

The problematic of decision-sharing: deconstructing 'cholesterol' in a clinical encounter

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Abstract

Shared decision-making is increasingly advocated as a means of interacting with patients but there is also a widely accepted view that many factors will militate against this ideal. While some patients may not wish to take on the responsibility of decision-making, it is also evident that many find it difficult to assimilate probabilities about future events and overestimate the likelihood of some outcomes, especially when terms such as 'stroke', 'bleeding' and 'heart attack' are used in consultation and bring with them emotional connotations and reactions. Under such circumstances, should clinicians portray risks as best they can, in the hope that even a marginally improved understanding will be an improvement on unilateral professional decision-making? Or, conversely, should they 'guide' the decision process, acting in a way that is known as 'professional agency'? Developing some perspectives put forward in recent work by the authors and applying it to a distinct clinical context, this paper will provide (i) a discourse analytic exploration of a single extended example from clinical practice employing aspects of Bakhtin's theory of dialogism, and (ii) a discussion and summary of what we can learn from this analysis in the context of shared decision-making and risk communication.

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Introduction

There are conflicting positions becoming apparent in the debate surrounding the involvement of patients in decision-making. Those who advocate patient autonomy often take the view that clinicians are reluctant to accommodate patient self-determination in the course of their practice.¹ Clinicians take practical stances and cite the constraints of time and the complexity of individual case backgrounds, foregrounding informational requirements, and the often less

than enthusiastic stance of patients when asked to take part in decision-making.² When patients themselves are asked about their preferred roles in decision-making, albeit by methods which use largely hypothetical scenarios, they vote for being given more information in preference to increased involvement in decisions.^{3,4} Although there is considerable interest in increasing the participation of patients in decision-making, it is also true that neither the theoretical nor the practical aspects of this proposal have been satisfactorily resolved. Naturally these two aspects

interact, with the former bearing on the realization of the latter. Without a proper understanding and interrogation of professional and discursive roles performed, practical applications of discourse will not succeed. In effect, this is an issue of congruence. The bureaucratic problems of modern health-care systems, their narrow temporal bandwidths,⁵ and the differential power and information gradients in consultations all militate against equal participation in complex decisions. The development of professional competences has been suggested as a means of taking this work forward;⁶ but we provide here an example of a clinical interaction that suggests there is even more complexity in certain dimensions of the decision-making process, notably those that are embedded in context, previous cultural assumptions and prior patient expectations.^{7,8} Whereas in an earlier publication⁹ we examined the intrinsic difficulty of successfully managing a shared decision in a consultation where a proposed treatment was contested, resulting in the questionability of any truly 'shared' outcome, we now wish to explore an interaction where a clinician attempts to share a decision about the management of a high cholesterol level when the patient is clearly unsure of the precise meaning of 'high cholesterol'. In other words, a common enough scenario in modern medicine, but one in which the asymmetry of knowledge, and a dissonance of explanatory models between patient and doctor prejudices against a successful outcome to the consultation. Further, there appears to be an ideological reformation required from both parties about the role of participants in shared decision-making. A lack of interrogation of epistemological and professional/institutional underpinnings of the practice of medicine results in an ineffective deployment of discursive strategies.

Shared decision-making and risk communication

Shared decision-making straddles the middle ground between medical paternalism and the other extreme where patients are given the sole responsibility for making decisions, an approach

that has been called 'informed choice'. Detailed descriptions of the shared decision-making principles and suggested competences can be found elsewhere,¹⁰ but it is worth noting here that it involves the defining of a problem that requires a decision, an identification of options, provision of information and finally a decision-making process. This outline hides a great deal of complexity of course, not least the fact that shared decision-making should be regarded as a flexible approach,¹¹ one that recognizes the frequently ambivalent roles that patients wish to play in the decision-making process and allows professionals, once they have explored their patients' views, to guide the decision-making process.

Health-care professionals spend much of their time discussing the risks and benefits of treatments or care with their patients.¹² The exact ways in which this is done, and the goals of such communication, have been the subject of a considerable amount of research.¹³ A common thread in these investigations is that patients frequently express high levels of interest for information even if they do not desire a high level of involvement in the decision-making itself.¹⁴ Risk information which is relevant to (even calculated for) the individual patient, based on their own situation, previous medical events, and presence of risk factors, has been found to be most 'effective' in intervention studies.¹³ These findings from research on risk communication raise a number of important issues when considering health-care encounters with individual patients. How should individual risk information be made available during the encounter? Is it feasible in terms of time available? Is it a process with which professionals can become familiar or gain aptitude? Crucially, does it facilitate shared decision-making? Considering these issues from data evident in a general practice consultation in South Wales, we will examine the processes and explore the lessons that may be derived for health-care providers and consumers.

While it is impossible to make general conclusions about behaviour of certain classes of people (such as doctors) from examination of a

single event, the detailed analysis that is made possible by such a focus certainly aids in pointing out pitfalls. Given that the barriers to a successful shared decision-making here are as much conceptual and epistemic as due to particular discursual habits of the participants, such a detailed study is instructive.

Background to the clinical encounter

The consultation chosen for this work is one in which an elderly female patient has attended a general practitioner to discuss the latest in a series of tests for cholesterol. However, before introducing the context of this consultation, we should explain that cholesterol is found in everyone's blood. It is an essential building block in human biochemistry. In simple terms, a high level of cholesterol in the blood is often associated with cardiovascular disease, linked in a complex multi-factorial model that involves the interaction of family history, high blood pressure and other factors, to the development of arterial atheroma (fatty deposits that restrict the efficiency of oxygen supplying blood vessels). However, the concept of cholesterol, as we will see, has, in the eyes of many people, moved beyond being a risk factor, to being a disease in itself, whereas in reality, a cholesterol level (although it may be above an agreed threshold level) is not automatically a problem that has to be addressed. There are other biochemical data (detailed lipid ratios for example), and biological factors (age, weight, blood pressure) and other lifestyle risk factors (exercise) that need to be considered before assigning risk and contemplating medication.

Cholesterol is potentially a most appropriate scenario for shared decision-making. But in the first instance we must be particularly concerned with the way in which the problem of cholesterol is framed against the broader sociocultural dimensions of illness representation. In other words, just how 'cholesterol' is perceived by the patient (and the doctor) in this consultation sends important messages regarding the medicalization of society at large, and of the elderly in particular.

Dialogism and the medical consultation

An approach to the study of medical consultations might be made via some of the ideas of Bakhtin, notably through the principle of 'dialogism' or 'double-voicedness'.^{15,16} According to the dialogic principle, the individual self is socially constituted through its relationship to the other, or put another way, it is through a process of co-voicing with another person that we establish individual identity. Indeed, it might be argued that all understanding is dialogic in nature.¹⁷ Hall cites Holquist and Clark¹⁸ on this issue: 'meaning belongs to a word in its position between speakers', and agreement between collaborators in the dialogic relationship is defined as 'co-voicing.' One of the current authors has discussed elsewhere the notion of co-voicing in respect of illness narratives recorded in ethnographic research,¹⁹ but the present paper affords the opportunity to consider how a dialogic perspective can also be used in the reading of a medical consultation.

Dialogism then, in its most frequent usage, suggests speaking with two voices. The term is applied to the regular or concurrent use of two distinct voices in a single speaker. This can result in the speaker making use of two voices in a piece of interaction, one of them indicating the 'authorial' voice, which stands back from the action and *describes*, the other a more participatory one, overtly involved in the 'action'. Often we might perceive dialogism being employed to comment reflexively on a context or situation, while remaining within that context. Thus an actor might make some remark commenting on his or her position as actor, or more pertinently, a doctor might step outside the 'voice of medicine' temporarily in order to reflect upon, or highlight, for whatever reason, the distinction between his authorial, professional voice and the 'authentic' voice of personal experience (or in Mishler's²⁰ terms, the 'life-world' view). For instance, a doctor, while advising a patient on the advisability of a course of action might say: 'If I were in your position I would...' or 'If it were my child I would...'. In such a case a doctor would be using the frame of

‘doctor’ as ‘authorial voice’ and the individual aside would represent a realignment within the consultation, employing, temporarily the voice of an actor or participant.

Dialogism is a particularly apt method with which to analyse what goes on in a medical consultation in which a doctor adopts a strategic role that overturns or at least questions the traditional authoritative voice of medicine. Doctor–patient consultations, certainly among older patients, tend to conform to the traditional ‘doctor knows best’ school of thought.⁹ In other words, doctors are traditionally, and idealistically represented as addressing patients ‘monologically’, using a single, undisputed voice, wherein the complicated business of science is translated and transmitted in easily communicated terms that are comprehensible to lay listeners. Where a doctor self-consciously subverts that voice with another voice, that of ‘sharing a decision’, the patient is liable to become confused, or at best uncertain, as to what is expected of him/her in the interactive process of consultation. In such a setting the epistemological ground has shifted in the act of ‘doing being a patient’, and we find ourselves in a situation where there is a ‘mixing of intentions of speaker and listener’, as well as the constant need for utterances to position themselves in relation to other utterances, typical features of dialogic discourse.²¹

We shall then, in this paper, consider two extracts from an extended consultation between a 33-year-old male physician and a 73-year-old woman who has been tested for lipid levels, and is attending the clinic in order to receive the ‘result’ of her tests. Additionally, and in keeping with practice which enables readers better to understand the sociocultural framework of the setting, it should be pointed out that the doctor speaks English with received pronunciation and the patient has a marked regional accent. At the outset the patient is told that her cholesterol is ‘a little bit high’. We need to balance this information against the likely effects of risk information-giving discussed above, and to bear in mind the possible misunderstandings which such a prognosis might have on a patient who does

not have a clear concept of ‘cholesterol’ as a predisposing factor in the risk of heart disease, but rather, as this patient appears to have, a notion of cholesterol as an illness in itself.

The consultation

In the first instance we would like to consider an extended extract in which the physician, who is explicitly attempting to achieve a shared decision in this encounter, presents the patient with the options, as he sees them, and answers the patient’s questions on what cholesterol actually is (see Box 1):

Box 1 Key to transcription symbols

Parentheses surrounding a period (.) indicates a pause of < 1 sec
 Numerals within parentheses indicate longer pauses
 The symbol [between lines of dialogue indicates overlapping speech
 Underlining indicates emphasis
 = Indicates that an utterance is contiguous with previous (or following) utterance
 A colon : indicates elongation of preceding sound

-
- 35 P its uh its a good case um (.) and try to keep fit (.)
 this is why
 36 I’m trying to (.) lower this cholesterol thing
 37 D mm (.) well it does sound like you are (.)
 38 doing everything possible to be fit
 39 P yes
 40 (.)
 41 D um (.) I guess (.) the thing we need to discuss (.)
 now
 42 is whether or not anything else needs to be done
 43 about the cholesterol (.) in the way of treatment
 44 (1.0)
 45 P what sort of treatment?
 46 D well (2.0) possibly tablets treatment (P: yes) was
 that what
 47 you were expecting?
 48 P I wasn’t expecting anything really I mean you know
 49 I just (.) they said I had to see you so I thought I
 (trails off)
 50 [
 51 D okay fair
 52 enough yeah (.) um (.) well I think it’s fair to say it’s
-

53	not <u>clear cut</u> whether you should have treatment or
54	whether you shouldn't have treatment (.)
55	P I see
56	D so so what I'm thinking is that we we just need to
	have
57	a bit of a talk about it and and try and <u>decide</u>
	what's what's
58	going <u>on</u> really (P: yes) and what to do <u>next</u> really
	(P: mm) um
59	and basically I would say the (.) yes the <u>two</u>
	options are (.)
60	whether we <u>leave</u> things alone as they are (.) doing
	what
61	<u>you're</u> doing (.) <u>dieting</u> (.) making be being careful
	about what
62	you <u>eat</u> and so on (.) or whether we <u>also</u> go for
	<u>treatment</u> with
63	some <u>tablets</u>

In lines 41–43 the doctor (D) first introduces the idea that the two of them need to discuss the test results, and makes first mention of ‘treatment’ for cholesterol. Now according to lay models of illness, and the common sense principles of ‘prevention’ and ‘cure’, ‘treatment’ is only required for an illness condition. Medicines are perceived as reified objects for the treatment of reified disease. Consequently, the patient (P) inquires ‘what sort of treatment?’ to which the doctor retorts, extremely hesitantly, ‘well (2.0) possibly tablets treatment’. He enunciates this utterance slowly and with exaggerated diction. Such care in the delivery of a simple option is puzzling, but not if we consider that mention of treatment might elicit in the patient the notion that she was suffering from a specific disease condition which could be ‘cured’ by the taking of tablets. It would seem, unfortunately, that this is the model the patient has, and it lies at the source of subsequent misunderstandings and failings of communication between herself and her doctor throughout the remainder of the consultation.

At once, after the patient’s confirmatory ‘yes’, the doctor asks the question: ‘was that what you were expecting?’ to which the patient responds, candidly: ‘I wasn’t expecting anything really... I just (.) they said I had to see you so...’. It is apparent therefore, that not only is the patient’s understanding of the workings of ‘cholesterol’ or

the means of its ‘treatment’ hazy, but that, quite possibly, in spite of this being her third cholesterol test within a few months (and therefore part of a process that this particular doctor might not have wished to initiate himself), she is not in fact aware in what sense her condition constitutes a problem. Indeed, she appears to view her ‘cholesterol thing’ (l.35) as part of ‘keep[ing] fit’ (l.36). In fact, she links it in some way to an operation for an ‘implant in [her] head... for the hearing’ (ll.29–33). We will shortly examine an explicit acknowledgement from the patient that she lacks complete information in cholesterol. In any case, her turn trails off and the doctor attempts to ‘repair’ the interaction with ‘okay fair enough’ (ll.51–52). He states (ll.52–54) that it is not ‘clear cut’ whether or not this patient should have treatment or not.

The doctor then presents what needs to be achieved in the consultations as a ‘bit of a talk’ in order to decide ‘what’s going on really’ and ‘what to do next really’ (ll.56–58). It is important here to reflect that this elderly patient has been recalled to the surgery in order to receive test results, and, we must presume, advice and recommendation on the basis of those results. Again, it should be emphasized that this doctor was not her usual doctor, and had not sent her for these tests. From the outset she is being told that ‘we’ (that is, she and the current doctor) must try and decide on a course of action, and is implicitly (although not yet *directly*) involved in the decision-making process. The doctor gives her two options: either to ‘leave things as they are’, which in this instance means ‘dieting’ and ‘being careful about what you eat’, or else to ‘go for treatment with some tablets’.

64	P	well I I think I'd like to try and get rid of it because I've had it
65		for an awful long time
66	D	mm well you have that's right=
67	P	=um (2.0) what exactly does cholesterol <u>do</u> ?
68	D	right well what it does is it uh: (.)
69	P	clots your blood more or less doesn't it?
70		[
71	D	well that's right

72 it's one of the factors which hardens the arteries
 73 and that makes you more at risk of having heart
 74 problems
 75 P well ahm they did say (.) uh I did have (1.0) treat-
 76 ment for
 77 (.) h:ea:rt thing many years ago oh before I retired
 78 um (1.0)
 79 mm fifties I think when I was fifty odd (D: mm mm)
 80 um
 81 because I couldn't (.) hurry (.)
 82 D oh yes
 83 (.)
 84 P If I hurried I'd (.) get short of breath and I had pain
 85 you know
 86 D right
 87 P I had (.) um treatment for that I think (.)

After expressing a wish to 'get rid of it' because of the length of time she's 'had it' (again indicating a reified understanding of cholesterol based on the 'disease model') the patient then asks, after a lengthy pause (1.67) 'what exactly does cholesterol do?' Having just stated that she's 'had it' for a long period of time, there is a loss of face implicit in this question, which she compounds by mispronouncing the word 'cholesterol' as 'cholosterol'. In response to the doctor's careful explanation, which she attempts to 'fill in' for him when he pauses (11.68–69), the patient then begins to recite an episode from her past when she received treatment for the 'h:ea:rt thing' because she was becoming 'short of breath' and 'had pain' when she 'hurried' (11.75–83). The doctor makes two confirmatory/feedback comments (11.79 and 82) but does not pursue the patient's story with any substantive questions, choosing instead to introduce his offer of making a shared decision:

84 D okay (.) well (.) just to um just so that (.) w
 85 we're sure
 86 that we're going down the right track with (.)
 87 whatever we decide I've got some information here
 88 which I could (.) uh (.) tell you about (.) um
 89 what it does is
 90 it it (.) tries to put things in perspective so that
 91 we know

89 exactly (1.0) you know
 90 [
 91 P why
 92 D (.) why? are you at risk (.) of getting a
 93 heart problem
 94 P yeah=
 95 D =and how much is that risk (P: mm mm) okay
 96 and it
 97 actually calculates it for us (.) and that that
 98 may help us
 99 to work out what to do (.) for you
 100 P yes
 101 D and as I say I think it it's not clear cut and I think (.)
 102 I don't know
 103 what you feel but I think it's partly (1.0) a decision
 104 for you
 105 and it's partly a decision for me
 106 (1.0)
 107 P why?
 108 D I don't know it depends wha what do you
 109 feel about that?
 110 (1.0)
 111 P well I'd like to get to the bottom of it=
 112 D =mm well let's see what we can do (.) now (.)
 113 I've got a (.) a chart here which we've we've copied
 114 from a (.) um a medical magazine (.) all right? and it
 115 tells us about the risks of heart problems (P: yes)
 116 in folk like yourself (.) okay? (1.0)
 117 and what it does is it gives you
 118 points for each of a number of dierent factors (.)
 119 and then (.) it calculates the num that number
 120 of points
 121 into your actual risk of having a (P: mm) a
 122 heart problem

Using statistical or graphic information as tools in the formulation of shared decisions is a participatory consulting strategy which might well assist clinical practice.²² In lines 84–89 the doctor explains that this information will help 'put things in perspective so that we know exactly (1.0) you know'. The patient then interrupts at a moment of doctor hesitation, with the single word 'why', uttered without rising intonation. It is unclear whether the 'why' is meant to question the principle of sharing information (rather than being told which path to follow by her doctor) or whether the patient is simply helping the doctor to complete his utterance.²³ The flat intonation in this utterance would suggest that the second reading is the correct one. But the interruption appears to take the doctor

by surprise: after a pause he repeats the word 'why?' as if it were a question, but then attempts to complete his own sentence (ll.92–94) as if it were *not*. He objectifies the 'information' or chart as something which 'calculates' the risk of a heart problem 'for us' and which may, therefore help 'work out what to do'. Having received patient acknowledgement of this explanation (l.97) the doctor then declares that the issue of treatment is not 'clear cut', and expresses his wish to reach a shared decision: 'I don't know what you feel but I think it's partly (1.0) a decision for you and it's partly a decision for me'.

It is interesting that whereas the patient is ascribed 'feelings' on the subject of decision-making (what you feel) the doctor himself 'thinks'. 'Thinking' is a rational, empirical exercise, whereas 'feeling' is emphatically not. This might appear a minor point but in the light of later lexical choices needs to be considered seriously. Bernstein²⁴ defines the ability to hypothesize from a particularistic standpoint as a typical feature of the 'elaborated code' of middle class speakers as opposed to the more universalizing tendencies of a 'restricted code' associated with lower socio-economic groups. Typically, utterances by speakers inclined towards the elaborated code are often prefixed by the words 'I think'. In the twelve and a half minutes of recorded consultation the patient uses 'I think' five times whereas the doctor says it no less than 16 times. The doctor never once directly asks the patient what she thinks although he does, on one occasion (l.194) ask her 'what are your thoughts?', but on four occasions asks what she 'feels' about an option. Meanwhile the patient twice asks the doctor what he 'thinks', but never once what he 'feels'.

It should be noted that the doctor's use of 'I think' (see ll.98–100 for example) also appears to be used as mitigating his authority as 'doctor'. In these lines, part of this has to do with what he says. 'I think it it's not clear cut' owns as personal opinion the fact that in this case at least medical diagnostics will not provide a ready made answer. This appears to be something of an act of solidarity, or at least partnership,

paving the way for the doctor 'thinking' that it is 'partly (1.0) a decision for you and it's partly a decision for me'. The emphasis on 'you' and 'me' is further evidence of this. At the same time, 'I think' does not mitigate enough, as evidenced by the reformulation 'I think (1.0) I don't know what you feel but I think'.

Following the doctor's stated preference for a shared decision, which is in turn followed by another pause, the patient asks 'why?' (l.102), and this time it is certainly a question, and appears to be directed at the immediately preceding utterance by the doctor. The patient is overtly questioning the principle of shared decision-making, but rather than answer her question, the doctor replies hurriedly: 'I don't know it depends wha what do you feel about that?'. The suggestion that the doctor doesn't know *why* 'it's partly (1.0) a decision for you and it's partly a decision for me' is alarming since this questions the rationale of shared decision-making as a consulting method, so it is charitable to assume that he was taken off guard by the question, and he improvises his way to answering the question with a further question: 'wha what do you feel about that?'. Again he selects the verb 'feel' rather than 'think' as the more appropriate term for this patient's evaluative powers. Another pause follows, and then the patient responds with 'well I'd like to get to the bottom of it', presenting this request as though solving a mystery to which there *was* a 'clear cut' solution. The doctor responds to this statement of intent by producing a chart 'copied from a...medical magazine' which 'tells us about the risks of heart problems...in folk like yourself'. The words 'heart problem' are enunciated slowly and deliberately, and the details of risk factors are demonstrated with the visual aid of the chart.

Throughout this passage (ll.84–114) run two adjacent and complementary themes. First, despite the doctor's apparent efforts to supplant the traditional role of paternalistic doctoring with an approach more conducive to shared decision-making, he unwittingly reinforces his doctor's authority by insisting upon a shared decision approach even after the patient has

questioned its usefulness (a question which the doctor never satisfactorily addresses). Secondly, the extract brings into focus important issues relating to the social construction of 'cholesterol levels' and, by extension of 'health' in general. If the patient holds a faulty model of her condition as being a disease that can be successfully treated, and which can be made to 'go away', how should the doctor correct that mistaken view without upsetting the delicate power relationship so radically as to render a genuinely 'shared decision' unattainable? By appealing to the doctor's superior knowledge in her question: 'what exactly does cholesterol do?', the patient allows the doctor to slip back into 'expert mode', and provide her with an explanation of 'cholesterol'. The doctor provides a minimal explanation (ll.72–74), but apparently, at least from her comments that follow, the patient fails to grasp the nature of 'high cholesterol' as providing a predisposition towards disease, rather than constituting disease itself. If this is the case, and the patient's understanding of her condition is not helped by this consultation, *and* we add to this the question of how worthwhile it is treating elderly patients of her type for marginally elevated lipid levels, the exercise of achieving a shared decision begins to appear entirely arbitrary, and quite possibly not in the interests of this particular patient at all.

However, there is a second extract that we need to consider before arriving at any conclusions on this account. This follows a lengthy sequence in which doctor and patient peruse the charts relating to cholesterol and assess the patient's score in points, a process which the doctor introduces in lines 107–114. The doctor has been through his patient's score on specific details of whether or not to take treatment, considered the side effects of treatment and the statistical benefits of bringing cholesterol levels down through drug therapy. He suggests to her (ll.225–6) 'that one possibility is (.) that we get people to take the treatment and (.) see (.) if there are any problems'. The patient then interrupts him with her own suggestion (l.228):

-
- 225 D so again one possibility is (.) that we get people
to take
- 226 the treatment and (.) see (.) if there are any
problems
- 227 [
- 228 P what say
- 229 I carry on with this low fat thing and dieting (.)
for say
- 230 another month and see if it makes any
difference (.) and if not
- 231 (1.0) I consider taking tablets what do you think?
- 232 D I think=
- 233 P =or do you think I should take the tablets?
- 234 (.)
- 235 D well (.) I think it's hard
- 236 [
- 237 P let's have your honest opinion now
- 238 D okay (1.0) I think (.) doing that for another month
isn't going to make any difference (.) I think you've
239 been doing everything that you possibly can
240 (P: yes)
- 241 all right so I think that would just be uh (.) ducking
242 the question=
- 243 P =have I brought it down at all since the last
I had uh
- 244 time I had it done?
- 245 D no uh no
- 246 [
- 247 P I haven't?
- 248 D no I think it's up=
- 249 P =so it hasn't helped at all?
- 250 (1.0)
- 251 D not a lot (.) I think it it's up and down
- 252 P if I haven't brought it down I I (D: yeah) it's
253 worth taking the treatment then isn't it
254 (1.0)
- 255 D uh (.) quite possible (.) um (.) as I say just (1.0)
256 jus (.) I'm giving you the facts if you like=
- 257 P =yes I'm physically (.) quite fit apart
from the cholesterol?
- 258 (2.0)
-

The patient's response to the doctor is to suggest that she begin treatment and 'see (.) if there are any problems' (l.226). She sets off with 'what say' followed by a pause, and then makes her suggestion, which in essence refers directly back to the doctor's first presentation of the choices in lines 60–61, indicating that she has indeed attained a full grasp of the options open to her, even if lacking a full understanding of what constitutes 'cholesterol'. (In l.60, we might recall, the doctor presented the first option as

being to 'leave things as they are (.) doing what you're doing (.) dieting (.) making be being careful about what you eat and so on'.) She then suggests, quite legitimately, in the light of what the doctor has told her, to (a) continue with the diet for a limited period, but if this makes no 'difference', to (b) take the tablets anyway, (with no mention of adhering to a low fat diet). But the way the doctor (eventually) responds indicates that the choice really was not between careful eating and a low fat diet versus tablets on the other, but simply whether or not the patient wants to take the tablets. In a sense the dieting, at least in the short term, is a red herring, since it is, according to the doctor's earlier suggestion (l.62) something she would be well-advised to follow in any case, tablets or no tablets. This indicates that the doctor has set up a false dichotomy between choices in lines 60–63, one which he will himself eventually overturn when pressed in the lines that follow. He begins to answer the patient's question (l.233) but is interrupted by her re-statement of the second option presented to her at the beginning of the consultation (or: do you think I should take the tablets?).

The doctor's reply to the patient's questions in lines 231 and 234 are delayed by the appearance of a demand or directive (l.237), although he attempts to begin an answer. The patient's retaking of a turn prevents the doctor from saying what he 'thinks'. The patient's insistence for an answer is also a reframing of the question. The patient suggests her preferred option (ll.228–31), interrupts with another option (l.234) and again interrupts with an open question. The reformulation is spotlighted by the patient's demand in line 237 'let's have your honest opinion now', which allows the doctor to disregard the previously articulated options all together. In so far as it is a demand it is a face-threatening act, openly challenging the authorial voice of medicine through its representative. It inverts the normal role of doctor as questioner and patient as provider of responses. Further, by being formulated as an open question and demanding an 'honest opinion' it challenges the authenticity of the doctor's performance (as apparently interested in shared decision-making). If the

doctor now needs to be asked for his 'honest opinion', what has been delivered up to this point must in some way be other than 'honest'.

The doctor's immediate response 'okay' (l.238) only serves as a discourse marker, and is followed by a pause. The doctor has taken the floor here: he reiterates 'I think' for the third time in as many lines, followed by another pause. He then ventures what we must assume to be his 'honest opinion', suggesting that 'the low fat thing' and 'dieting' (which he has himself endorsed) 'isn't going to make any difference'. He commends the patient on 'doing everything that you possibly can' (to which she offers minimal feedback) and then tells her that following that particular course of action (the very one with which he presented her in line 60–61) would in fact 'I think...just be ducking the question'. It could well be the case that here the doctor is rejecting the idea that further dieting by the patient might, of itself, lower her cholesterol in the short term. If this is so, he does not make it explicit to the patient, nor does she appear to have understood as much. This indicates a disturbing development in the interaction. To find oneself presented with a choice of two courses by a physician and then be told, after lengthy debate, that opting for one of those choices, even for a limited period, would be 'ducking the question' raises the issue of why in the first place the choice was offered. While it could be argued that the patient has, in this passage, set up a *third* option, in which 'I carry on with this low fat thing and dieting (.) for say another month and see if it makes any difference', and it is this unrealistic expectation which the doctor is rejecting (ll.238–242), this is because he has not satisfactorily conveyed to her the long-term characteristics of an elevated cholesterol count. This failure of communication is nicely illustrated by the patient's utterance: 'I'm physically (.) quite fit apart from the cholesterol?'.

The patient's response to the doctor's advice, then, is to return to the issue of 'cholesterol', which she still clearly does not understand. She is apparently caught in a 'disease model' understanding of cholesterol, in which 'high cholesterol' equals illness and low cholesterol

equals a bill of clean health. She does not adequately understand that 'high cholesterol' is not itself a disease condition, but, supposedly, a predisposing factor in other disease conditions. Her doctor has, it must be conceded, formulated this quite clearly in lines 71–73: 'it's one of the factors which hardens the arteries and that makes you more at risk of having heart problems or a stroke' but he makes no attempt to ensure that this information has been understood or even acknowledged and the patient's subsequent talk disappears down a cul-de-sac of vague memories and distant family connections with 'heart problems'. The essential precondition of any shared decision, that is, a common understanding of the basic problem confronting the patient, has somehow never been fully addressed. Without such understanding of a shared problem, choosing a course of action that leads to a shared decision becomes practically impossible.

Discussion

In the last extract we considered here, the patient says 'let's have your honest opinion', and in this utterance seeks to break out of role-play and back into a familiar doctor-led consultation, one in which his voice leads, and she follows. But more than this, there is a sense of the dialogic, of one voice predominating (the doctor's professional register) which he has now (for purposes which the patient cannot or may not wish to understand) abandoned and supplanted with a 'democratic voice'. This request is made after considerable doctor prevarication (ll.233–235). By expressing a wish to hear the doctor's 'honest' opinion we would suggest that what has been voiced to date is perceived by the patient as somehow circumlocutory or disingenuous – that the doctor has been holding back what he really thinks. What happens in such consultations is a *subversion of patient expectations*, which, combined with the doctor's failures to adhere to script, that is, his failure to remain convincingly either within the voice of medicine or else to project himself satisfactorily as speaking in a lifeworld context, leaves him isolated from pur-

poseful communicative action. And when the doctor does speak from within the lifeworld context his utterances only achieve a kind of modified accommodation, in expressions such as 'folk like yourself' (l.110) which is clearly neither part of the doctor's professional register nor of his personal idiolect. Moreover, the infelicitous choice of identifying an individual as belonging to a category of others 'like yourself' invites the possibility that, in the doctor's eyes, this patient belongs to a group of 'folk' who share certain characteristics (perhaps united by their common misunderstanding of the term 'cholesterol').

The issue of register is central to an understanding of this consultation. According to White, Bakhtin did not have access to the word register, but he wrote: '[T]here is interwoven with... generic stratification of language a professional stratification of language, in the broad sense of the term 'professional', the language of the lawyer, the doctor, the businessman, the politician, the public education teacher and so forth...'.²⁵ White goes on to say 'Every register is typification, a style, the bearer of specific sociocultural intentions; at the same time register is the bearer of self-referential identity which we recognize as such'. We would argue that the doctor, in this consultation, undermines the doctor register by speaking in it, yet not offering its normal concomitant 'gift' – the advice and recommendation that the patient requests and requires. By seeking always to 'do shared decision making' the doctor is in conflict with his own professional register of doctor, whose attributes he otherwise so fully displays – social class difference, the maintenance of an asymmetrical relationship (folk such as you) and the discursive attributes of an elaborated code. As we have seen, despite the explicit claim to be sharing the decision-making, medical professional ideologies are manifest.

One of the consequences of this is a total absence of narrative coherence to the consultation: there is a dissonance between our narrative expectations of what 'should' take place in a consultation of this kind and the actual results as evidenced in the transcript. Narrative expectations are, of course, specific to cultural

context, but we might take as a tested formula the narrative features described by Labov²⁶ as comprising *abstract, orientation, complicating action, evaluation, result* and *coda*. It has been suggested¹⁹ that these narrative features might map onto the phases of the practitioner–patient consultation delineated by Byrne and Long,²⁷ converting every consultation into a narrative of sorts. Instead, in this instance, the consultation twists and turns around a poorly defined central strategy of ‘shared-decision-making’, and there is no sense of progress towards narrative *telos*, or conclusion. At its heart lies the impossibility of either foisting a decision on, or eliciting a decision from its central character, a woman who is in the situation of not knowing what is wrong with her. Partly this is because she confuses a predisposition with an illness condition, but also because she has evidently received conflicting discourses from different medical professionals in helping her to reach a decision which she would, by her own account, happily have had made for her by her physician.

From a wider perspective, exposing elderly patients to lipid testing when they have little understanding of the underlying rationale for the test and understandably become anxious about the supposed associated risks, raises doubts about whether this is in the best interest of both individuals and society. When placed alongside the significant emerging debate about the diet–heart linkage,^{28–31} we would do well to ponder the overall assumptions we see in this interaction. Coupled with the difficulty of explaining the limited benefits of dieting or exercise on lipid levels that are only marginally raised, is this not an example of a pervasive medicalization that makes more demands on doctors’ and patients’ time and stress levels than is strictly necessary? The recent introduction of lipid lowering medication (in developed economies), although expensive and associated with significant side effects, is known to reduce the incidence of ischaemic events. This only complicates the explanatory work that has to be performed whenever a move is made to perform a cholesterol test. The difficulty of this initial explanatory work was clearly left undone for

this patient and in all probability for countless others. The subsequent misunderstandings and unshared agendas are poor starting positions for negotiated decisions about therapy. But this is an increasing feature of modern medical practice as the limit between normal health and ageing is drawn backwards.³² A certain type of health professional would cynically summarize this by describing a healthy individual as one who is inadequately investigated.

Conclusion

We have set out to display how this consultation proved problematic both for the doctor and for the patient. The patient receives medication which may or may not be of any benefit to her, but who in any case appears to have been unnecessarily unsettled by the series of events that have led to this consultation. Nor, it can safely be assumed, does she leave the consultation with a much more informed notion of what is ‘wrong’ with her. The doctor, meanwhile, remains convinced that he was dissuading the patient from attempting to pursue a wrong option, namely that a further short-term period of dieting would have any benefits on her cholesterol. However, the text offers no evidence that the patient understood him in this respect, and little evidence that the doctor was successful either in allaying her concerns about cholesterol in general, or of the specific likelihood of heart disease arising from it.

Following, or attempting to follow, a theory-driven agenda in a consultation of this kind raises the possibility of shared decision-making becoming a dogma of its own devising, as the scenario described falls short in at least two of the criteria necessary to the achievement of a shared decision. First, it is clear that the patient does not have a satisfactory understanding of the nature of the problem under discussion, and secondly, she does not appear to be involved in the process of information-sharing that is necessary for a successful outcome in any consultation involving shared decision-making. It is perhaps an obvious conclusion that in such a situation the patient has to be given information

about medical conditions and treatments. But information is never just information. The failure of the doctor to realize exactly how information is not being taken up is not simply an oversight. It signals that the *performance* of subversion of professional roles is simply that.

The concept of shared decision-making is not shared either. When the doctor says: 'I don't know what you feel but I think it's partly (1.0) a decision for you and it's partly a decision for me' the patient responds with the blunt question 'why?'. This is clearly a point at which the doctor has the opportunity to explain the concept of shared decision-making. The dialogic construction of the doctor's performance, in which the role of professional is subverted and the voice of 'co-constructor of a decision' is adopted, seems only to confound the patient. The doctor's refusal to accept the option chosen by the patient, in effect taking it off the table when it is accepted, can only be further confounding. This lack of congruence between what is said and how it is said will be an impediment to any discourse strategy – unless the strategy is to confound. Thus there must be congruence intra- as well as interpersonally.

The necessary participation in the 'shared decision' is clearly not forthcoming, as evidenced by the patient's request that the doctor give his 'honest opinion'. In fact, this request suggests that the doctor has been 'found out'. The patient is aware that he is 'playing' at decision co-construction. The adoption of innovations like shared decision-making cannot successfully be achieved without a corresponding ideological shift which seeks to actually subvert, or rather interrogate, the epistemic underpinnings of professions and concepts such as 'health' and 'illness'. The textual evidence of this consultation suggests that unless specified prerequisites are fully met with, a genuinely shared decision will remain unattainable.

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