Addressing possible problems with patients' expectations, plans and decisions for the future: One strategy used by experienced clinicians in advance care planning conversations

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ABSTRACT

Objective: Giving terminally ill people opportunities to participate in advance care planning involves tensions between: endorsing and supporting patients' expectations, plans and decisions, and addressing how realistic these are. The latter risks exerting undue pressure to change plans; undermining autonomy; jeopardising therapeutic relationships. Our objective is to describe how experienced hospice doctors raise potential/actual problems with patients' expectations, plans or decisions.
Methods: Conversation analysis of video-recorded consultations between five UK hospice consultants, 37 patients and their companions.
Results: Eleven episodes involving five doctors were found. In all of these we identified a 'Hypothetical Scenario Sequence' where doctors raise a hypothetical future scenario wherein current plans/expectations turn out to be problematic, then engage patients in discussing what could be done about this. We describe features of this sequence and how it can circumvent the risks of addressing problems with patients' expectations and plans.
Conclusion: Our research breaks new ground, showing that by treating expectations, plans and decisions as *potentially* not *actually* problematic, practitioners can recognise and support patients' preferences whilst preparing them for possible difficulties and inevitable uncertainties.
Practice Implications: Where professionals judge it appropriate to raise problems about patients' preferences, plans and decisions, this sequence can manage the associated risks.
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1. Introduction

Patient autonomy and agency in decision-making are valued across medical contexts, and in palliative care where cure is not the objective, patients' role in determining what constitutes a successful outcome is particularly important [1]. However, difficulties may arise when a patient's understanding of the nature of their potential or likely future is inaccurate or unrealistic. In this paper we explore one way in which palliative medicine doctors attend to potential or actual problems with terminally ill patients' plans and expectations for the future.

Interdisciplinary in nature and encompassing many different health care professionals, "palliative care is the active, total care of patients whose disease is not responsive to curative treatment" [2]. Most palliative care patients want involvement in decisions about their care [3]. Advance care plans (ACPs) involve patients and their families making plans and sharing preferences for end-of-life and it "usually take[s] place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others" [4]. ACPs generally tend to improve outcomes for patients and families [5,6] and, despite healthcare professionals' concerns, this planning does not adversely impact on patients' wellbeing or hopefulness [7]. However, professionals are often reluctant, and find it difficult to initiate ACP discussions [8,9]. It is also important to manage patients' (and their families') expectations to prepare them to make the decisions required [10].

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Palliative medicine doctors' knowledge and experience about end-of-life means they often recognise potential problems within patients' expectations, plans and decisions. Moreover, these doctors' remit includes working to ensure the best end-of-life experience possible and that patients' significant others have the least possible regret or distress in bereavement. This presents social and interactional challenges. For example, because less aggressive end-of-life care is associated with better quality of life [11] doctors may want to question ACPs that include invasive interventions such as resuscitation or chemotherapy when there is little chance of benefit. There can thus be tensions between supporting patients' expectations or plans and building realistic understandings of their feasibility or likelihood. Furthermore, working to ensure patients' expectations and plans are realistic can risk putting patients under undue pressure to commit to something they do not want. To ensure best possible end-of-life care, clinicians need to manage these tensions *before* ACPs are implemented.

Discussing end-of-life issues is a delicate activity, as is evident in people's use of various communication practices that soften the impact of addressing them [12]; it involves navigating multiple, competing tensions [13]. Existing research has focused on the difficulties in broaching and making decisions, here we explore communication where plans have been made.

We identify one strategy doctors used to address potential/actual problems with patients' expectations/plans. We term this the Hypothetical Scenario Sequence. We examine the design features and functions of this strategy such as how it circumvents social and interactional problems entailed in managing expectations.

2. Methods

Our full dataset comprises 37 consultations in one English hospice, involving five palliative medicine consultants and 37 patients with terminal diagnoses (and any companions). The methodology of the overarching programme of video-based research is described elsewhere [14] and in brief here. Data were transcribed verbatim, and episodes selected for detailed analysis were transcribed using Jeffersonian transcription [15] (see Appendix), identifying information was pseudonymised.

Conversation analysis (CA) is a methodologically distinct approach to studying naturalistic interaction with three key features: talk and gestures are treated as social actions; these are understood as making up sequences of actions; and sequences show stable patterns so that behaviour/talk has a broadly predictable outcome [16]. This orderliness is a result of participants' co-construction of shared understanding through interaction [17,18].

Medical interactions are almost completely accomplished through talk and gestures, so CA is ideally suited to analysing it [16,19]. With over 30 years of medical interaction research, CA seeks "to understand and document *what* social actions and activities are accomplished by participants in medical encounters and *how* participants use interactional resources and sense-making practices to accomplish their goals" (p. 577) [20].

As a CA study, analysis involved working inductively, watching recordings and reading transcripts. Multiple possible phenomena were identified. One of these was a collection of instances in which doctors addressed potential or actual problems with patients' existing plans and expectations. The whole dataset was searched for all instances of this phenomenon which resulted in a collection of 11 cases. All 11 instances were subject to detailed conversation analysis which involved watching the recordings repeatedly. Gestures are noted in the transcript when pertinent to the analysis presented (e.g. nods are included in transcripts below) but were considered more fully during the analysis. Analysis was undertaken primarily by two of the authors with analytic input from two further authors. All authors contributed to the writing up of the research.

3. Results

The collection comprises 11 episodes (from 9/37 consultations) in which five doctors addressed potential or actual problems with patients' plans or expectations. These problems related to: place of care (5/11); no hospice bed being available (3/11); treatment options (2/11); and when to implement plans for the last days of life (1/11).

3.1. The hypothetical scenario sequence

This strategy comprises a two-part sequence: the doctor introduces or draws on a hypothetical scenario that contrasts with the current plan/expectation, then the doctor talks with the patient about a plan to deal with that scenario. In most of the episodes (8/11) we identified where the doctors raised problems with expectations and plans, their very first attempt at doing so was via the hypothetical scenario sequence. In the remaining episodes (3/11), the doctors had already unsuccessfully attempted to raise problems in other ways.

In what follows, we introduce the strategy by examining three extracts. Then, with three further extracts, we describe its features and show how these help to deal with the potential risks of raising difficulties with patients' expectations and plans. Next, with a further extract, we provide preliminary evidence that doctors seek *patient-generated* solutions for dealing with the hypothetical scenario. In the final section of our results, we probe further into how and why this communication strategy is well-fitted to some important difficulties in managing expectations and raising problems with plans.

The patient in Extract 1 has planned for end-of-life care at home. Before the transcript begins, the patient described his brother's death at the hospice – including that he was "really bad at the finish" (not shown). As the extract begins, the doctor refers to what the patient has said to introduce a hypothetical scenario involving the patient's own dying stage (line 1) and adding another element, that is, his wife "struggling" (line 3). The doctor then offers a potential option for that scenario with "would you come here?" (line 5). Note that using "would" rather than "will" conveys this as tentative. The patient clarifies the question (line 9) before agreeing (line 13).

```
Extract 1 [VERDIS_DOCTORS36_34.17]
 1  Doc:   If you were in that situation and you were dying¿
 2  Pat:   Yeah.
 3  Doc:   And your wife was struggling¿
 4  Pat:   Yeah.
 5  Doc:   Would you come here?
 6            (1.0)
 7  Pat:   hhhh
 8            (0.5)
 9  Pat:   What? Rather than stop ut 'ome?
10  Doc:   Well ra[ther than going to hospital.
11  Pat:          [(Mm)
12  Doc:   If your wife was struggling.
13  Pat:   Oh yeah. Oh yeah.
14  Doc:   Okay.
```

So, the doctor treats dying at home – the patient's expressed preference – as potentially problematic if a particular eventuality (his wife struggling to care for him there) arises, then moves rapidly to establish an alternative plan. The doctor's experience of people at the end stages of this patient's illness equips her with the knowledge that the patient's wife may be unable to cope, and she treats the patient as potentially unaware of this. We also note that a potential problem has been addressed whilst the original plan available when the patient is at the dying stage (Extract 2, line 2) and seeks a decision for that contingency (line 6). Precisely who is responsible for finding a solution to the problem is left ambiguous with 'we' (line 6). As in Extract 1, the original plan is not criticised, rather, the doctor validates it (lines 3 and 5) but identifies a possible eventuality that could render it problematic in the future.

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Extract 2 [VERDIS_DOCTORS37_11.46]
 1  Doc:   .hh Thee only- thee only thing just to touch on I
 2          suppose is if we don't have a bed at the time, So
 3          normally we do:¿
 4  Pat:   Y[eah.
 5  Doc:    [But occasionally we don't. .hh
 6          Wh[at would we- What would we do then.
 7  Pat:      [.hh
 8  Doc:   Mcht I guess:
 9  Pat:   Mcht
10            (0.4)
11  Doc:   Mhhh
12            (.)
13  Pat:   I guess if I could manage hold #on.#

((18 lines omitted while the patient explains that he wouldn't
expect to be very bad with the implication that he would be
hopeful he could wait until a bed was available))

31  Pat:   Uhm (0.8) mcht .hh (1.2) I guess if I wus
32          as bad as I was last weekend, the only other
33          alternative would be oncology and then #transfer out#
34          w[ouldn't it?
35  Doc:    [Yeah.
36  Doc:     Yea[h.
37  Pat:        [.hh If needs be.
```

remains intact, and that the doctor has thereby avoided directly criticising or ruling out the existing plan. Moreover, in this case and others in the collection, by couching future difficulties as hypothetical the doctor gently introduces the subject of the patient's deterioration.

Extract 2 illustrates the more common pattern of the doctor seeking, rather than offering a solution, in the first instance. This patient has planned for end-of-life care at the hospice. The doctor introduces a hypothetical scenario – that no hospice bed is

In Extract 3, a patient has planned for end-of-life care at home. The doctor introduces a potential future scenario in which the patient has suffered a crisis related to his cancer (lines 1–2, 4) and seeks a decision for that eventuality (line 7). After a relatively long silence (one second is approximately the maximum silence tolerated [21]) with no response from the patient or his partner (COM in the transcript), the doctor lists three options (lines 9–11), and the partner then responds, ruling out one of these. In this way, the doctor informs and prepares the patient and his partner for a possible crisis of which they may have been unaware.

```
Extract 3 [VERDIS_DOCTORS20_15.31]
1   Doc:    Okay. .h And if there was a bit of uh (0.2) bang,
2           if there was a b[it'v .h bleeding or some other =
3   Com:                    [((nods))
4   Doc:    = cr[isis
5   Com:        [Mm. ((nodding))
6   Pat:    Mm. ((nodding))
7   Doc:    How would you want to handle that do you think?
8             (1.0)
9   Doc:    .hh In my head the options being, y'know, sitting it out
10          at ho:me, if we've got a bed coming in here, or going tuh
11          hospital. Those are the kind['v-
12  Com:                                [No it wou'n't be hospital.=
13  Doc:    = No.
```

In these three episodes, doctors raise possible eventualities that may occur as patients' illnesses progress, and which could render the existing plan/expectation problematic. Their hypotheticality mitigates the potentially distressing impact of topicalising 'dreaded issues' [22]. They treat patients and their companions as potentially unaware of these eventualities, and they do not rule out or directly criticise the existing plan.

3.2. Design features of hypothetical scenario sequences

This strategy often involves considerable interactional work. We examine eight key features associated with the hypothetical scenario sequence (summarised in Table 1). At least one of these occurred in each episode and many co-occurred within Extract 4, thus we use this extract to illustrate.

(a) Referring to another professional

Sometimes, as part of the strategy, doctors refer to other doctors' views or communications. In one instance, the doctor refers to a team of doctors as the source of the advice imparted as a possible solution to the hypothetical scenario. In another three episodes, the doctor attributes the reason for addressing a particular hypothetical scenario to another doctor. In Extract 4, the doctor refers to a "thing Dr Cartwright was asking about" to move into discussing the provision of injectable medications in preparation for the eventuality that the patient is very sleepy (and by implication, unable to swallow tablets or medicines). This feature bolsters the justification or rationale both for the doctor raising potential/actual problems and for the patient to engage in talking about associated plans/solutions.

Table 1
Summary of interactional features.

Feature	Example	Function
(a) Referring to another professional (this was found in 4/11 episodes)	"what Doctor Cartwright was wondering which I think is a good question to ask"	Bolsters the case for addressing the scenario.
(b) Building on patients' talk or previous experiences (this was found in 4/11 episodes)	"Do you remember when you first came on the ward here? . . . Things were pretty desperate . . . And we got you on a little syringe pump with the pain medicine in?"	Points towards a plan for the eventuality before actually raising it. Helps make the hypothetical scenario more familiar through drawing on the patient's existing knowledge and experience. Implies the future eventuality is relatively likely.
(c) General case formulations (this was found in 4/11 episodes)	"sometimes when **people** are really unwell" (*our emphasis*)	General case formulations were found in longer, more complex sequences, and soften the direct relevance to this patient.
(d) Minimising the seriousness of the contingency (this was found in 3/11 episodes)	"nothing too bad"; "little delay"	Downplays the putative impact of the hypothetical scenario.
(e) Emphasising conditionality (this was found in 3/11 episodes)	"I'm not expecting that you're gonna have a real struggle like that again"	Downplays the likelihood of the eventuality and the possibility that the patient's current plan/expectation is unrealistic, less likely to be heard as unduly pessimistic.
(f) Managing the timeframe (this was found in 3/11 episodes)	"at some point in the future, hopefully a while away"	Minimises the threat entailed by emphasising the distance between the present circumstances and the potential scenario.
(g) Conveying questioning as incidental (this was found in 6/11 episodes)	"the only thing just to touch on I suppose"	Downplays the seriousness of the potential problem with the patient's existing plan or expectation.
(h) Validating the original plan or expectation (this was found in 5/11 episodes)	"we'd want you back here? And you want to come. Which is fine"	Counters a hearing that addressing potential problems constitutes opposition or disagreement.

```
Extract 4 [VERDIS_DOCTORS09_20.38]
 1   Doc:   An' [[(0.2) tcht >one other thing< Dr. Cartwright =
 2   Pat:       [(Yeah)
 3   Doc:   = was a:sking about [wa:s so sometimes when
 4          peop- nothing too bad, but sometimes when people are
 5          really unwell (0.2)
 6   Pat:   Mm:?
 7   Doc:   Uhm I guess when they're really poorly, what we do
 8          is we get them some medicine at ho:me, (0.2) tcht so if they
 9          can't take their pills (0.2) their painkillers
10          for example [they can have an injection of painkiller.
11   Pat:               [°Yeah.°
12          (0.2)
13   Doc:   Does that make sense?
14          (0.5)
15   Pat:   M:yeah: uhm I'm  I'm more likely to
16          be coming here (I)
17   Doc:   You're fine at the minute.
18   Pat:   Yeah.
19   Doc:   >Do you remem[ber< when first- do you remember =
20   Pat:                [(I am)
21   Doc:   = when you first came on the war:d here?
22   Pat:   Yeah:?
23          (0.2)
24   Doc:   When things were pretty desperate.
25   Pat:   ((nod)) They were desperate weren't they. = Yeah.
26   Doc:   And we got you in a little syringe pump with the pain
27          medicine in¿

((21 lines omitted in which the doctor seeks to establish the patient's
previous experience))

50   Doc:   I'm not expecting that you're gonna: (0.5) °have° a
51          real struggle like that again¿
52          (.)
53   Doc:   .h But I suppose I'm thinking if at some point in the
54          future, (0.5)
55   Pat:   Yeah¿
56   Doc:   Hopefully a while away: actually you weren't so well:
57          you were y'know maybe very sleepy or drowsy (0.5)
58          [you were really unwell. For exam[ple.
59   Pat:   [Yeah.                           [Yeah.
60   Doc:   .hhh Uhm how would we get the painkillers in you.
61          (0.5)
62   Doc:   That's the question.
```

(b) Building on patients' talk or previous experiences

Sometimes doctors build on the patient's talk and/or previous experiences. In Extract 1 above we saw that the doctor drew on the patient's just-prior talk about his brother's death. In Extract 4, the doctor refers to the patient's previous experience of using a syringe pump for medication (lines 27-8), thereby making available, in advance, a plan for the hypothetical scenario the doctor subsequently raises and showing the plan is one the patient is already knowledgeable about. This feature also helps imply the hypothetical scenario is a reasonable one to consider.

(c) General case formulations versus patient specific pronouns

In Extract 4 the doctor's initial hypothetical is a general case formulation: "sometimes when people are really unwell" (lines 4–5). General case formulations allow patients to make inferences about their own situation without the doctor making this explicit [23]. These occur in longer or more complex sequences and make available information which the patient may use to make plans. Presenting the scenario as broadly applicable – matters concerning anybody – actively reduces the conveyed threat to the specific individual [24]; this may work to help patients experience less fear when being informed about, and when discussing future eventualities that do not fit their current plans/expectations.

(d) Minimising the seriousness of the contingency

Doctors may minimise the seriousness of the contingency. In Extract 4 this takes the form of "nothing too bad" (line 4). Or, it may involve using minimising terms: "a bit of a bang", "a bit of bleeding" (Extract 3, lines 1 and 2); or "little delay" (Extract 6, line 6). These downplay the threat posed by the scenarios. Again, this seems to be designed to reduce the distressing or fear-inducing consequences of addressing these problems.

(e) Emphasising conditionality

Doctors may emphasise the conditionality of the hypothetical eventuality with, for example, "I'm not expecting that you're gonna have a real struggle like that again" (Extract 4, lines 50-1). By foregrounding the eventuality's unlikelihood, the doctor downplays the possibility that the patient's current plan or expectation is unrealistic and is less likely to be heard as unduly pessimistic.

(f) Managing the timeframe

Most commonly, managing the timeframe entails doctors pushing the hypothetical scenario further into the future. In Extract 4 this is achieved with: "at some point in the future, hopefully a while away" (lines 53-4 and 56). Emphasising the distance between the present and hypothetical minimises the potential threat. Extract 5 illustrates a more ambiguous timeframe construction. The patient has motor neurone disease. Before this extract, he has reported not needing his NIV (non-invasive ventilation) machine to assist breathing in the daytime, and that he stays awake in the daytime. He gave a delayed, less-than-fulsome agreement to a question from the doctor about whether he would have concerns using the machine if he was 'nodding off' during the day. Therefore, when the doctor states the hypothetical scenario in Extract 5

he might anticipate further resistance. The doctor begins with "say at some point in the future, I don't know . . . I'm making up a number" (lines 2–3 and 5) then, in contrast to our other examples, he specifies a relatively short timeframe – "three months away" (line 5). Thus, the doctor conveys the matter raised from line 1 onwards as delicate, and not relating to the present, but by also specifying a short timeframe, he brings the scenario into the patient's *near* future.

hypothetical scenario to validate the patient's existing plan to die at the hospice ("we'd want you back here? And you want to come. Which is fine" lines 1 and 3). This helps mitigate against the implication of disagreement inherent in raising possible or actual problems.

```
Extract 5 [VERDIS_DOCTORS30_7.38]
1   Doc:    .hh So from your (.) point of view Derek (.)
2           say (0.2) say at some point in the future I
3           don't know [(0.2) mcht I'm making up a =
4   Com:               [Mm.
5   Doc:    = n-umber three months [a- three months away: =
6   Pat:                           [°(Yeah.)°
7   Doc:    =actually you felt you were dozing off in
8           the afternoon.
9   Pat:    tcht Yeah.=
10  Doc:    = Typically .hhh the breathing team would say
11          we would say .hh actually that might be a si:gn
12          that a bit more En I Vee in the afternoon might
13          be helpful[:¿
14  Pat:              [Right.
15  Doc:    And then people can decide whether they like
16          the idea of that [or or not.
17  Pat:                     [(Yes.)
18  Com:                     [Kkhh Yeah.
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Extract 6 [VERDIS_DOCTORS09_23.28]
1   Doc:    If you're really poorly we- we'd want you back here?
2   Pat:    Yeah[:.
3   Doc:        [And you want to come. Which is fine. .hh If there was a
4           little delay coming back (.) for example say we didn't have
5           a bed that day and you needed to wait a day or two¿
6   Pat:    >Oh yeah yeah yeah yeah. Yeah.<
7   Doc:    Then- an' you weren't feeling well enough to take yih
8           methadone pills?
9   Pat:    Yeah.
10  Doc:    Would it be helpful to have some methadone (0.2) injection
11          at home that the nurses could come and do for a few days
12          before you came back in.
13  Pat:    It would. Yes.
```

(g) Conveying questioning as incidental

Doctors often use language to convey that addressing actual/ potential problems through the hypothetical scenario sequence is a casual matter (not a major agenda item): "I suppose I'm thinking" (Extract 4, line 53) and "the only thing just to touch on I suppose" (Extract 2, lines 1–2). These downplay the problem's seriousness and reduce the extent to which doctors might be heard as critical of the existing plan/expectation.

(h) Validation of the existing plan or expectation

Sometimes doctors validate patients' original plans/expect- ations. In Extract 6 the doctor interrupts his own production of the

To summarise: the hypothetical scenario sequence encourages patients to base plans/expectations on accurate understandings of their condition and likely future, while the associated features described above are attentive to, and help mitigate the possible problematic nature of raising possible or actual problems.

3.3. Possible preference for seeking rather than offering a solution to the scenario

Although our dataset contained too few instances to be definitive in quantitative terms, there is interactional evidence

of a preference for doctors to seek patient-generated adjustments to plans for dealing with the future scenarios, rather than for doctors to go straight into proposing them. The former means that patients put forward a plan, while the latter puts patients in the position of having to agree (or not) in response.

One piece of evidence is that in those cases where it was at least possible that the patient might have the knowledge required to propose a plan for the contingency, doctors tended initially to seek patients' proposals. Only when this was unsuccessful did doctors go on to make proposals. In Extract 7, a patient has a plan for end-of-life care at the hospice. After outlining the hypothetical scenario of a hospice bed being unavailable (line 10), the doctor seeks a plan for that contingency (line 11). After a half-second silence with no response, the doctor provides two candidate plans: home (line 15) or hospital (line 18).

offers the option of transfer to the hospice should that situation arise.

At least one of these pieces of evidence was found in all but one – Extract 1 – of the 11 episodes. That is, Extract 1 is the only extract in which the doctor does not initially seek a plan, where there is no obvious evidence that the patient could or would not have done so, and where the doctor does not provide information for the patient to do so prior to an offer of a plan.

3.4. Functions of the hypothetical scenario sequence

Primarily this strategy functions to add to an original plan/expectation with reference to *one particular* eventuality. Eight cases involve doctors creating (or building on) a hypothetical scenario *before* seeking/offering a plan for that contingency *only*.

```
Extract 7 [VERDIS_DOCTORS18_39.14]
1    Doc:   Uhm (1.9) u:h (0.4) I su- the only- (.)
2           I'm looking (.) slightly hesitant (.)
3           but normally we've got beds for people who come?
4             (0.4)
5    Doc:   Occasionally we haven't s[o it's having a=
6    Pat:                            [Sure.
7    Doc:   =little bit of a back-up.
8    Pat:   M:m.
9             (0.5)
10   Doc:   Y'know if if we haven't got a bed here
11          what would you do:?
12            (0.5)
13   Com:   [Mm
14   Doc:   [So I guess the options then (0.8) would
15          probably be >staying at home?<
16            (0.7)
17   Pat:   Mmhm?
18   Doc:   Or possibly going to hospital,
19            (0.3)
20   Pat:   I- I do[n't-
21   Doc:          [Depending on what the
22          issu[es were really
23   Pat:       [I don't really want to die at home,
24          I just don't think it would be very nice
```

A second piece of evidence is that doctors sometimes provide information for patients to draw upon to make decisions. In Extract 4, introduced above, the doctor provides information about what is usually done "when people are really unwell" (lines 4–5) and "can't take their pills" (line 9) prior to producing a hypothetical scenario involving this patient being in that situation. In another episode (not shown) a doctor provides information about a way to handle a situation immediately after they have raised the hypothetical situation. This equips the patient to proffer a solution rather than agree (or not) to the doctor's.

Third, where doctors initially offer candidate plans for the hypothetical scenario, there is often evidence that patients couldn't (lack of knowledge) or wouldn't (disagreement) have provided the decision. For example, in an episode in our collection (not shown) a patient expresses concerns about emergency admission to hospital and subsequent deterioration whilst there. The doctor articulates this as a risk of becoming "stuck" in hospital to which the patient laments "we can all wish for things but you can't do anything about it if it happens", suggesting she is unable to produce an alternative plan for the contingency. The doctor then

This works as a very low risk strategy for questioning patients' plans/expectations because the patients' original decision remains intact. This strategy is also a gentle way of topicalising illness progression and ensuring patients understand the implications of their decisions without being overly pessimistic.

In the remaining three instances the hypothetical scenario sequence was used to push for a comprehensive change to the original plan. In these episodes there had already been more direct attempts to change a patient's plan/expectation, which were unsuccessful because the patient resisted the doctor's rationale (2/3) or proposed plan (1/3). Only when these direct attempts were unsuccessful did doctors use the hypothetical scenario sequence. Extract 8 illustrates. Just prior to the extract, the doctor tried to change a patient's plan for end-of-life care in hospital by emphasising the decision's implications: the busy/noisy nature of hospital care compared with the hospice. However, for the patient, hospice care means giving up on treatment which he is reluctant to do. The doctor then uses the hypothetical scenario sequence to reframe his proposal as an option to be considered in the future, rather than a decision to be made currently (lines 2–6).

```
Extract 8 [VERDIS_DOCTORS31_34.17]
 1  Doc:  I mean from my point of view that would
 2        certainly be an option if: if things- if you didn't
 3        go to the Roy:al or even if you did but later on
 4        .hhh (.) you felt "actually time's getting shor:t,
 5        I want to be somewhere peaceful (.) not at home" then
 6        we'd be very happy tuh (0.2) look after you here¿
 7  Pat:  Oh brilliant.
 8  Doc:  °Yeah.°
 9           (0.5)
10  Pat:  hhh (It's) very reassuring
11  Doc:  ((nodding)) °Yeah o[kay.°
12  Pat:                     [Very reassuring.
```

Therefore, the hypothetical scenario sequence can be used to manage patient resistance to plan changes. The proposed change is reframed as a possible option to be considered if the original plan is untenable *at the time of its implementation*. The decision is thus pushed into the future and the hypotheticality of the scenario makes it very difficult for the patient to reject the doctor's proposal outright. Both options are kept 'on the table', the patient's autonomy is preserved, and explicit disagreement/rejection is avoided.

4. Discussion and conclusion

4.1. Discussion

Decision-making does not end with decisions made: plans and expectations can be revisited. The hypothetical scenario sequence is one way in which doctors question patients' plans/expectations. It involves describing or drawing on a hypothetical future scenario in which a patient's current plan/expectation is rendered potentially or actually problematic *at the time of its implementation* and seeking/offering a course of action for that scenario. In most of our cases (8/11) this strategy is used in the first instance to develop patients' decisions rather than to change them. However, it is sometimes (3/11) used after other methods to change patients' plans have been unsuccessful. In this context, it works to manage resistance by reframing doctors' proposals as suggestions to be considered in decision-making in the future. As the patient's original decision remains intact in all 11 episodes, the alternative is produced as a contingency plan. This makes the strategy a very low risk approach for questioning a patient's plan or expectation.

Hypothetical questions are powerful tools for enabling participants to imagine projected scenarios as real [25], and work well in engaging people in discussions, because it is difficult to resist engaging with a matter that is 'merely' hypothetical [24]. The strategy we have described can thus be useful in circumstances where the patient (and/or their companion) are resistant to engaging with some matter, and where it is clinically appropriate to nevertheless gently encourage this engagement.

Hypothetical questions have been most thoroughly explored in counselling settings [22,24, 26, 27,28] where their objective is primarily to encourage talk about feelings. They have also been shown to be used for view-testing across a range of settings [29] but particularly in Gender Identity Clinics where psychiatrists use them to present a future in which treatment is withdrawn from or surgery denied to transsexual patients [30,31]. These contingencies are within the psychiatrists' (or the institution's) control and the purpose of asking is to test patients' views and commitment to treatment. By contrast, the hypothetical scenarios here are used in service of decision-making and, more specifically, to refine or develop decisions where patients *already* have some plan/expectation.

The eight design features identified reflect the delicate, sensitive work this strategy strives to achieve. Although potentially upsetting, patients benefit from truthful portrayal of their situation [32]. This strategy encourages patients to have plans and expectations based on accurate understandings of their condition and likely future, while the associated features are attentive to the possible problematic nature of doing this. Broadly, these features provide a basis for questioning (referring to another professional, building on patients' talk or previous experiences), minimise the threat posed by the hypothetical scenario thereby helping doctors avoid being heard as unduly pessimistic (general case formulations, minimising the seriousness of the contingency, emphasising conditionality and/or managing the timeframe); and/or mitigate the potentially delicate activity of questioning, including being heard as overly critical (conveying questioning as incidental, and validation of the existing plan or expectation). The work done through these features reflects the multiple and sometimes competing overarching goals that doctors are working to achieve: not to be too pessimistic or critical while giving patients a realistic understanding of their condition and prognosis, to involve patients in the decision-making and meet their preferences/expectations, and to give patients the best possible end-of-life experience.

Persuasive communication does not preclude shared decision-making [33]. Indeed, this strategy is attentive to maintaining patient autonomy, giving patients information, and building on patients' talk and/or experiences contribute to patient inclusion. Moreover, tentative evidence suggests a possible preference for patient-generated plans.

For terminally ill patients, uncertainty is inevitable. If this uncertainty is not recognised and managed skilfully it can negatively impact on their end-of-life experiences [34]. The doctors' use of hypothetical scenarios for clarifying expectations and adjusting or adding to plans is one way of managing this unavoidable uncertainty. Rather than make decisions for the future in the present, a key objective of ACP should be to prepare patients and families to make the best possible "in-the-moment" decisions [35]. Above all, hypothetical scenario sequences prepare patients for contingencies by equipping them for decision-making in the future.

The in-depth analysis offered by CA is a strength of this study. Moreover, analysis of naturalistic interactions offers insight into this phenomenon in real-life consultations. To our knowledge this is the first study to examine, through analysis of actual recordings, how professionals address potential or actual problems in patients' and their companions' expectations, plans, and decisions. We

recorded highly skilled palliative medicine consultants, giving us access to examples of practice based on many years' experience. A limitation of the study is the small number of episodes and the specialist setting. Nevertheless, existing studies of hypotheticals suggest that it is likely to function similarly in other settings. Consultations in this study are from a hospice with a holistic approach, lengthy appointments and in all but one of these interactions the doctors had met the patients previously. Whereas, more usually physicians "do not know the patient, do not routinely address patients' nonmedical goals, and often fail to provide patients with sufficient information about prognosis to allow appropriate decisions" (p.1994) [6]. The challenge is therefore to translate these skills to inform the care of all patients.

4.2. Conclusion

Our study describes one element of what good practice in ACP looks like. Managing expectations is recognised as a challenging element of communication in palliative care and advance care planning [10]. This study describes the structure and functioning of a strategy through which professionals can do this.

Providing good palliative care involves identifying and preparing for patients' future needs as well as their current needs [36]. Although patients may be experts regarding their own preferences, doctors have knowledge and experience that may make them better placed to anticipate those future needs. By treating decisions as hypothetically – rather than actually – problematic, the strategy we have described here provides a way for practitioners to communicate about possible future scenarios while recognising patients' preferences. Although doing this may be interactionally difficult, not doing so may result in a worse end-of-life experience. Thus, the hypothetical scenario sequence provides a sensitive and effective way to do so.

4.3. Practice implications

Where appropriate, the hypothetical scenario sequence can be used to manage patients' expectations while being attentive to the associated risks. Our description of the structure and functioning of this strategy provides practitioners with the explicit language to reflect on and develop communication competence.

Informed consent and patient details

I confirm all patient/personal identifiers have been removed or disguised so that the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

Patients and companions gave verbal consent prior to recording and written consent subsequently. Doctors gave general permission prior to recordings and again to confirm consent after recording. NRES Committee West Midlands—Coventry & Warwickshire, UK (ref14/WM/0128) provided ethical approval.

Conflicts of interest

The authors report no conflict of interests.

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Appendix A. Transcription key

?	Talk ending with rising intonation
¿	Talk ending with slightly rising intonation
.	Talk ending with falling intonation
underline	Emphasised talk
°°	Talk inside the symbols is quieter than surrounding talk
><	Talk inside the symbols is faster than surrounding talk
[]	Overlapping talk
(word)	Unclear talk, words contained within are the transcriber's best estimate
(())	Gestures or descriptions of non-verbal information
.hhh	Inbreath
hhh	Outbreath
–	The sound prior to the hyphen is 'cut off'
:	The sound prior to the colon is lengthened
=	Talk is 'latched' to preceding talk so there is no silence at all in between
(0.8)	Length of silence, measures in seconds
(.)	A silence of less than a tenth of a second

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