also indicate aspiration/breathiness if within a word (not laughter).
w(h)ord	Indicates abrupt spurts of breathiness, as in laughing while talking.
£word£	Pound sign indicates smiley voice, or suppressed laughter.
#word#	Hash sign indicates creaky voice.
~word~	Tilde sign indicates shaky voice.
(word)	Parentheses indicate uncertain word; no plausible candidate if empty.
(())	Double parentheses contain analyst comments or descriptions.

Table 2: Contextual information for excerpts

Excerpt	Patient PID	Clinician PID	Consultation type	NICE risk category for Localised Prostate Cancer	Treatment options identified at multidisciplinary team meeting

1	21	3	Treatment Information	Intermediate risk	TCI, High-intensity Focused Ultrasound (HIFU) or Active Surveillance (AS)
2	15	8	Biopsy result	Low risk	AS recommended
3	2	3	Treatment Information	Intermediate risk	TCI
4	9	9	Biopsy result	Intermediate risk	TCI or HIFU
5	1	3	Treatment information	Intermediate risk	TCI or watchful waiting: AS was not offered on basis of age
6	8	7	Treatment information	Intermediate risk	TCI
7	17	7	Treatment information	Intermediate risk	TCI

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Highlights

- Couples regularly expressed treatment-related preferences during consultations.
- Clinician disalignment from expressions of preference caused interactional discordance.
- This led to couples silencing themselves, indicative of conflict management.
- Clinicians inhibited exploration of couples' preferences and viewpoints.