A discursive psychological investigation of patients' preferences in post-diagnostic prostate cancer treatment appointments

Charles William Baker

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Dedication

This work is dedicated to

Amanda Baker 18/03/65 - 02/10/09

and

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Abstract

This thesis examines the role of patients’ preferences in post-diagnostic prostate cancer treatment appointments, focusing specifically on patients’ preferences as interactive constructions. Patients’ preferences are acknowledged as key to shared decision-making while prostate cancer treatment decisions are considered highly preference sensitive. Despite recognition of patients’ preferences and a desire for routine shared decision-making, little is known about patients’ preferences in situ with empirical observational research scarce. Prostate cancer is an ideal site for investigating patients’ preferences because treatment options for localised prostate cancer have equivalent effectiveness.

Twenty-one naturally occurring post-diagnostic prostate cancer treatment appointments were recorded to collect the empirical materials. A combination of discursive psychology and conversation analysis was used to analyse the recordings and explore the role of patients’ preferences.

Across the three analytic chapters I focused on the ways that patients constructed preferences and the forms patients’ preferences could take and made the following observations. First, patients indeed constructed preferences in situ and there was heterogeneity both in the forms of preferences and the interactive work comprising their construction. Second, I reported that rather than being straightforwardly elicited and integrated into decision-making business, preferences met with two distinct patterns of receipt and handling by clinical nurse specialists. Third, the production of laughter was revealed to be consequential for decision-making business by functioning to perform subtle preference work and sanction progress.

This thesis therefore provides support for treating patients’ preferences as interactive constructions and extends our understanding of preference construction in treatment decision-making by demonstrating heterogeneity in the conversational and discursive resources that patients mobilise. Observations about the distinct handling of patients’ preferences responsive to their interactional consequences also extend conversation analytic work on differences between shared decision-making behaviour as modelled and attempts at accomplishment in situ.

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Thesis introduction

Why, how and interest and motivation

This research arose out of conversations with my research supervisor Dr. Mike Rennoldson, around the difficulties in the clinic of making informed decisions about cancer treatment. He'd noticed in his clinical practice working as a psycho-oncologist in a local Urological Cancer service that there were several live issues around how men with prostate cancer make treatment decisions – particularly regretting treatment choices after the fact. Looking further into this, the case of prostate cancer became a particularly interesting case because of the issue of treatment equipoise, which had attracted some media attention such as a Radio 4 discussion. I was already alive to many of the issues around treatment decision making and treatment effects in cancer through prior work on a cervical cancer support project.

I came into the project with a strong interest in language and social interaction, so naturally this was the lens I brought to bear on the issue, and I started to read more deeply into the history of research and practice in treatment decision making. Shared decision-making (SDM) was the culmination of a push towards a more involving and equitable practitioner-patient relationship after longstanding historical acceptance of a paternalistic model. Subsequently SDM has become an increasingly commonplace aspect of contemporary healthcare research and practice. Indeed, in the United Kingdom SDM is a central pillar of the National Health Service's (NHS) long-term plan and concept of Universal Personalised Care (NHS England, 2019). Furthermore, SDM is largely understood to be ethically admirable or in some cases an ethical imperative or part of a legal framework (Coulter et al., 2017).

There remains, however, much work to be done both on SDM and the component parts of the decision-making process such as patients' preferences. The most pressing practical issue, I discovered, is that practitioners were seen to attempt only infrequently to involve patients' preferences in decision-making and in some cases attempt no patient involvement (Couët et al., 2015). Furthermore, patients' preferences do not accord with the final treatment received but rather the standard medical concerns of the clinician (Scherr et al., 2017).

I therefore became interested in focusing on preferences themselves, such as how preferences being checked or elicited came to become recognisable preferences. My primary research question was therefore: How do patients' preferences shape treatment discussions in decision-making appointments?

For the second component of my research question, I focused on two related but distinct moments in the appointments. The first was the ways that the clinical nurse specialists (CNSs) responded to patients' preferences, which would be the crucial pivot on which the feasibility of patients' preferences would hinge. Related to this first moment was the consequences that patients' preferences had for the decision-making business, as revealed in three insightful conversation analytic studies (Landmark et al., 2015, 2016, 2017).

Having discussed the inspiration behind my research and the motivation for taking a language and social interaction position, I will now briefly summarise the individual thesis chapters.

Overview of chapter structure

My first chapter is part one of a two-part background literature review that contextualises and provides the rationale for my original research. Chapter 1 recounts how the first model of SDM eventually replaced centuries of paternalistic care before it covers and reviews subsequent developments. A particular focus will fall on patients' preferences and how they assumed notable prominence as an essential element of SDM while simultaneously proving to be a difficult concept to implement in practice.

In chapter 2 I cover approaches to the study of face-to-face healthcare interactions, outlining and reviewing three distinct traditions. First, interaction systems analysis; second, critical interaction analysis; and third, language and social interaction research. As I take the language and social interaction approach, I subsequently overview the branch of this research dedicated to healthcare interactions in detail. After demonstrating the applicability to SDM and patients' preferences, I highlight key gaps in the research literature and then make the case for using discursive psychology specifically.

In chapter 3 I cover my research design and methodology in addition to providing more contextual information about the research site. To begin, I provide relevant information about prostate cancer treatment appointments and the role of CNSs. I then report the process of attaining ethical approval, discuss related ethical issues, and outline the data collection process. The data management strategy is then discussed, per my arrangement to archive research data for ten years post-completion. A detailed account of my theoretical and analytical framework spanning ethnomethodology to conversation analysis and discursive psychology follows before an account of transcription conventions concludes the chapter.

Chapter 4 is the first analytical chapter and focuses on patients constructing preferences in situ as linguistic and psychological phenomena. Across the chapter I examine the distinct forms that patients' preferences can take, and the varied strategies patients use to construct preferences. I first inspect straightforward construction projects and constructed preferences to establish familiarity with the phenomena and argument for constructedness. Furthermore, I demonstrate how the construction work of accounting for a firm, or decision-implicative, preference came after the formulation of that preference rather than lead up to it. Next, I focus on patients using and invoking psychological phenomena such as cognitive processes, emotion categories, and mental states as resources for preference construction. Lastly, I explore extended multi-turn construction projects wherein patients using previous experiences as an explanatory resource for constructing present preferences. Ultimately, my analysis reveals that not only did patients construct preferences in situ, but that both preferences and preference construction projects were heterogenous.

Chapter 5 begins with the suggestion that preferences alone may be insufficient to influence the treatment decision. In turn, I extend the analytic focus from preference construction to the receipt and handling of patients' preferences by the CNSs. I report on two patterns of CNS-side receipt and handling that were seen throughout the dataset. The first pattern was receiving patients' preferences as straightforward and unproblematic. Closer analysis revealed that this pattern was typically associated with preferences that had simple sequential and institutional implications, such as requesting the institutionally recommended treatment of surgery, which CNSs could therefore sanction with relative ease. By contrast, the second pattern of receipt and handling was preferences that proved challenging to the business of the appointment. This pattern was observed when the sequential and institutional implications were less straightforward such as seeking to avoid an unavoidable side effect or requesting an unconfirmed treatment option. I go on to reveal how CNSs moved to either undermine the preference or avoid ascriptions of accountability around preferences that cannot be sanctioned.

Chapter 6 remains focused on patients' preferences but examines more tacit preference behaviour. I focus on laughter production in decision-making conversations and the function of laughter for both SDM and patients' preferences specifically. Laughter production was seen to be consequential for sequential progress, and therefore also relevant for accomplishing decision-making business. First, I report on one function of laughter being to straightforwardly sanction sequential progress comparable to standard acknowledgement tokens such as mm or uh huh. I contend that laughter approximates a positive preference by demonstrating that there is no present problem to what a patient wants from their healthcare. The second function of laughter was also relevant for sequential progress but involved longer and typically shared laughter sequences. In this section I explore how parties use laughter to either manage or avoid potentially delicate moments by creating distance and space to exchange laughter. Finally, I examine the pattern of treating seriousness as a flexible interactive resource to frame or receive talk as serious, non-serious, or a combination of both. A flexible notion of seriousness allowed patients and clinicians alike to soften potentially delicate actions either ins service of restoring or preserving sequential progress. Ultimately, laughter was seen to be a subtle but effective way to negotiate the state of preferences in situ as appointments progressed.

Lastly, chapter 7 concludes the thesis with the first section summarising the rationale for my research, the aims of my research, and my analytic findings by chapter. I then discuss limitations of the research before going on to detail the contributions that my research makes to the varied academic literatures. Recommendations for clinical practice derived from my analytic findings and focused on accomplishing SDM and performing meaningful patient involvement, follow. The final section posits future directions to take for furthering research into SDM and patients' preferences.

Chapter 1: The antecedents, development, and adoption of shared decision-making

Chapter overview

This opening chapter will provide the first of a two-part literature review and background section to introduce, situate, and present the rationale for my original research. The particular focus is on my research topic, broadly shared decision-making (hereafter SDM), and more specifically patient's preferences. To begin, the practitioner-patient relationship will be introduced, and its development traced from historically paternalistic approaches up to the cusp of SDM. Shared decision-making as an approach to the practitioner-patient relationship will subsequently follow and the first definitions and models shall be detailed. Next, I cover the models and developments that followed this initial work and introduce patients' preferences as a key component of SDM. A discussion of some of the problems with and facing SDM and patients' preferences rounds out this coverage. The penultimate section provides information about prostate cancer such as diagnosis, treatment options, and long-term outcomes to give the clinical context of my research. I conclude this chapter by first bringing together prostate cancer and SDM and then summarising the chapter.

1.1 The practitioner-patient relationship: Paternalism and the sick role

Across this chapter I will attempt to provide an overview of the development of the practitioner-patient relationship as it eventually moved into SDM. The historical narrative of this overview, however, is an Anglo-centric one, and there are two reasons for this approach. The first reason is that the historical evidence on practice is scarce and the account reflects this limited prominence. Secondly, in attempting to keep to major contributions to the development of SDM, I found that a lot of this work occurred in the Anglosphere. The research that this introduces, then, is situated in that intellectual and practice context so it is highly relevant, even if we must acknowledge that practices in other places are neglected by this literature. I also wish to make a note on terminology before proceeding further. When discussing research literature, such as in chapters 1, 2, and 7 I use the terms practitioner and practitioner-patient relationship to encompass the diversity of healthcare roles represented in the literature reviewed. However, when focusing on my research in chapters 3-6, I use the terms clinician and clinician-patient relationship since my data concerns clinical nurse specialists. The only exception is the interprofessional model of SDM (Légare et al., 2011) which is a model inextricable from its precise terminology choices and for which I used the authors' specific term.

The practitioner-patient relationship is usually an integral part of the provision of care by healthcare practitioners to the sick. A healthcare encounter necessarily consists of a healthcare practitioner and an individual requiring some form of medical attention or advice. Although healthcare encounters predate the Hippocratic Oath, it provides a useful starting point from which to trace the traditional approach to practitioner-patient relationships and its subsequent development. The Hippocratic Oath put in place a code of practice and provides an early example of medical ethics. Beneficence, or the act of providing the best care to the best of a practitioner's ability, is one of the guiding principles of the Hippocratic Oath (Kaba & Sooriakumaran, 2007). The related concept of nonmalfeasance, meaning not to cause harm, is another guiding principle. Taken together, beneficence and nonmalfeasance stand as the starting point of what would become the paternalistic approach to practitioner-patient relationships. Taken to the extreme, beneficence and nonmalfeasance preclude divergences from practitioners' views of the best care. Practitioners' views on the best care may be subject to bias and might disregard patients' suggestions where the practitioner considers an option to carry excessive risk.

One of the earliest academic understandings of the paternalistic practitioner-patient relationship was found in Talcott Parsons' book *The Social System* (1951). Parsons, one of the leading voices of sociology, was chairman of the social relations department at Harvard and was particularly interested in the structures comprising societies. In addition to being published by one of the leading voices of sociology, there was another reason that *The Social System* was significant. That is, Parsons had embedded a historical model of the practitioner-patient relationship in a contemporary model of society and social systems. In turn, the suggestion was that this model of the practitioner-patient relationship was not a historical relic but rather both operative and contemporary. Parsons' model of the practitioner-patient relationship, then, reflected the lack of mainstream progress to date in terms of establishing an equitable and involving practitioner-patient relationship. Here it is crucial to remark that Parsons, being a sociologist more broadly rather than a medical sociologist, was interested less in practitioner-patient interaction specifically and more in the social world and social order. In turn, it especially noteworthy that Parsons' concept of the sick role, which I will discuss in the following paragraph, became a widely adopted and long-standing feature of medical sociology (Burnham, 2014).

Illness, for Parsons, was therefore part of the social order of the world and held a particular role within the workings of the social world and its order. Patients would occupy the sick role, an undesirable state of illness where they seek assistance from and henceforth cooperate with professional medical expertise to avoid claims of motivated social deviance (Parsons, 1951). Those occupying the sick role were exempt from their typical responsibilities while those that were well had obligations to support the ill (Parsons, 1951). As occupants of the sick role were exempt from typical responsibilities, it was considered important that occupants appeared unmotivated. Parsons contended that "the sick role involves a *relative* legitimacy" (Parsons, 1951, p. 211, emphasis in original), which was seen in this requirement that patients appear unmotivated. Unmotivated meant that the patient was not actively engaged in the deviant act of not performing their societal role but rather genuinely unable to perform that role (Parsons, 1951). Since the sick role entailed a deviation from social order Parsons' argument rested on assumptions of deviance and legitimacy. Parsons further argued that the sick role was acceptable if the illness and subsequent cooperation with professional medical expertise were legitimate (Parsons, 1951).

Critics of Parsons' functionalist concept of the sick role argued that it was effectively a normative ideal rather than a record of variable illness behaviour (Segall, 1976; Twaddle, 1969) Furthermore, that Parsons characterised the sick role as a set of expectations, particular rights, and obligations. Parsons, they argued, had constructed an ideal type of individual behaviour instead of characterising the behaviour of sick individuals. As Parsons' project was theoretical, it is unsurprising that the sick role was conceptual and theoretical in nature. That said, it is a problem that the sick role does not have an empirical basis if it was to be treated as representative of interactions between patients and practitioners. Another issue that Parsons' critics took with the sick role was that they considered it problematic for chronic illnesses. That is, for people with chronic illnesses, a temporary exemption from duty could never be sufficient. Therefore, critics of Parsons' vision of the sick role suggested his system excluded this large and important group of patients (Segall, 1976). While Parsons might not have made sufficiently clear that the sick role was not exclusive to acute illness in *The Social*

System (1951), he clarified his position in a talk given over 20 years after its publication (Parsons, 1975). Furthermore, some later scholars would also consider the critics' characterisation of chronic illness as an issue as having been a misrepresentation of Parsons' work (Gerhardt, 1987).

That said, Parsons' notion that people must be unmotivated in occupying the sick role sits uncomfortably with later 20th century treatment approaches which require patients to actively contribute to decisions, such as those developed for chronic or terminal illnesses. Parsons' sick role concept also found itself replaced over time by a newer focus on health behaviour, which suggested that a more active approach to health and illness had assumed greater prominence (Burnham, 2014). Although Parsons (1951) may have formalised a model of the paternalistic practitioner-patient relationship, this was not his sole aim nor the singular intended function of *The Social System*. Indeed, Parsons' sick role was simply part of his larger theory of social order and social systems, of which illness comprised one component. It is therefore necessary to consider subsequent developments in the practitioner-patient relationship that focused squarely on this relationship.

1.2 Developing alternatives to the paternalistic relationship

Only five years later psychiatrists Thomas Szasz and Marc Hollender (1956) outlined a more diverse characterisation of patients' roles. Although psychiatrists, Szasz and Hollender wrote about healthcare encounters more generally and outlined activity-passivity, guidance-cooperation, and mutual participation as three basic models of the practitioner-patient relationship. These three models were also conceptual and would later be used to illustrate a historical overview of the practitioner-patient relationship (Szasz et al., 1958). In the activity-passivity model, practitioners and patients would provide and receive medical activity respectively with no active role for patients. Activity-passivity was considered appropriate only when patients' conditions precluded active roles in the encounters. Patients did have an ostensibly active role in guidance-cooperation; however, the expectation of the role was that patients simply comply with the practitioner's direction. A patient would not be expected to contribute, but rather follow the practitioner's directives, the roles therefore being asymmetric. In turn, the name guidance-cooperation is partially misleading as patients' cooperation is effectively compliance or obedience rather than working together. Activity-passivity and guidance-cooperation were both paternalistic models of the practitioner-patient relationship, and therefore only one of the three models proposed was considered to have an active role for patients. Szasz and Hollender (1956) characterised activity-passivity as prototypical of parent-infant relationships and guidance-cooperation prototypical of parent-child relationships. Here, the influence of the psychoanalytic ideas on the childhood origins of adult social behaviour of Szasz and Hollender's time was visible in their characterisation.

The third model was mutual participation (Szasz & Hollender, 1956) and this approach was distinct from the paternalistic activity-passivity and guidance-cooperation. Mutual participation afforded contributory roles both to patient and practitioner. Patient and practitioner would establish a partnership and work to help each other towards a solution to the patient's problem. Unlike activity-passivity and guidance-cooperation, mutual participation was prototypical of a relationship between two adults. Increasing the focus on the patient as a person and active participant was a feature of the psychoanalytic tradition of Freud and Breuer (Kaba & Sooriakumara, 2007). Szasz's view of the psychoanalytic contribution to the practitioner-patient relationship was as follows: "Breuer and Freud's historical role lies (among others) in having reintroduced, as it were, the patient into the medical arena as an active, cooperative – and indeed collaborative – participant in illness and in health" (Szasz, et al., 1958, p. 526). In addition to Breuer and Freud, the contribution of then-contemporary American psychiatry was to see patients as partners with rights to self-determination and to see this characteristic as important for therapeutic relationships (Szasz et al., 1958). Whether psychiatric or general medical practice, the authors believed chronic illnesses were influential in requiring a practitioner-patient relationship wherein both parties collaborate to manage patients' conditions (Szasz et al., 1958).

The influence of psychoanalysis and focusing on the patient as a person and active participant also included the work of Hungarian psychoanalyst Michael Balint (1957). Balint trained in psychoanalysis and medicine and could therefore bring both traditions to bear on the practitioner-patient relationship. Indeed, it was Balint who first explored the practitioner-patient relationship in general practice appointments (Lakasing, 2005). Balint extended Breuer and Freud's line of patient-as-active reasoning towards a biopsychosocial notion of illness and the healthcare encounter (Kaba & Sooriakumara, 2007). To determine the full sense of why a patient sought medical advice, practitioners had to investigate patients' psychological and social contexts. Balint (1957) posited the idea of mutual investment whereby patient and practitioner work to establish trust, confidence, and share relevant knowledge about the patient and their biopsychosocial context.

Mutual investment necessitated a series of healthcare encounters and the benefits of this would accrue over the series. The issue with mutual investment, and relatedly the model of mutual participation, was that it was most applicable to chronic illness or psychoanalysis where care ordinarily takes place over such a series of healthcare encounters. Indeed, Szasz and Hollender (1956) listed chronic illnesses and psychoanalysis as the domain of clinical application for mutual participation. Balint was interested in general practice, however, and we might consider the relationship between a family practitioner and their patients an example of mutual investment (Lakasing, 2005). Modelling the practitioner-patient relationship on chronic illness or psychoanalysis would not provide the kind of universality necessary for application across illnesses and experiences. Therefore, practitioner-patient relationships required a more generalisable principle around which to organize and advocate.

As should be becoming clear, the developments in the practitioner-patient relationship were typically conceptually or historically derived. This conceptual or historical derivation was significant because these developments, then, were not typically rooted in empirical observations from healthcare encounters. In turn, the practitioner-patient relationship was not often being informed by or brought into line with the actual business of real healthcare appointments. That said, work on the practitioner-patient relationship was getting away from the broad social structures of Parsons' work and moving further towards medical specificity. A separate approach was taken by bioethicist Robert Veatch (1972), who outlined and considered four models of the practitioner-patient relationship as part of his wider project to establish access to healthcare as a human right. These four models were the engineering model, the priestly model, the collegial model, and the contractual model. The last of these, the contractual model, was of particular significance to the forms of SDM that were to follow.

The engineering model conceptualised the practitioner as an applied figure, presenting the facts to a patient and addressing the problem with respect to their choice. The priestly model was one where the practitioner was valorised as a figure of repute and expertise. Practitioners follow the principles of beneficence and nonmalfeasance but also retain complete responsibility for decision-making. The collegial model glosses the practitioner-patient relationship as comprising a couple of colleagues in pursuit of the legitimate shared goal of restoring the patient's health. Therefore, the collegial model was one of equality wherein the legitimacy of a shared goal and practitioner-patient confidence and trust were essential to the practitioner-patient relationship. In Veatch's (1972) case, these types were derived from hypothetical considerations of practitioners in alternative professions or social roles such as engineers or close acquaintances of patients.

The contractual model stipulated that practitioners and patients both have obligations but also expected benefits. An assumption of the faithful fulfilment of obligations is implicit but there are social sanctions in place to safeguard divergences from this assumption. The view is that patients need control over the choices that are significant to their life and only where the practitioner cannot in good conscience abide the choice should the contract go unfulfilled or broken. Veatch remarks: "In the contractual model, then, there is a real sharing of decision-making" (Veatch, 1972, p. 7). Patients, therefore, were conceptualised as contractors. Crucially this is not a legal contract, and more of a symbolic covenant such as marriage. Patients can control the overall decision-making without having to involve themselves in every individual aspect of decision-making. Trust and confidence are similarly central to the collegial model, but the structure of the contractual model is one of greater security.

The significance of Veatch's model was that it would signify a notable change in the legal framework and understanding of medical ethics in practice as they pertained to informed consent. Leading up to and contemporary with Veatch's (1972) considerations of ethical practitioner-patient relationships, shifts were occurring in medical ethics. In particular, the notion of informed consent was becoming more important and clearly defined in the USA due to a series of notable court cases (Murray, 1990). The shift in perspective towards informed consent as a patient's right and ethical requirement was also responsive to the patient advocacy movement. For instance, The Patients Association was founded in 1963 in the UK by Helen Hodgson as a patient advocacy group, and later charity. In part, the establishment of The Patients Association was driven by issues with the drug Thalidomide where patients were tested without giving informed consent and received the wrong treatment (The Patients Association, 2020).

In the USA, the case of Mr Canterbury versus Dr Spence was a significant milestone for informed consent. In brief, Dr Spence was ruled not to have informed Mr Canterbury, nor his mother who gave consent, of the risk of paralysis that his surgery, a laminectomy, carried. The ruling stipulated that informed consent was something for the patient to give, and that practitioners were required to provide sufficient information for patients to be able to choose their treatment (Emanuel & Emanuel, 1992). Informed consent was subsequently characterised as requiring the following dimensions. Patients need to know their diagnosis and the diagnostic procedures involved, treatment procedures must be described clearly and intelligibly including information about inevitable and collateral risks, all available treatments must be outlined, and the expected results and their likelihoods must be discussed thoroughly with the patient (Murray, 1990). Going forward, informed consent became a key issue among other aspects of patient autonomy and involvement for the advancement of patients' rights in the 1980s (Stiggelbout et al., 2015). The shift in understanding and importance of informed consent varied in year across countries but was often similarly spurred by a legal ruling.

Nine years later, in the United Kingdom, the Chatterton versus Gerson court ruling was significant for establishing that, in practice, a basic notion of valid consent was sufficient for a procedure to take place (as cited in Jones et al., 2005). Indeed, informed consent itself differed between the US and UK, as the US notion necessitates that practitioners inform patients of all relevant information prior to seeking consent, while the UK allows for basic, valid consent, to be given and then further informing to occur (Hastings, 2008). I must note, however, that the modern definition of valid consent in the National Health Service (NHS) stipulates that consent must be both informed and voluntary to qualify as valid consent (NHS England, 2019). As such, the work that Veatch (1972) produced had an immediate relevance in the US and would proceed to be persistently relevant as the practitioner-patient relationship evolved away from paternalism towards patients as partners.

The space for involvement in Veatch's contractual model (Veatch, 1972) and the shift in dynamics of informed consent stimulated increasing interest in patient autonomy and involvement. Throughout the 1980s, patients' rights, as part of a broader consumer rights movement, pushed this agenda of improving patients' involvement in their healthcare (Stiggelbout et al., 2015). In 1982, in the USA, the government published a report that would both advance the understanding of informed consent and be consequential for its practical accomplishment. The 1982 President’s commission (President's Commission for the Study of Ethical Problems in Medicine, Biomedical, & Behavioral Research, 1982) report was a document concerning the understanding of informed consent and implications of a requirement for informed consent to undergo medical procedures. In turn, the report claimed that beyond a legal concept, informed consent was an ethical imperative and core part of the SDM process, and that a greater exercise of patient autonomy or sovereignty should accompany informed consent (President's Commission for the Study of Ethical Problems in Medicine, Biomedical, & Behavioral Research, 1982).

Twenty years after Veatch (1972) outlined four models of the practitioner-patient relationship, Emanuel and Emanuel (1992) would also outline four models of the relationship. An important distinction between Veatch (1972) and Emanuel and Emanuel’s (1992) work was the ethical contexts that produced them. Veatch’s article came out in the same year as the Canterbury v. Spence case (1972, as cited in Murray, 1990), which was a hugely significant ruling for informed consent, and pre-dated the 1982 President’s Commission report by a decade. In turn, Emanuel and Emanuel’s (1992) work was produced in the context of a well-established ethical mandate for patient-led informed consent. As with Veatch’s work, Emanuel and Emanuel were also working theoretically, although they did relate the models to a clinical example of breast cancer to demonstrate the distinctions between the models. Therefore, the ethical pursuit of the earlier proposal (Veatch, 1972) was being supplemented with a clear eye towards clinical practice and real patients. That said, any model endorsed would still require a solid empirical grounding of observable insights from decision-making appointments. Acknowledging the impact of patient autonomy on medical decision-making, Emanuel and Emanuel called for a reformulation of the practitioner-patient relationship. Therefore, they outlined four models of the practitioner-patient relationship with the intention of determining the preferred model for accomplishing appropriate medical decisions while respecting patient autonomy.

The paternalistic model had similarities to what Veatch (1972) termed the priestly model and presented the practitioner as a skilled professional identifying patients’ conditions and most suitable treatment. Either patients receive enough information to consent or the practitioner acts on their skill to dictate the particulars of treatment. In a paternalistic relationship there is an assumption of an objective best and the practitioner can find a patient’s best interest with minimal patient contributions. In an example of the strict application of beneficence, practitioners will prioritise patient's health above their autonomy; indeed, assent is the extent of patient autonomy. The informative model was comparable to Veatch's (1972) engineering model and centred around the provision of relevant knowledge. Patients present with a problem, practitioners inform them of their condition and treatment options, and the patient selects an option to receive. An informative relationship is transactional, and practitioners simply provide the information and corresponding treatment. Patient autonomy is greater in this model, however, as patients control the treatment decision.

The interpretive model requires practitioners provide the relevant information and treatment options. However, the practitioner works with the patient to determine the treatment that aligns best with their values (Emanuel and Emanuel, 1992, p. 2221). It is worth remarking here that Emanuel and Emanuel use the term values but not preferences, nor preferences and values, which is an important terminological point. Furthermore, that values are never clearly defined but rather taken-for-granted as "patient's values are well-defined and known" (Emanuel & Emanuel, 1992, p. 2221). As with the informative model, the practitioner's values are not central, and the process is one of reaching the most appropriate treatment relative to the patient's values. The interpretive model emphasises understanding, with a joint understanding and patient self-understanding important to the model. Patient autonomy is comparable to the informative model barring the leading potential of practitioners' interpretations.

The deliberative model involves practitioners providing patients with information and treatment options, plus the values corresponding to these options. Practitioners engage patients in a discussion of both the broader health-related values, these meaning values affecting or affected by the illness and treatment, and those of the treatment options. The aim is to conclude which treatment option would be best relative to the importance of health-related values as the patient judges them. A practitioner can recommend a particular treatment based on their understanding of what the patient wants and their principle of providing the best care. However, the deliberative model is not a coercive one and the patient remains autonomous. It is a developmental model whereby the practitioner teaches the patient and assists them in the decision-making process. Perhaps the key distinction between the deliberative and interpretive models, as they are broadly comparable, is that practitioners assume that patients' values are not fully formed in the former while in the latter the patient requires guidance towards “the best health-related values” (Emanuel & Emanuel, 1992, p. 2222).

From Emanuel and Emanuel’s ethical perspective, the paternalistic model is untenable except for life-threatening emergencies where taking informed consent might take time necessary to treat the patient, and therefore cannot be the preferred model. The informative model attends insufficiently to patients’ values or patient-relevant health-related values. It was also considered problematic to preclude practitioner recommendations and give complete decisional control to a patient, even an informed one. While the interpretive model accommodates the possibility that patients might be uncertain about their wants, and subsequently change their mind, it might prove challenging in practice. For example, where the technical specialisation of practitioners, time constraints, and pressures of illness might not engender the ideals of this model. Not attempting to recommend or guide patients to the full extent limits practice and might be problematic where there is recourse to advocating, for example, behavioural change. Therefore, the interpretive model posits more of an ideal than an actual conceptualisation of practitioner-patient relationships in practice. The immediate issue with the deliberative model is whether practitioners have the right to promote specific health-related values while judging patients’ values. In particular, the possibility that patients’ and practitioners’ values conflict. Interpretive and deliberative models also encompass the risk of playing out as a paternalistic relationship in practice. Emanuel and Emanuel (1992) ultimately favoured the deliberative model, considering it the ideal of the four. It is important however to clarify that Emanuel and Emanuel’s work was a theoretical consideration, and therefore not modelled on actual decision-making encounters.

1.3 The development, definition, and modelling of shared decision-making

Amidst the development of all these models of practitioner-patient relationships the concept of SDM first appeared. Indeed, it was Robert Veatch (1972) who wrote of SDM when characterising the contractual model, although he did not propose a model. This, however, did not impede the development of SDM as a concept. Rather, alongside concerns about patient autonomy and informed consent, SDM became part of the discussion about medical ethics. The first definition of SDM came in 1982 when the United States’ President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural

Research’s report on making health care decisions was published. The commission’s report described SDM the following way: “Simply put, this means that the physician or other healthcare professional invites the patient to participate in a dialogue in which the professional seeks to help the patient understand the medical situation and available courses of action, and the patient conveys his or her concerns and wishes” (President's Commission for the Study of Ethical Problems in Medicine, Biomedical, & Behavioral Research, 1982, p. 38).

Subsequently, the notion of a division of facts and values began to form. Practitioners would provide facts through their knowledge of medical information, while patients provide their personal values with which to evaluate treatment options (Brock & Wartman, 1990). The collaborative process of contributing and working with these facts and values is the one that leads practitioners and patients to share decision-making (Brock & Wartman, 1990). Eddy (1990) also endorsed the division of facts and values but presented the division as a two-step process whereby facts precede values prior to decision-making. Although designating a contributory role for patients and practitioners, practitioners were tasked only with dispensing information to patients (Emanuel & Emanuel, 1992). Therefore, these definitions too closely resembled the informative model of practitioner-patient relationships.

There was, then, increasing emphasis on patient autonomy and involvement in the practitioner-patient relationship and sharing decisions with patients. Despite this focus, the first model of SDM did not appear until 25 years after Veatch’s work (1972) in 1997. Charles et al. (1997) noted the developments in treatment decision-making work but also the limited clarity about what exactly SDM meant and comprised. Their attempts to provide clarity through fundamental characteristics led them to propose the now-classic model of SDM. The model (Charles et al., 1997) comprised four key characteristics that the authors consider necessary for sharing a treatment decision. First, patient and practitioner both must be involved; however, SDM is not an exclusively dyadic process or relationship. Second, patients and practitioners both take active roles participating in treatment decision-making. Here, practitioners attempt to facilitate patient involvement while patients take responsibility for aspects of the decision-making process. For example, patients engage by asking questions, presenting preferences, and assessing options. Whereas practitioners elicit preferences, provide technical information, and establish treatment preference.

Third, information sharing is a requirement of SDM in that patients and practitioners must share relevant information with each other. The minimum requirement is that patients have sufficient information about treatment options to provide informed consent. Practitioners bring technical knowledge and medical expertise while patients bring illness narratives and experiential knowledge. Fourth, a patient and practitioner must choose a treatment option that they both agree upon. This option is not necessarily the best option as a practitioner might view it, but both parties are willing to accept it and share decisional responsibility. Taken together, these four characteristics were deemed the necessary criteria for engaging in SDM, but they were presented as continuous rather than dichotomous criteria. That is, Charles and colleagues (1997) considered the elements of SDM they outlined to fall along a gradation. Rather than having a dichotomous view that an element of SDM is met or not, there are degrees of meeting each element, and in turn, SDM is also not a dichotomous process.

Acknowledging this, the immediate value of SDM was in offering a compromise between the extremes of patient-led or practitioner-dominated approaches to treatment decision-making (Charles et al., 1997). A crucial point to make is that Charles et al.'s model of SDM (1997), while hugely important, was not necessarily dynamic. Yes, the continuum of SDM was noted, but it was not clear in the model that the decision-making approach may change in situ and that parties might assume different roles at various points yet still make a shared decision. For instance, when a practitioner needs to explain multiple treatment options and related effects and outcomes, they might take an informed approach for that requirement (Charles et al., 1999). The notion that practitioners and patients might necessarily be positioned differently for different requirements was not made explicit in the first model.

In 1999, Charles and colleagues revised their model of SDM into a three-stage process. Charles and colleagues (1999) aimed to make the practical application of SDM clearer by demonstrating the flexibility and dynamism of the decision-making process. These analytical stages were information exchange, deliberation, and deciding on treatment to implement (Charles et al., 1999). Information exchange was considered to flow bidirectionally between patient and practitioner to accomplish SDM. On one hand practitioners provide technical knowledge about treatment options, potential risks and benefits, and the resources available. On the other hand, patients provide contextual information about their medical history, fears and beliefs, and knowledge of their illness. Patient-side information exchange was considered particularly important because practitioners would not otherwise have this information.

Although not mandatory, patients and practitioners can exchange role preferences at this stage to clarify upcoming involvement, which per the continuous nature of SDM characteristics might vary across an appointment or appointments. For instance, a patient might follow the practitioner's lead during information exchange but later claim greater decisional responsibility. For bidirectional information exchange, the minimal requirement was that practitioners provide all decision-making relevant information and patients respond with their knowledge, preferences, and values relative to that information.

Deliberation centres on available treatment options and both parties expressing and discussing their preferences for treatment. For SDM, deliberation is interactional, and this is to include the patient and practitioner in the stage. Practitioners and patients each have stakes in the treatment decision. Namely the health of the patient and the practitioner's concern for the patient's wellbeing. Patients and practitioners must both be aware of treatment options; whether between, for example two active treatment options, or an active treatment versus monitoring. To participate in the decision-making process, each party must express their treatment preference in addition to exchanging information. Depending on whether patients and practitioners exchange treatment preferences at the beginning of the consultation, deliberation might involve negotiation. If negotiation ensues, then practitioners may make specific recommendations but must remain responsive to patients and why they might not want that option.

Patients can remain fixed in their preferences and in such cases, practitioners might consider endorsing patients' preferences as a negotiated agreement. Drawing on the analogy of a tango Charles et al. (1997) suggested that it is appropriate for patients and practitioners to lead discussions at points where there is alignment with their expertise and experience in SDM. Deciding on treatment to implement was the final decision-making stage. To accomplish this stage, practitioners must receive a patient's informed consent prior to endorsing the treatment decision. Patients require practitioners to agree to implement their preferred decision before endorsing the treatment decision. For SDM, patients and practitioners use the deliberation stage of the process to work up to the agreement and endorsement of the treatment decision.

The revised model constituted an evolution in thinking about SDM, as Charles and colleagues (1999) characterised SDM as dynamic and flexible, unfolding across a bidirectional interactive process between active parties across an interactional relationship.

Moreover, the negotiated aspects of SDM were made clear and central to the process; indeed, SDM is defined as a process rather than an event. Charles and colleagues (1999) also emphasised that treatment decision-making needs to incorporate potential roles for individuals outside of the practitioner-patient relationship, to account for the totality of the decision-making process. That is, practitioners can operate as part of a multidisciplinary team (MDT), not of all of whom might attend decision-making encounters. Patients, moreover, may involve their family and possibly friends in their decision-making process.

Despite the work that was going into reshaping the practitioner-patient relationship (Emanuel & Emanuel, 1992) and developing SDM (Charles et al., 1997), there were still critics who questioned the need of SDM. Around the time of the first model of SDM, a review of the evidence for claims offered against SDM from its critics was published (Coulter, 1997). The criticisms that were reviewed included the claims that patients did not desire SDM, that risk and uncertainty information would stoke anxiety, and that some patients would demand too much of their healthcare (Coulter, 1997). To the first claim, the review found survey response evidence that close to half of patients wanted more information than they received and that a majority of patients wished to be involved in decision-making (Strull et al., 1984). In addition, the review also found that patients' views on their heavy menstrual bleeding were not known to general practitioners in 45% of cases (Coulter et al., 1994).

Evidence about the effect of risk and uncertainty information was mixed and ultimately inconclusive (Coulter, 1997). That said, a randomised control trial of an education intervention focused on patient involvement and facilitating patients' questions showed preliminary support for a relationship between patient involvement and improved health outcomes (Kaplan et al., 1989). As for patients' demands, the literature reviewed suggested that patients who were better informed and involved might actually decide against treatment where it may not be strictly necessary (Wagner et al., 1995). Similarly, it was observed that women with higher education status decided against hysterectomies more often than women with a lower education status (Kuh & Stirling, 1995). The review concluded that many of the criticisms of SDM might reflect an incomplete understanding of what exactly SDM was and what it entailed (Coulter, 1997). Considering the time of the review's publication, this might indeed be the case; and there was much more work on and developments in SDM to follow.

Following Charles and colleagues' revised focus on dynamic and interactional stages, subsequent conceptual work in SDM began to consider how to teach practitioners about, and how to perform, SDM. Towle and Godolphin (1999) considered a set of eight competencies, by which they mean knowledge, skills, and abilities for practitioners, and seven competencies for patients to accomplish SDM. Towle and Godolphin were academics working at North American universities who were interested in healthcare communication and communication skills for SDM and both trained healthcare practitioners. It is important to note that these competencies related primarily to communication skills and that patient competencies were considered preliminary. Patient competencies were considered preliminary because they had the weakest theoretical and empirical support and were derived from interviews with family practitioners and patient educators rather than patients. As with Charles and colleagues' revisions (1999), Towle and Godolphin proposed a framework rather than a prescriptive checklist. Six core concepts of SDM underpinned the eight competencies. Namely partnership, explicit dialogue, an informed patient, an informed practitioner, SDM, and completeness (Towle & Godolphin, 1999).

Table 1: Towle and Godolphin's (1999) SDM Competencies for Practitioners and Patients

Practitioner competencies	Patient competencies
1. Develop practitioner-patient relationship	1. Define practitioner-patient relationship
2. Establish patient information preferences	2. Develop partnership with practitioner
3. Establish patient role preferences and uncertainties	3. Systematise and articulate feelings, expectations, beliefs, and health problems
4. Respond to ideas, expectations, and concerns patients have	4. Appropriately and clearly communicate relevant information for mutual understanding
5. Identify choices with patient input and assess relative to patient	5. Accessing information
6. Provide evidence to patient relative to their preferences	6. Evaluating information

7. Make a decision in partnership	7. Negotiate decision including possible conflict resolution and make action plan
8. Agree an action plan for follow-up	

It is also remarkable that Towle and Godolphin (1999) referred to informed shared decision making throughout their article. As such, they were not just writing about a decision that patients and practitioners share in, but one that was "informed by best evidence, not only about risks and benefits but also patient specific characteristics and values" (Towle & Godolphin, 1999, p. 766). The competencies were characterised as akin to communication training but specifically communication skills that were more advanced than the medical school training of the time. Crucially, the competencies were not sold as a behavioural checklist but in line with the suggestion that SDM elements fell along gradations and were subsequently likely to receive differing emphasis and attention depending on the encounter (Charles et al., 1997; Towle & Godolphin, 1999). Towle and Godolphin's work (1999) provided a useful next step in the evolution of SDM. The most striking development was that Towle and Godolphin went beyond the more general language of Charles et al. (1997, 1999) and proposed more detailed expectations of particular communication behaviours and sequences. In addition, Towle and Godolphin's (1999) competencies clarified that patients and practitioners were expected to undertake more complex subject positions in their encounters.

Another competency framework shortly followed (Elwyn et al., 2000), which took a set of previously proposed competencies (Towle, 1997) and ran focus groups with general practitioners. The use of previously proposed competencies is notable because it suggests an attempt at consistency with other developments that might prove useful for attempting to achieve consensus on SDM. These focus groups were designed to explore the attitudes of general practitioners to SDM and patient involvement in decision-making. Immediately, then, there are two considerations; the first of which was that the informant population came from a distinct primary care background. Primary care presents different decision-making considerations to the more acute secondary care context that had previously been prominent in SDM modelling and theorising. Indeed, this issue of population generalisability was one that the authors raise as a potential caveat in their conclusion (Elwyn et al., 2000, p. 899). As for focus groups, however, researchers from the language and social interaction tradition have raised issues about this method of data collection. Chiefly, that the performative and public nature of the focus group, with clear roles as researcher and research participant, could influence participants to offer the responses they anticipate the researchers wanted to hear. That is, the production of talk that is gotten up for research purposes rather than talk that would occur without a researcher's presence or agenda might not be considered to faithfully represent the interaction (Edwards & Stokoe, 2004; Potter & Hepburn, 2005).

The informants endorsed the idea of involving patients in the decision-making process but only to the extent that patients stated (Elwyn et al., 2000). In addition, while supportive of SDM, the informants suggested that it might be more suitable for certain conditions than others. Conditions that presented the possibility of multiple effective treatment options were specifically highlighted as good fits for SDM (Elwyn et al., 2000). Notably, informants reported that patients' involvement preferences should be established after the patient knows their options and has been provided with the relevant information (Elwyn et al., 2000). Furthermore, informants did not consider checking whether patients accepted the decision-making process to necessarily be a verbal practice, as they reported that practitioners provide cues and respond to patients' signs in situ. Where the competences referred to professional equipoise, this means a scenario where there is more than one treatment option available and the practitioner displays no clinical preference (Elwyn et al., 2000). It is worth noting that informants considered it necessary to explain to patients that the absence of clinical preference was not due to a lack of knowledge, to avoid anxiety or inspiring low confidence in the practitioner (Elwyn et al., 2000).

Table 2: Elwyn and colleagues' (2000) SDM competences for practitioner

Practitioner competences
1. Involve patient in decision-making process (implicit or explicit)
2. Explore patients' expectations, fears, and ideas about the problem and treatment options
3. Present treatment options and highlight where professional equipoise exists
4. Provide relevant information to patients in their preferred format
5. Check patients' understanding of and reactions to information
6. Check patients' role preference
7. Discuss and either make or defer a decision with the patient

8. Arrange follow-up with patient whether a decision was made or not

Some of the key differences between the competency frameworks, then, included that Towle and Godolphin (1999) proposed competencies for patients while Elwyn and colleagues did not (Elwyn et al., 2000). As such, practitioners were ascribed substantial responsibility for ensuring a shared decision was made (Elwyn et al., 2000) as opposed to the sharing of competencies and responsibility (Towle & Godolphin, 1999). In Elwyn and colleagues' (2000) competences there was also less emphasis on explicitness, as practitioners in the focus group suggested that involvement could be done more implicitly by a practitioner. Moreover, the recommendation from Elwyn and colleagues' (2000) informants was that patients ought to be told their options before practitioners elicited their role preferences. I wish to note that Towle and Godolphin (1999) used the term competencies while Elwyn et al. (2000) used competences and I have maintained the original usage across this discussion.

At this point it is worth remarking upon the context within which these early models were developed, both in terms of intellectual and cultural climates. In terms of cultural context, it is worth recalling that this Anglo-centric history of the practitioner-patient relationship is reflected in the development of SDM. Charles, Gafni, and Whelan for instance, were all working in Canada at McMaster University in various medical or health-related departments. Subsequent developments that I shall discuss also came primarily from the academies of the USA, the UK, and Canada. Indeed, Charles and colleagues went on to revise their model of SDM in 1999, around the time that further work began to appear. As such, our conception of SDM has largely been shaped in the intersection between the academy and medical practice in the anglosphere. One consideration worth remarking on is that Charles and colleagues' model (1997, 1999) and most subsequent developments (Towle & Godolphin, 1999; Elwyn et al., 2000) were not empirically rooted, but rather conceptual, historical, or theoretical. In turn, while providing the first model of SDM was hugely insightful and useful, it comes with the caveat that we might consider it idealised.

While substantial work and research had gone into developing a more ethical and less paternalistic practitioner-patient relationship, the first model of SDM only arrived three years prior to Elwyn and colleagues (Charles et al., 1997). Moreover, Charles and colleagues reformulated their model of SDM from more of a checklist (1997) to a framework (1999). As such, these models that sprung up around the turn of the millennium were responsive to the earliest conceptions of SDM. This meant that they had relatively few examples of SDM research to assess the models and were at risk of falling behind another shift or reformulation. That said, in focusing on competencies and frameworks rather than viewing SDM as an absolute with a prescriptive checklist (Charles et al., 1997), the developing understanding of SDM had a strength that would carry forward well. It must be noted, however, that both Towle and Godolphin (1999) and Elwyn et al.'s (2000) models were informed by practitioner-centric views. A practitioner-defined or derived model runs the risk of failing to account for the party whose preference might reasonably be expected to shape a shared decision. Indeed, the conceptions of SDM in Elwyn and colleagues' (2000) work lacked an empirical dimension that might tell us something about how decision-making is actually and observably done in the wild of treatment appointments.

1.4 Developing shared decision-making for clinical practice

Shared decision-making had begun to proliferate in the wake of the publication of the now-classic early models and definitions. A decade after Charles and colleagues' (1997) model, a review (Moumjid et al., 2007) undertook to establish whether the research literature was using a clear definition of SDM. It sought also to ascertain whether the articles that defined SDM subsequently used these definitions consistently in the rest of the article. The results of this review identified several clear definitions by Charles and colleagues (1997, 1999), Coulter (1999), and Towle and Godolphin (1999) among others. All these definitions exhibited similarities, particularly on information exchange and involving patients and practitioners. These clear definitions, however, were cited by only 25 of the 76 articles under review. Even where a definition was cited or provided, the term could often remain inconsistent throughout a paper or even subsequent papers (Moumjid et al., 2007, p. 543). Furthermore, there were several instances where SDM and informed decision-making were used interchangeably. There were also 21 articles that referred to SDM without explanation, neither defining SDM themselves nor providing an existing definition or citation. In turn, the research literature presented a confusing and impoverished picture of SDM, which would prove to be problematic for furthering research into SDM. That is, the conceptual confusion resulting from a paucity of definitions and subsequent inconsistent use would make establishing routine SDM difficult. As a result, Moumjid and colleagues (2007) called for both a clear definition of SDM and a typology of relevant decision-making terms.

Contemporary with Moumjid and colleagues' (2007) work, another systematic review aimed to identify the number of definitions of SDM; to determine the elements, qualities, and citations offered to support these definitions. The review identified 418 articles where 257 referred to but did not define SDM, which meant that only 161 articles provided a definition of SDM. From these definitions, Makoul and Clayman (2006) coded 20 elements and qualities that were present in a minimum of 10% of definitions. Of the 20 elements, "patient values/preferences" and "options" were the only elements present in over 50% of definitions at 67.1% and 50.9% respectively (Makoul & Clayman, 2006, p. 304). While 56 of the articles under review failed to cite a model of SDM, it was Charles and colleagues' (1997) initial model, appearing in 21.1% of the articles, that was the most cited choice. Of note also was the absence of conceptual definitions with 60% of articles not providing any definition of SDM. In sum, the review concluded that there was no mutually agreed-upon definition of SDM.

Makoul and Clayman (2006) subsequently proposed an integrative model of SDM. The aim being a model with conceptual soundness, usefulness in guiding research, and applicability for clinical practice. Although Makoul and Clayman (2006) offered a new development in proposing an integrative model, they continued to work conceptually and theoretically in their model. That is, once again, the long-running tradition of proposing a model that was theoretically deductive rather than inductively generated from empirical observations of real decision-making appointments was taken. It is worth remembering subsequently that while these elements that Makoul and Clayman (2006) proposed were indeed stable concepts in the extant SDM literature they required empirical grounding and support. A model was proposed on the back of several essential elements necessary for accomplishing SDM. These essential elements derived from the elements, qualities, and citations coded in the review process. To accomplish SDM the following essential elements must occur. Patient or practitioner must define the problem being presented and subsequently declare the options available to the patient. A discussion of available options relative to risks and benefits and patients' preferences and values should then follow. Practitioners and patients should also discuss a patient's ability to adhere to the treatment options. The practitioner should communicate all relevant knowledge and, where applicable, their recommendation to aid the option discussion. Throughout the decision-making process patient and practitioner should check their understandings of the information and perspectives they exchange. Finally, patients and practitioners should make or defer a decision including arranging for appropriate follow up (Makoul & Clayman, 2006).

Having an integrative model of SDM is a useful tool for providing an operational approach to research and clinical practice. Although not perfect, it also offers a comparatively robust referent for attempting SDM in clinical practice on an individual level. It does not answer Moumjid and colleagues' (2007) call for a single agreed-upon definition, however. Therefore, it is worthwhile looking at the results of Makoul and Clayman's (2006) coding for the essential elements they identify and subsequently integrate. Namely, patient values/preferences as the most included element of SDM, which appeared in 67.1% of the articles reviewed. Although options appeared in 50.9% of articles, the presentation of options is beholden more to the profile of illnesses and less to patient involvement. One key distinction between Makoul and Clayman's (2006) model and those that came before it was that the preceding models generated a combined 31 concepts. Makoul and Clayman's (2006) integrative model reduced this to nine essential elements necessary for SDM and four ideal elements that might be additive but nonessential (see p. 305).

A second key distinction is that the integrative model was responsive to a conceptualisation of "the degree of sharing on a continuum" and the observation that "patient participation and SDM are not isomorphic" (Makoul & Clayman, 2006, p. 307). That is, patients and practitioners both contribute to appointments and if one party dominates the encounter then this would not be a shared decision. For instance, a decision that was led entirely by the patient would feature substantial patient participation but would not be a shared decision. A shared decision, then, lies somewhere between the two poles of a patient-led and practitioner-led continuum for Makoul and Clayman (2006). When we couple this notion of a continuum of sharing with the view of SDM elements as falling along gradations (Charles et al., 1997), we have a dynamic and collaborative process that extends far beyond a simple success or failure. In the section below, I will cover two of the more recent developments and proposals of SDM models that intended to respond to the developing conception of a dynamic SDM process.

1.5 SDM in the 2010s: Alternative developments and novel models

Following the proposal of an integrative model of SDM (Makoul & Clayman, 2006) there were fewer alternatives put forward, but three models merit discussion. The first model of the three was packaged as an interprofessional model of SDM (Légaré et al., 2011) because it was aimed at a multidisciplinary team of professionals rather than a practitioner-patient dyad. Légaré and colleagues (2011) contended that a dyadic view of SDM was not representative of the wide-ranging contributions made by distinct healthcare professionals. As such, they proposed a model of SDM that aimed to account for the range of professionals involved in medical decision-making. Furthermore, to acknowledge not just the micro level of decision-making pitched at the patient but also the meso and macro levels of healthcare systems (Légaré et al., 2011). The model, then, operated on the assumption that at least two healthcare professionals with distinct roles or institutional specialisms would collaborate with the patient to make a shared decision. Notably, professionals could either work simultaneously or appear at various points in the patient's decision-making process. I will list the individual level steps that the patient is expected to go through in a table below, and then discuss what Légaré and colleagues (2011) mean by the meso and macro level influences of healthcare systems.

Table 3: Légaré and colleagues' (2011) decision-making steps for patients

Decision-making steps for patients
1) Patient presents with a health condition
1) Patient told a decision is required and that they have more than one option (equipoise)
2) Exchange information
3) Clarify patients' preferences and/or values
4) Consider how feasible each option is
5) Establish the preferred choice
5) Make the actual choice
6) Implement the choice made
6) Evaluate health outcomes of the decision-making process

In addition to collaboration and a focus on interdisciplinarity, Légaré and colleagues (2011) suggested that shared understanding of decision-making elements and the influence that individuals may have over the decision-making process were key to SDM. The meso level, then, referred to the various and distinct healthcare professionals that could be involved in the decision-making process alongside the patient (Légaré et al., 2011). At the macro level, Légaré and colleagues (2011) grouped together various forces from the broader environment of healthcare systems that could prove influential, such as healthcare policy; resources available; and the social context of the healthcare system. In addition to the levels, it was said that not only do the team of healthcare professionals influence the SDM process by their collaborative work with the patient, but the culture and organisational structure of the healthcare system also influences the team of professionals by shaping their organisation and function (Légaré et al., 2011).

Other models of SDM leave open a space for institutional or organisational factors to influence the decision-making process such as options being limited to those a patient is suitable to receive (Charles et al., 1999). None of those models, however, have such a clear and inextricable role for the meso and macro level influences of healthcare systems of patients' decision-making processes (Légaré et al., 2011). In turn, there was also an acknowledgement that an express desire for SDM to occur might be insufficient if the macro level factors do not support or help facilitate this goal (Légaré et al., 2011). The interprofessional model was derived by collating prominent models, frameworks, and theories of SDM alongside systematic reviews of interprofessionalism and extracting key concepts. Subsequently, Légaré and colleagues (2011) invited a group of healthcare professionals and researchers to a workshop intended to develop the interprofessional model of SDM. Invited informants ranged from physicians to psychologists and were asked to work in three groups to devise an interprofessional model of SDM based on the key concepts provided (Légaré et al., 2011). Informants concluded that an interprofessional model was indeed necessary to account for the totality of decision-making as a process in a particular institutional context.

Two models were most highly rated, and one was at the level of the individual patient while the other concerned the healthcare systems wherein decisions get made (Légaré et al., 2011). Informants were then reassigned to two groups to refine the two highly rated models and those were subsequently integrated and became the final model I overviewed above. The interprofessional model has been suggested as having an impact on the barriers to SDM posed by confusion and communication issues between teams of professionals and professionals and patients (Légaré et al., 2011). More specifically, communication and information exchange between various professionals and the patient was intended to foster useful collaboration between professionals and make space for contributions from roles and specialisms that might not otherwise have been made. An important point to note is that emphasis was increasingly falling on communication and shared understanding with this model. I mention this focus on communication because it will be a feature of the second model discussed and the thesis at large. The second model was proposed by an important figure in the historical development of SDM, Glyn Elwyn, in 2012 and it conceptualised the SDM process as a journey through three distinct stages of talk (Elwyn et al., 2012).

In this model there was a first stage of choice talk, a subsequent option talk phase, and finally a decision talk phase (Elwyn et al., 2012). A big part of the rationale offered for this model was that it would attribute or increase agency to the patient, and practitioners would support the patient in the decision-making process and deliberation. As such, Elwyn and colleagues (2012) posited that the two means of attributing agency to patients was by providing them with information and supporting their decision-making process. This model was expressly designed for clinical practice and proposed as a simple three stage process that would take patients from initial to informed preferences (Elwyn et al., 2012). The first stage was choice talk and this stage focused on informing patients about their available options while also allowing for planning work (Elwyn et al., 2012). After choice talk came option talk and this second stage involved providing further information about the options such as harms and benefits and distinctions between options. At this point of the decision-making process the practitioner might also provide or direct the patient to a decision aid to support their deliberation (Elwyn et al., 2012). In the final stage of decision talk the emphasis fell on eliciting the patient's preference and then approaching a preference-based decision, which is the end goal.

As a set of important terms, it is worth distinguishing between initial and informed preferences, with the former based on patients' initial reaction and existing knowledge and the latter responsive to new information about options (Elwyn et al., 2012). As with the interprofessional model (Légaré et al., 2011) there was a clear focus on communication with the three stages labelled as stages of talk (Elwyn et al., 2012). There was not a strong empirical grounding to the model, however, and this overreliance on deductive theoretical reasoning limits confidence in its applicability to decision-making as it occurs empirically. Before moving on to discuss some of the problems that SDM and patients' preferences have faced, I will remark on the revised three talk model of SDM (Elwyn et al., 2017) and a subsequent model. Five years after the initial model and several suggested revisions and refinements from researchers and practitioners, Elwyn and colleagues (2017) decided to formally revise and develop their model. A global group of academics worked with the model authors and proposed a second draft model. This second draft model was then circulated to patients and patient interest groups as an online summary with the feedback summarised and provided to healthcare professionals (Elwyn et al., 2017).

After collecting feedback, Elwyn and colleagues (2017) decided to replace the first stage of choice talk with team talk and emphasise that these stages could in fact be fluid and that decision-making might be recursive. To clarify the distinction between choice and team talk, Elwyn and colleagues (2017) stipulated that team talk would involve the following three components. First, ensure patients are aware of existing options; second, support the patient in deliberation and decision-making; and third, work with patients to identify and set goals relevant to their issue or problem (Elwyn et al., 2017). I mentioned that these three models overviewed were similar in terms of having a clear focus on the importance of communication, which I believe is necessary for accomplishing a shared decision. Elwyn and colleagues (2017) acknowledge a potential tension between their simple three stage process and the vast range of communicative work that could be involved in SDM (Elwyn et al., 2017, p. 6). This acknowledgement of the complexity of communication involved and the recursive nature of the stages of talk and decision-making process are insightful and additive developments. Moreover, developments that suggested an area of empirical observational research into the visible communication work that decision-making entails.

Despite the three talk model being a model that received substantial support, and the revisions being met favourably (Elwyn et al., 2017), a recent third model merits discussion. Of particular interest, is that this model arose from qualitative research aimed at uncovering more information about attempts to implement and achieve routine SDM. Indeed, the research that led to the proposal of the model actually recruited practitioners who had received SDM skills training in line with the three talk model (Elwyn et al., 2017). Breast cancer and pre-dialysis consultations were examined using thematic analysis and this analysis revealed a more complex picture of SDM than previously proposed. The team, option, and decision talk stages of the three talk model were observed but so too was a previously unreported preparation phase (Joseph-Williams et al., 2019). The authors suggested that other models might presume a preparation phase, but it was this model that first made it clear. Furthermore, while the research did provide support for the three talk model it also observed variability in the way that the steps of that model were performed in practice. Indeed, the authors concluded that SDM as performed by practitioners in situ was more complex than published models suggested.

Of the notable observations were a striking absence of decision aids and a surprising degree of tailoring the decision-making to the individual patient (Joseph-Williams et al., 2019). In addition, less risk communication was observed than expected but more emotional and practical support was seen. Therefore, the Implement-SDM model (Joseph-Williams et al., 2019) was a proposal that both emerged from the existing promising work of the three talk model (Elwyn et al., 2017) and sought to better ground SDM in practice. It is notable that the authors aligned the Implement-SDM model with a broader conception of SDM (Cribb & Entwistle, 2011). That is to say, the Implement-SDM model was framed as being interested in more than SDM as an isolated process. Rather, the work of preferring to discuss decision-making, of establishing and developing a fruitful practitioner-patient relationship, and work between parties that was considered co-constructive (Joseph-Williams et al., 2019).

In terms of key differences between the Implement-SDM and three talk models, the authors observed the preparation phase, a changing presentation of options, and a planning discussion in the decision talk phase (Joseph-Williams et al., 2019). The areas where comparability, but also new elements, were found included the incorporation of the family members of patients' preferences alongside those of the practitioner, the greater prominence of practical and emotional support, and the inclusion of the notion of distributed decision-making (see Rapley, 2008; Joseph-Williams et al., 2019). A preparation phase was present in all consultations but differed between breast cancer and pre-dialysis. Similarly, options were presented in all consultations, but breast cancer patients often had more choice than pre-dialysis patients. Tailoring options to patients as consultations progressed, including when clinical equipoise or equivalent effectiveness between breast cancer treatments was present, stood out as noteworthy. The authors, then, argued that option discussions appeared to be shaped by, or at least partially responsive to, patients' expressed preferences.

One of the other aspects that changed over time and spoke to a wide decision-making process was the notion that decisions were distributed not just between patients and practitioners but also family and significant others. While decision support was typically emotional and practical there were cases of decision aids being used albeit primarily as a resource for patients to take away with them (Joseph-Williams et al., 2019). With preference elicitation, practitioners were reported to generally attempt an elicitation process congruent with the patient's emerging preference. In a similar fashion, the decision process developed according to the particulars of the illness, as it was clear that a decision had stages and need not be made immediately in the pre-dialysis consultations. Additionally, practitioners were reported to be "developing informed preferences during the SDM process about what might be suitable for the patient" (Joseph-Williams et al., 2019, p. 1781). Another aspect that arguably goes under-reported in SDM models are factors that could facilitate or contribute to accomplishing SDM. In these consultations, the contributory factors identified were awareness, being meaningful to patients, patients' emotions, and an urgent sense of need for decision-making.

All three models share an interest in communication and an increasingly wide range of input from varied informants. As such, they stand distinct from earlier work that focused on general practitioners (Elwyn et al., 2000) or physicians (Towle & Godolphin, 1999) as informants. The interprofessional model perhaps represents the totality of decision-making most faithfully with its awareness of and role for various healthcare professionals and an institutional structure that could constrain or facilitate SDM (Légaré et al., 2011). The fact that Légaré and colleagues (2011) built the global and institutional contexts of healthcare systems into SDM was a vital contribution that other models had not made nor acknowledged for its central importance to the process. By contrast, the three-talk model focused less on the healthcare systems environment and instead worked in terms of distinct stages of talk and interactive work (Elwyn et al., 2012).

In particular, the revised three talk model focused on the way that a recursive process or set of elements for SDM (Charles et al., 1997, 1999) might be shaped by iterative interactive work between stages of talk (Elwyn et al., 2017). Moreover, the aim of taking patients from initial preferences to informed preferences was instructive and insightful in both setting a valuable aim and foregrounding a prominent essential element of SDM (Makoul & Clayman, 2006). That said, the Implement-SDM model (Joseph-William et al., 2019) took the work of the three talk model further than its conceptual, informant-heavy, approach into the realm of empirical observation. As such, it immediately stood out from the other models discussed and had a novelty that was validated by its additive observations. By demonstrating support for the stages of talk proposed by the three talk model but also revealing variability in stages across illnesses, and observing an additional stage, there was clearly more to be accounted for (Joseph-Williams et al., 2019).

In terms of clinical practice there was no singularly outstanding model of SDM. The revised three-talk model (Elwyn et al., 2017) with a simple and intuitive set of stages of talk and a clear role for patients' preferences, is particularly appealing. That said, the observation of variability in stages of talk across conditions and an additional preparation phase (Joseph-Williams et al., 2019) suggests that there remains more to add to the three talk model. I do consider the acknowledgement of the scale of complex communicative work and recursive nature of decision-making and decision-making talk to be additive and instructive contributions to our modelling and understanding of SDM. In turn, while I find the three talk model promising, and will make further reference to it, I would endorse the Implement-SDM model as the most exciting and faithful to clinical practice to date.

Although these models represent significant progress, I do hold reservations over how mainstream SDM models typically deal with decision-making and, especially, patients' preferences empirically. For instance, the acknowledgement of the centrality of complex communicative practices to SDM (Elwyn et al., 2017), and support for the stages of talk in the SDM process (Joseph-Williams et al., 2019) are promising developments but remain somewhat broad. A clear space exists for the provision of finer-grained detail about this communication, especially where it concerns patients' preferences in decision-making conversations. The reasons for this endorsement are two-fold and represent two points and positions. First, the Implement-SDM model is closest to clinical practice by virtue of being an empirical study of practitioners who had received SDM skills training (Joseph-Williams et al., 2019). In addition, this skills training was based on the three-talk model of SDM (Elwyn et al., 2012, 2017), which was the most promising conceptual model but still lacked an empirical grounding. Implement-SDM, then, is an example of work that begins to bring SDM closer to a model that reflects clinical practice and decision-making in practical terms. The second reason is that I believe the social interaction approach is rooted in social interaction approach that I take can enrich and expand this promising empirical work. Focusing on how talk-in-interaction shapes decision-making conversations and accomplishes decision-making business can provide a finer-grained complementary empirical observational analysis. In the next section, I will first discuss some of the problems that SDM has faced, and then some of the problems specific to patients' preferences.

1.6 Problems with SDM and patients' preferences

With the advent of the early models of SDM, interest soon turned to developing the concept for reliable use in clinical practice. As such, this section will discuss some of the challenges that SDM research and practice faced. One of the main aims of SDM research became standardising a process for routine clinical implementation and assessing it for outcome measures and process quality. Standardising and assessing SDM are goals consistent with Charles and colleagues' (1997) aim to clarify what exactly SDM meant. However, Charles and colleagues (1997) also acknowledged the potential challenges to standardising SDM and thereafter measuring the process. Namely, that elements of SDM were not to be understood by a dichotomous view that they were either accomplished or not, but rather as falling along gradations of being met (Charles et al., 1997, 1999). Moreover, although elements of SDM overlap across frameworks, these elements can receive distinct amounts of time and focus depending on the specific encounter (Towle & Godolphin, 1999).

As such, there was not a linear process of SDM, necessarily, but rather a more recursive one that could be shaped by interactions between patients and practitioners. Therefore, it is difficult to assess in practice whether each feature of SDM was unequivocally present, and to account for variation in degrees of patient involvement (Charles et al., 1997). Charles and colleagues (1997) concluded that standardised checklists would be inappropriate for SDM because SDM can take different routes and patients and practitioners do not have fixed preferences. Instead of attempting to standardise the SDM process, and seeking to empirically measure an objective state, Charles and colleagues (1997) suggested establishing a number of core principles. A purportedly objective shared decision may not be consistently perceived as such by patients or practitioners. Given these considerations of gradations of SDM elements and a recursive interactively shaped shared decision, it is timely to remark on some of the problems that SDM has faced.

1.6.1 Conceptual confusion

Despite the insightful contributions and developments that were made by the more recent models overviewed above there have been problems with developing the concept of SDM and its practical accomplishment. The first problem relates to conceptual confusion or a lack of consensus around the essential SDM element of patients' preferences. By the time of the integrative model of SDM, patients' preferences had become an increasingly central aspect of SDM (Makoul & Clayman, 2006). Indeed, the revised three talk model considers supporting patients in the move from initial to informed preferences to be one of its aims (Elwyn et al., 2017). The increased focus on patients' preferences reflected the broader shift from paternalistic models of healthcare delivery (e.g., Parsons, 1951; Szasz & Hollender, 1956) to approaches centred on informed consent and patient involvement (Veatch, 1972; Emanuel & Emanuel, 1992). Although patients' preferences had become foregrounded in SDM, there were still issues with how this element was integrated into models of SDM and brought to bear on clinical practice. For one, it was observed that preferences as a term was being used interchangeably with such terms as attitudes, beliefs, and values (Elwyn & Miron-Shatz, 2010). As such, it was difficult to track the use of the term preferences throughout the literature; plus, terms such as beliefs and attitudes have their own technical definitions.

Tracking the use of the term preferences becomes harder still when we consider that authors do not routinely define what they mean by preferences when they use the term (Street et al., 2012). Even when preferences are defined, the term is not then used consistently with the definition offered (Street et al., 2012). Perhaps the most substantial conceptual issue, however, is that patients' preferences are argued to be unique constructions responsive to patients' options and accompanying information (Elwyn & Miron-Shatz, 2010). Patients, it is suggested, do not carry around stable and unchangeable preferences in their heads, but rather construct preferences in situ responsive to the context and content of their encounters and the decision to be made (Elwyn & Miron-Shatz, 2010). By virtue of being constructed, patients' preferences are also considered to lack logical transitivity. That is, preferring option a to option b and preferring option b to option c does not presuppose preferring option a to c (Elwyn & Miron-Shatz, 2010). The argument that preferences are constructed is not a new one, but it is not one that has typically been applied to SDM. Indeed, there is a long-standing tradition of psychological and economics research into the construction of preferences (see Lichtenstein & Slovic, 2006 for an overview).

To provide a brief but instructive example of what a constructed preference means I will remark on the preference reversal phenomenon. First outlined by Lichtenstein & Slovic (1971, 1973), preference reversals are inconsistencies between two wagers that have comparable pay outs. In their study, Lichtenstein and Slovic (1971, 1973) observed that participants more frequently chose the wager with a higher chance of winning a small amount of money than one with a lower chance of winning a large amount of money. However, when participants were asked to name the lowest price that they would sell these wagers for, a higher price was named for the lower chance to win a large amount of money (Lichtenstein & Slovic, 1971, 1973). Preferences themselves can therefore appear inconsistent or changeable depending on the context they are formulated in. As such, it became apparent that preferences were not a fixed phenomenon but rather something that varied with information and situation in getting constructed. Indeed, preference reversals were recurrently observed by researchers interested in the phenomenon and by the mid 90s Slovic remarked that "people's preferences are often constructed – not merely revealed – in the process of elicitation" (Slovic, 1995, p. 365). This notion of preferences as responsively constructed and ostensibly inconsistent can prove difficult for a standardised approach to SDM or patients' preferences to account for, which will become clearer in the overview of problems measuring SDM in the next section.

1.6.2 Problems measuring and standardising SDM

As previously mentioned, there has been a recurrent suggestion that elements of SDM fall across gradations rather than fitting a dichotomous view of success or failure (Charles et al., 1997; Elwyn et al., 2017). Moreover, that these same SDM elements, and SDM itself, might be a recursive process (Towle & Godolphin, 1999). In turn, it is perhaps unsurprising that one area where SDM has faced problems is measuring phenomena. The first model of SDM was proposed in 1997 and by 2001 there was a systematic review of measurement instruments that purported to assess patient involvement in decision-making (Elwyn et al., 2001). In the review, the authors concluded that those instruments that met the review criteria were insufficient to adequately measure patient involvement. None of the instruments reviewed had been designed for the specific purpose of measuring patient involvement and they lost this focus by trying to cover too many aspects of the consultations (Elwyn et al., 2001). One issue is that the elements these measurement instruments addressed and how they assessed SDM also varied between instruments. For instance, SDM measurement instruments were seen to have assessed patients' preferences, decisional conflict, self-efficacy, and perceived involvement and satisfaction with decision-making (Simon et al., 2007).

Furthermore, instruments generally measured one of the following: assessments of decision-making needs, support provision for decision-making, or the process and outcomes of SDM

(Simon et al., 2007). As such, the concept of SDM and decision-making elements purported to be measured markedly differed between assessments. Although measurement instruments typically reported satisfactory reliability, they also had insufficient or no validation data, which is problematic for the utility of these measures (Simon et al., 2007). A subsequent review observed increasing movement towards dyadic assessments of SDM (Scholl et al., 2011), which is more consistent with a collaborative practitioner-patient relationship. However, measurement instruments continued to attend insufficiently to patients' observable clinical encounter behaviour (Scholl et al., 2011). The lack of focus on patients' behaviours is problematic because it diminishes the possibility of a collaborative dyadic assessment of SDM. In turn, it reinforces an approximation of SDM that is driven primarily by practitioners, which runs counter to the collaborative participation of SDM (Charles et al., 1997, 1999). Although reliability continued to be generally acceptable, validation presented a persistent issue for SDM measurement research. A 2018 systematic review of 40 measurement instruments judged an overall lack of evidence for measurement quality partly because of poor validation studies (Gärtner et al., 2018).

Another issue with measuring SDM is whether the outcome of the ostensible SDM process being measured reflects the experiences of both or either patients or practitioners. For instance, in a study of healthcare encounters in Norway, where SDM is a legal requirement, investigating patient involvement in decision-making a pair of confusing findings were reported. Both the practitioners and patients were able to identify poor communication from the practitioner, and the practitioners were aware that they performed poorly on SDM (Gulbrandsen et al., 2014). Despite this poor communication and the confused attempts at SDM, patients gave positive reports of their appointments including global satisfaction scores. As such, it is possible that the measurement instruments captured the effort practitioners made to share the decision-making process rather than the quality of the decision-making process (Gulbrandsen et al., 2014). To date, then, measurement instruments have assessed various approximations of SDM and proximal decision-making elements (Simon, 2007) plus the effort put into attempting to share decisions (Gulbrandsen et al., 2014). It would appear from these measurement attempts that confusion exists about what SDM looks like and how it might be successfully assessed.

Confusion around the status of decision-making and what exactly SDM looks like is a real problem for measurement studies. Qualitative evidence has suggested that patients report difficulty identifying whether a decision had been made or were unsure what to consider as a decision (Entwistle et al., 2004). Informants also spoke about their experiences relative to SDM measurement instruments and some remarked that their appointments could be considered as patient-led or collaborative rather than one binary choice. As such, the SDM assessments might not faithfully capture what occurred in appointments and it might vary considerably from the way that patients interpret the process (Entwistle et al., 2004). This overview of the problems that attempts to measure SDM face will now be followed by a discussion of the difficulty implementing fuzzy concepts such as SDM and involving patients' preferences.

1.6.3 Difficulty implementing fuzzy concepts

Having discussed the conceptual confusion or perhaps lack of consensus around the term preferences in SDM, I will now move on to consider another issue. That is, there are crucial differences in perceptions between practitioners, who think they are doing SDM, and research findings that reveal SDM does not occur as often as practitioners think. Furthermore, this section offers a candidate explanation for these differences that allows both sides to think they are right.

It is worth remembering that while models of SDM have begun to foreground the extent and importance of complex communicative work for the process (Elwyn et al., 2017; Joseph-Williams et al., 2019), they are not designating preferences as unique interactive constructions (Elwyn & Miron-Shatz, 2010). As such, it is possible that practitioners may have entered decision-making appointments with an expectation of finding simplistic fixed preferences. A review of patient involvement in decision-making revealed that practitioners infrequently attempted to involve patients in their treatment decisions (Couët et al., 2015). This investigation of patient involvement systematically reviewed studies that used the observing patient involvement in decision making instrument (OPTION; Elwyn et al., 2003, 2005), which was specifically designed to assess the extent and quality of patient involvement in decision-making. The OPTION instrument assesses behaviours that range from explaining professional equipoise to patients to eliciting patients' involvement preferences and their expectations and ideas for addressing their problem (Elwyn et al., 2003). While the original OPTION instrument demonstrated acceptable levels of reliability and construct validity (Elwyn et al., 2003, p. 97), the revised instrument reported improved reliability, with the score increasing from 0.62 to 0.77 (Elwyn et al., 2005, p. 38).

Putting aside criticisms of measurement, in their own terms, attempts to systematise SDM have struggled to change practice. In addition to infrequent attempts to involve patients in decision-making, the review also reported instances where practitioners attempted no patient involvement behaviours (Couét et al., 2015). Of the patient involvement behaviours reviewed, those related to patients' preferences were consistently the least attempted ones (Couét et al., 2015). There was also no association between patients' stated preferences for decision-making role and variations in patient involvement behaviour (Couét et al., 2015), which suggests that practitioners were not handling preferences as particularly influential or consequential. Despite this review evidence of poor patient preference involvement, there has been a suggestion that practitioners do in fact routinely perform SDM. A UK-wide SDM initiative that surveyed practitioners reported that practitioners considered there to be minimal if any difference between SDM and their current practice (Joseph-Williams et al., 2017). Indeed, practitioners also reported that they involved patients in their decision-making and failed to view SDM as distinct. Notably, practitioners also endorsed decision aids as important tools and a factor in accomplishing SDM (Joseph-Williams et al., 2017). This point is notable because the instances where practitioners performed patient involvement behaviours in the review were those where decision aids were used (Couét et al., 2015).

As such, it is possible that practitioners take a more rigid view of patients' preferences as the fuzziness of construction is difficult for them to implement in their practice. The fuzziness also extends to the perception of desire for SDM, as practitioners in the UK SDM initiative claimed that patients did not routinely want SDM (Joseph-Williams et al., 2017). When patients' role preferences were reviewed, however, most patients reported wanting to be involved in decision-making (63%; Chewning et al., 2012). When a measure under review explicitly identified SDM as an option there was greater preference for sharing decisions, while only a small number of patients stated a preference for practitioners to decide (Chewning et al., 2012). That said, patients' preferences can vary across aspects of SDM, as while some patients might want their practitioner to decide (52%), a large majority may also want to be offered options and have their input heard (92%; W. Levinson et al., 2005). The apparent fuzziness of SDM as a recursive and interactively accomplished process plus that of patients' preferences as constructions might, then, be a difficult idea for practitioners to meaningfully bring to bear on treatment decisions. Alternatively, it could be the case that the fuzziness of preferences and a recursive decision-making process are in tension with the way that practitioners have historically gotten preferences or choices on the record.

This overview of problems facing SDM draws the SDM history to a close, for now, as the next section will discuss prostate cancer; first, relevant clinical information, and second its relation to SDM and patients' preferences. The reason for this focus on prostate cancer is that it provides the healthcare context for my research, as I will be investigating and analysing prostate cancer decision-making conversations.

1.7 Prostate cancer diagnosis and treatment

1.7.1 Prostate cancer diagnosis, prevalence, and survival

There are instances where patients' preferences have importance beyond satisfying the conditions for SDM. For instance, illnesses or conditions where there are multiple but comparable treatment options have heightened preference sensitivity. Preference sensitive decisions can be defined as those where there is no objective best course of action, due to reasons such as inconclusive evidence for low benefit to harm ratio (Stiggelbout et al., 2015). Prostate cancer is an example of needing to make a highly preference sensitive treatment decision because curative treatments for localised prostate cancer are equivalent in their effectiveness (Xiong et al., 2014). Instead of deciding entirely on treatment effectiveness, decisions are shaped also by what individuals personally consider important. For example, trade-offs between side effects or functional and long-term outcomes.

Prostate cancer is the most common cancer diagnosis for men in the UK, with a yearly total of 48, 487 new cases between 2015-2017 (Cancer Research UK, 2020). With 11, 855 deaths per year between 2016-2018, prostate cancer is the second highest cause of cancer mortality for males in the UK (Cancer Research, 2021). Survival rates are typically high with recent 5- and 10-year estimates at 86.6% and at 77.6% respectively (Cancer Research UK, 2020). Patients are diagnosed with localised prostate cancer when the cancer is contained entirely within the prostate gland. Locally advanced prostate cancer is diagnosed when the cancer has spread to tissues surrounding the prostate gland. If the cancer has spread beyond the surrounding tissues into lymph nodes, and possibly the bones, then advanced prostate cancer is diagnosed (Cancer Research UK, 2016). There are also gradations within diagnoses with stages one and two corresponding to localised prostate cancer, stage three to locally advanced, and stage four to advanced cancer with these gradations being consequential for treatment (Cancer Research UK, 2016). Localised and locally advanced prostate cancer are both curable and several treatments exist for each diagnosis. Advanced prostate cancer is not curable, although there are non-curative treatment options (Cancer Research UK, 2019).

1.7.2 Prostate cancer treatment options

Prostate cancer can grow slowly and therefore patients might not require active treatment. In slow-growing cases, practitioners might recommend monitoring the cancer. Options for monitoring are active surveillance or watchful waiting, however, monitoring varies between these two approaches. Active surveillance monitors localised prostate cancer with the intention of providing curative treatment if the cancer starts or continues to grow (Cancer Research UK, 2019). Watchful waiting, by contrast is offered to patients for whom active treatment would be inappropriate. For example, patients with locally advanced or advanced prostate cancer but no symptoms, or patients with multiple health problems would be offered watchful waiting (Cancer Research UK, 2019). Watchful waiting typically involves an annual blood test to measure prostate specific androgen levels. Active surveillance, however, involves triannual or quarterly blood tests, an annual or biannual digital rectal exam, and after one year a prostate biopsy (Prostate Cancer UK, 2019).

Although monitoring can be offered to patients with localised, locally advanced, and advanced prostate cancer there are various active treatments. Curative treatment options for localised prostate cancer include radical prostatectomy, external beam radiation therapy, and brachytherapy. A radical prostatectomy requires removing the entire prostate gland and typically tissues from the surrounding area. As radical prostatectomy removes the entire prostate gland it removes the entire cancer. External beam radiation therapy is offered independently when cancer is localised, but low dosages can be combined with brachytherapy where there is a risk of cancer spread. The process involves aiming beams of radiation at the prostate gland, focusing these beams, and repeating the process over a course of weeks (Prostate Cancer UK, 2018). Brachytherapy is either low dose rate and permanent or high dose rate and temporary. High dose rate brachytherapy is offered across treatment grades, while low dose rate is only appropriate for grade group one (Cancer Research UK, 2016). Both brachytherapy options involve inserting doses of radiation into the prostate albeit with differing strengths. Brachytherapy also has the advantage of not targeting tissues surrounding the prostate gland (Prostate Cancer UK, 2019). For locally advanced prostate cancer, curative treatment options are external beam radiotherapy and hormone therapy, or radical prostatectomy followed by external beam radiotherapy (Cancer Research UK, 2016). This said, it is important to note that treatment provision can vary between hospitals, as not every hospital offers every treatment.

There are two more treatment options available for patients with localised prostate cancer with low to moderate risk of spread. Both treatments are surgical procedures and in the UK are only offered at specific cancer specialist centres or as part of clinical trials. The first is cryotherapy, which uses a set of needles to pass freezing gases into the prostate to destroy prostatic tissue (Prostate Cancer UK, 2018). High-intensity focused ultrasound is the second procedure, and this involves placing a probe into the rectum that a surgeon moves around to direct high intensity ultrasound energy into the prostate (Prostate Cancer UK, 2015/2018). Both treatments use extreme temperatures and require either a warming catheter in the case of cryotherapy or a cooling balloon for high-intensity focused ultrasound to avoid damaging the back passage. Cryotherapy and high-intensity focused ultrasound are both less intrusive than robotic assisted laparoscopic prostatectomy and may be had following radiotherapy if prostate cancer recurs (Prostate Cancer UK 2015/2018, 2018). The common side effects of urinary incontinence and erectile dysfunction do also occur with cryotherapy and high-intensity focused ultrasound, but the latter carries a reduced likelihood than robotic assisted laparoscopic prostatectomy (Prostate Cancer UK, 2015/2018).

Advanced prostate cancer does not have a curative treatment, and options focus instead on controlling cancer, such as slowing growth and managing pain. Treatment options include external beam radiation therapy, hormone therapy, and chemotherapy. External beam radiation therapy aims to ameliorate pain and assist bone repair by shrinking the cancer and slowing its growth (Prostate Cancer UK, 2018). The treatment course is shorter and the radiation dosage lower in advanced cancer treatment (Prostate Cancer UK, 2016). Hormone therapy intends to slow the growth of or shrink cancer. To shrink or slow the growth of cancer, hormone therapy impedes or blocks the body's production of testosterone. There are both continuous and intermittent hormone therapies and these options depend on clinical factors (Cancer Research UK, 2019). Chemotherapy is offered for symptom management and impedes the growth of cancer. The effects of chemotherapy are reducing the pain that patients experience and facilitating patients preserving a greater quality of life (Cancer Research UK, 2019).

One other possibility for prostate cancer patients is that their disease recurs after curative treatment. Typically, the primary indicator of potential recurrence is a sustained increase in the prostate specific antigen level, which is a protein released by prostate gland cells. Estimates are that 20-30% of prostate cancer patients will experience some form of recurrence (Moffitt Cancer Centre, 2018) but it is impossible to accurately predict recurrence. Whether monitoring prostate cancer or following curative treatment, patients receive prostate specific antigen tests for up to two years to spot any possible rises in prostate specific antigen levels.

1.7.3 Prostate cancer treatment outcomes

A network meta-analysis of observational management, prostatectomy, radiotherapy, and cryotherapy found no one treatment superior for all-cause mortality (Xiong et al., 2014). In addition, no superior treatment was found for cancer-related mortality either. Furthermore, a comparison of active surveillance, external beam radiation therapy, and radical prostatectomy reported poorer sexual function and urinary incontinence after three years; however, no other clinically significant declines in health-related quality of life were observed beyond twelve months (Barocas et al., 2017). In turn, "men with localized prostate cancer face a decision that is emblematic of a "preference-sensitive" choice"" (Shirk et al., 2017, p. 786). There is a view therefore, that treatment for localised prostate cancer should be responsive to patients' individual preferences and not just clinical factors such as age and aggressiveness of tumour (Sommers et al., 2007), but this is not always the case. There are instances where a treatment option is better suited on clinical factors such as radical prostatectomy or external beam radiation therapy for medium and high-risk tumours (Sommers et al., 2007). In these instances, however, there is still room for responsiveness to patients' preferences in decision-making unless the presentation is acutely life-threatening.

Long-term follow up of a large active surveillance cohort of patients with prostate cancer reported fifteen prostate cancer-specific deaths of 993 patients and 13 cases of developing metastases (Klotz et al., 2014). Of a combined 4000 patients across seven long-term studies, a 93% all-cause/general survival rate was seen with prostate cancer-specific survival rates at 99.7% (Klotz et al., 2014). When comparing follow-up for radical prostatectomy and observation for early prostate cancer on prostate cancer-specific mortality comparable rates were found. For surgery, 27 patients died (7.4%) and for observation 42 died (11.4%; Wilt et al., 2017). Observation led more frequently to disease progression, but surgery was associated with more frequent urinary and erectile problems (Wilt et al., 2017). Therefore, trade-off in this decision might centre on a patients' preferences for potential disease progression treatment and side effects.

Follow up of a randomised control trial comparing monitoring, radiotherapy, or surgery all-cause and prostate cancer-specific mortality investigated 10-year outcomes. 10-year prostate cancer-specific survival was excellent across groups at 98.8% with no significant differences (Hamdy et al., 2016). All-cause mortality was consistent with active monitoring at 59, surgery at 55, and radiotherapy at 55 deaths respectively. Active surveillance/monitoring was associated with greater disease progression rates, and rates of metastases, but 44% of these patients did not go on to radical treatment. Ultimately, mortality was typically low across treatment groups and therefore consideration should be given to the possible trade-off between the effects of radical treatment versus the risk of disease progression and metastases for monitoring (Hamdy et al., 2016). The consideration of trade-offs may be the aspect of decision-making where the preference-sensitivity of prostate cancer treatment is highest and a potential source of decisional conflict pending further research.

A study of long-term physical symptoms post-treatment reported that 90% of patients experienced one physical symptom, 75% reported currently experiencing one physical symptom, and 29% reported currently experiencing at least three physical symptoms (Gavin et al., 2015). Variations among treatments included higher rates of erectile dysfunction for radical prostatectomy, urinary incontinence for radiotherapy, and lower rates of both for brachytherapy (Gavin et al., 2015). In terms of functional quality of life, radical prostatectomy has been reported to associate with losing libido, erectile dysfunction, and psychological distress - in addition to urinary dysfunction (Baker et al., 2016). External beam radiation therapy was associated with sexual dysfunction and short-term bowel dysfunction, while urinary irritancy was a common issue across treatments (Baker et al., 2016). It is clear from these observations on outcomes that making treatment decisions for prostate cancer entails various complex considerations.

1.7.4 Prostate cancer and decision-making

Perhaps unsurprisingly considering the preference sensitivity of prostate cancer (Zeliadt et al., 2006), it is a condition especially relevant for SDM. As with SDM more broadly, there are conceptual confusions about and practical problems with patients' preferences. For one, it has been reported that patients' initial treatment preferences appear not to routinely influence or predict the treatment they receive (Scherr et al., 2017). Conversely, urologists' recommendations, being based on clinical factors such as age and Gleason score but not incorporating patients' preferences, did appear to routinely predict the treatment patients received (Scherr et al., 2017). The Gleason score is a system for grading prostate cancer in terms of how aggressively it is likely to grow and how abnormal the prostate cells look (Cancer Research UK, 2019). There is also a lack of clarity as to how the factors purportedly supporting SDM and patient involvement function in practice. For example, feeling that sufficient time to decide on treatment exists is seen not only to associate positively with SDM but also patient-led decision-making (Song et al., 2013). A prospective follow-up of treatment decision-making factors for localised prostate cancer identified 41% of patient only decisions compared to 45% of shared decisions (Song et al., 2013).

Decisional conflict is a phenomenon of personal uncertainty, particularly where there are questions of values, elements of risk, and anticipation of regret (O'Connor, 1995). Decisional conflict can relate to decisional regret, particularly with regards uncertainty and risk. Decisional regret is one of the main targets of SDM, with one of the aims being that an informed patient receives exactly their preferred treatment. As with decisional conflict, treatment trade-offs can be potential sources of decisional regret. The importance of informing patients adequately about potential sources of regret is that this regret is likely to present in the longer-term. Typically, patients report decisional regret post-treatment

(Christie et al., 2015) whereas immediate post-decision regret is less common (Gwede et al., 2005). In addition, it is suggested that decisional regret as a concept should be adequately explained to patients, particularly where it relates to factors frequently and strongly related to treatment modality (Christie et al., 2015). Patients' perceptions of negative side effects, then, might be informative in considering tailoring treatments to preferences and minimising decisional regret.

A systematic review of post-treatment regret identified treatment toxicity factors as most frequently associated with regret (Christie et al., 2015). Sexual and urinary dysfunction had strong significant associations with regret, and bowel dysfunction a non-significant but not infrequent association. Between 70 to 92% of patients reported sexual dysfunction across treatment modalities including impotency, losing libido, and losing sexual potency in another survey (Lehto et al., 2017). Moreover, three quarters of patients reported at least one psychological symptom, including worrying, nervousness, irritability, and concentration problems in the same study. Particularly relevant for decisional regret was that treatment outcome dissatisfaction was associated with indicators of wellbeing; and that common, multiple, and persistent negative effects were associated with active treatment (Lehto et al., 2017). Prostatectomy was the treatment associated with the highest rate of dissatisfaction (42%), a finding reported elsewhere (Christie et al., 2015), while hormone therapy (34%), external beam radiotherapy (24%), brachytherapy (22%), and active surveillance (15%) followed (Lehto et al., 2017). Notably, conservative disease management was associated less with regret (8.2%) than surgery (15%) and radiotherapy (16.6%; Hoffman et al., 2017).

Differences between prospective and retrospective appraisals of prostate cancer treatment experiences can also be insightful. For instance, prostate cancer survivors report on average two on-going side effects; with 30% reporting that side effects were as expected but 25% reporting them being worse than expected (Maguire et al., 2017). Alongside worse than expected side effects, higher fear of cancer recurrence was seen to be predictive of diminished quality of life (Maguire et al., 2018). Where patients' expectations are disconfirmed their quality of life can suffer, and they may experience distress. As a quarter of survivors reported worse experiences of side effects than expectations, this suggests that treatment preparation might not always be sufficient to minimise the possibility of decisional regret (Maguire et al., 2018). One potential challenge for SDM, then, that might need to be turned into a positive of the approach, is how it might be relevant for decisional regret.

Ensuring that patients have all the relevant information to make informed decisions is obviously important, but might there also be value in seeking to shape treatment decisions as fully as possible around their preference? That is, to acknowledge the centrality of patients' preferences (Makoul & Clayman, 2006), as unique constructions (Elwyn & Miron-Shatz, 2010), and attempt to work through as many of the aspects and implications of this preference that might subsequently be consequential for regret.

Before summarising the chapter, I shall briefly reprise the discussion of models of SDM to better situate my research. I will spotlight two recent models and discuss their relevance for my research. Of the models discussed throughout the chapter, I believe the Implement-SDM model (Joseph-Williams et al., 2019) shows the most promise, and I consider it to have extended the otherwise promising three talk model (Elwyn et al., 2017). The three talk model showed promise in clearly acknowledging the centrality of complex communicative work to accomplishing SDM (Elwyn et al., 2017). Moreover, it mapped the decision-making process onto three intuitive stages of talk amenable to clinical implementation. Although there was no focus on patients' preferences as unique interactive constructions, the notion of moving from initial to informed preferences across decision-making offered a more dynamic treatment of patients' preferences. Overall, then, the three talk model demonstrated a clear development from the earlier models of SDM and stands as the best of the predominantly theoretical models.

Not only did the Implement-SDM model provide support for the existence of choice talk, option talk, and decision talk, but it reported in situ variability between illnesses, and a further stage of talk (Joseph-Williams et al., 2019). As such, the Implement-SDM model becomes the primary candidate for best model, as it took the strengths of the three talk model and extended them further. In addition, it is difficult to overstate the step forward that the empirical evidence offered by the Implement-SDM model represented. Both models are closer to the language and social interaction approach I take in this research than previous models despite not belonging to that tradition. The aforementioned focus on communicative processes and stages of talk in the three talk model (Elwyn et al., 2017) and the focus on empirical observation and inductive reasoning in the Implement-SDM model (Joseph-Williams et al., 2019). I therefore offer a qualified endorsement of the Implement-SDM model (Joseph-Williams et al., 2019) on the grounds that it demonstrates the same promise as the three talk model and develops this by moving further away from theoretical to empirical.

This endorsement is qualified because I believe the Implement-SDM model (Joseph-Williams et al., 2019) represents the best of the current models. By being grounded in empirical evidence this model is a clear improvement in closeness to clinical practice and SDM as currently attempted. I consider the next step towards an improved model of SDM to be the incorporation of the language and social interaction perspective. The language and social interaction perspective would further foreground the centrality of the communicative process, in particular the link between what is said and subsequently gets done, plus how these distinct stages of talk get organized and navigated by the parties. A trajectory from choice talk to decision talk should be analytically tractable and the stages of talk could be given more detailed accounts and a characterisation based on actual interactions that occurred. Further to these spaces for interaction and expansion, it is also worth investigating how prostate cancer treatment appointments unfold compared to this succinct model. I do, however, believe that the Implement-SDM model (Joseph-Williams et al., 2019) is amenable to a language and social interaction perspective.

1.8 Chapter Summary

This chapter has told a story about the development of the practitioner-patient relationship, a necessarily selective and Anglo-centric story, that focused on the tradition of a paternalistic approach to care giving way to more ethical and dynamic developments. In section 1.1 I discussed the paternalistic approach and the sick role (Parsons, 1951) and section 1.2 overviewed participatory and ethical models of the practitioner-patient relationship (Szasz & Hollender, 1956; Veatch, 1972; Emanuel & Emanuel, 1992). For section 1.3 I covered the development of the first model of SDM (Charles et al., 1997), its subsequent revision (Charles et al., 1999), and competence frameworks for SDM (Towle & Godolphin, 1999; Elwyn et al., 2000). Section 1.4 remarked on the set of systematic reviews that prompted the proposal of an integrative model of SDM (Makoul & Clayman, 2006; Moumjid et al., 2007) plus the increasing prominence of patients' preferences as an essential SDM element. Problems with SDM and patients' preferences at both the levels of research and practice were then reviewed in section 1.5. Recent models of SDM that brought the field closer to attempts at clinical implementation were then covered in section 1.6. I introduced prostate cancer, as the healthcare topic of my research, in section 1.7 and illustrated its relevance for SDM and patients' preferences. Now, in section 1.8, I will provide a snapshot of the problems that I consider SDM and patients' preferences to continue to face, state the aims and intentions of this thesis, and signpost my second chapter.

As this chapter has attempted to demonstrate, there have been many substantial and insightful contributions to SDM since the first model was proposed (Charles et al., 1997). That said, SDM research and practice still faces problems, and I will re-state those problems before I do the same for patients' preferences. Theoretically or conceptually, I believe the first problem facing SDM research is the way that it defines patients' preferences and to a lesser extent SDM itself. I agree with the claims that patients' preferences are unique constructions that are responsively developed in situ relative to the context of the decision-making encounter (Elwyn & Miron-Shatz, 2010). As such, while I welcome promising developments such as an acknowledgement of the wide-ranging complexity of communicative practices involved in SDM (Elwyn et al., 2017), I think it is an issue that patients' preferences are not clearly designated as interactive constructions but rather stable phenomena amenable to straightforward elicitation. This omission of preferences as constructions is part of a broader problem with standardisation that SDM has encountered. Although there is an obvious appeal to standardisation for both research and especially practice perspectives, the first model of SDM came with a caution that standardisation was not an important concern (Charles et al., 1997).

Rather, focusing on the essential elements of SDM, and establishing these as touchstones for making a shared decision with the patient was emphasised (Charles et al., 1997). I argue that focusing on notions of standardisation to the neglect of the recursive and continuous nature of SDM elements (Charles et al., 1997; Towle & Godolphin, 1999; Elwyn et al., 2017) is detrimental to the practical accomplishment of SDM in situ. This neglect of the recursive and continuous nature of SDM elements throws the handling of aspects of the decision-making process into tension with the forms that they may take in situ. With the recurrent suggestion that SDM elements fall along gradations rather than being seen as dichotomous successes or failures (Charles et al., 1997; Elwyn et al., 2017), it is unclear how a standardised approach to either research or practice would faithfully capture these elements empirically. Furthermore, an expectation that, for instance, patients' preferences are stable phenomena interchangeable with opinions can set the wrong tone for an appointment where patients' preferences are key to decision-making business such as scenarios with professional equipoise (Elwyn et al., 2000).

I would contend also that other problems facing SDM such as trouble measuring the concept and its elements successfully relate to the issue of a poor fit or missing consensus between constructed and recursive phenomena on one hand and notions of firm standardised behaviour on the other. That is, a clash between a deductive checklist of and an inductive response to the behaviour that patients, practitioners, and any third parties exhibit in decision-making appointments in situ. Indeed, when surveyed as part of a UK-wide SDM initiative, practitioners reported that they perceived little difference between their practice and SDM (Joseph-Williams et al., 2017). However, practitioners have been reported to infrequently involve patients in decision-making and rarely perform involvement behaviours that concern patients' preferences (Couét et al., 2015). Without patient involvement it is unlikely that these encounters produced shared decisions; certainly not shared decisions in the spirit of making healthcare decisions collaboratively as opposed to checklist box-ticking. Healthcare is moving towards a goal of routine SDM (Coulter et al., 2017) but for that to mean anything, and reflect the ethical developments that preceded it, SDM needs to occur in a manner that includes the patient and responds to their preferences whenever possible.

In turn, there is a similar problem with patients' preferences, in that these are not treated as unique interactive constructions but rather as an opinion or belief (Elwyn & Miron-Shatz, 2010). The issue is that a model of SDM that purports to involve patients' preferences centrally and meaningfully fails at least partially in this task if it does not designate patients' preferences as interactive constructions. This problem of designation is obviously at the theoretical or conceptual level, but it may colour practitioners' perspectives on patients' preferences and lead to shallow treatment of what I consider a rich and core element of SDM. A similar practical problem is faced by patients' preferences too, as they are not routinely seen to be brought to bear on patients' treatment decisions (Scherr et al., 2017). Indeed, patients' preferences were reported to fall by the wayside in favour of clinical considerations around such factors as patients' age and Gleason score (Scherr et al., 2017). It is presently unclear, then, how exactly patients' preferences do, or can, influence patients' treatment decisions in situ.

This thesis, then, is intended to contribute to the study of SDM by focusing on the essential element of patients' preferences. I concur with the view that elements of SDM are recursive and indeed that the decision-making process is recursive and interactively accomplished. As such, I aim to provide empirical observational examples of patients' preferences as interactive in situ constructions from post-diagnostic prostate cancer treatment appointments. Furthermore, to analyse these preferences for the forms they take and ways that patients construct them with a view to addressing these absences in the literature. It is also my aim to help illustrate exactly how consequential the fine-grained detail of practitioner-patient interaction is for the phenomenon of patients' preferences as unique interactive constructions. In turn, how consequential this interactive communicative work is for the recursive and continuous nature of SDM elements. The primary claim of this thesis is that the practitioner-patient interaction is consequential for SDM and especially patients' preferences, at the level of the actual conversations. I do not assume that a practitioner will either succeed or fail to share a decision with their patient. Rather, I argue that patients and practitioners create and shape a sense of sharedness in their communicative contributions to treatment appointments. My contention is that if patients' preferences can shape the discussion of treatment options, and the ultimate decision that patients make, then this will be in the detail of what patients and practitioners say.

Chapter 2 will overview the research literature on patient-practitioner interaction and attempts to capture, characterise, and explain the behaviour within from three perspectives. To begin, the chapter will cover the development of interaction systems analysis and its subsequent uptake in healthcare encounters research. Then, the strand of critical qualitative microanalysis will follow before the language and social interaction research concludes the overview. Chapter 2 will close with my case for taking the language and social interaction approach of discursive psychology to investigate the role of patients' preferences in prostate cancer treatment appointments.

Chapter 2: A review of approaches to the study of interactions in situ

Chapter Overview

In chapter 1 I focused on the history of the practitioner-patient relationship and told a story about the development of SDM. While there was a large amount of material covered, and this presented much fascinating material, I found the absence of interaction research especially notable. As such, it appeared timely to consider the contribution that interaction research might make to the field of SDM. This chapter, then, forms the second part of my literature review and focuses on interaction research into healthcare encounters and SDM. The first section discusses Robert Bales and his interaction process analysis and its influence on subsequent interaction analysis studies of healthcare interactions. Section two moves closer to the study of interactions as sites of meaningful conversational work by covering critical interaction analysts and their interest in ideology and power. In section three, the language and social interaction approaches of conversation analysis and discursive psychology are introduced. Subsequently, I consider how these approaches to studying social interactions have been applied to the field of healthcare. To conclude the chapter, I make the case for adopting the language and social interaction approach of discursive psychology for my research and set up the coverage of methods in chapter 3.

2.1 Interaction systems approaches to face-to-face interactions

2.1.1 Interaction process analysis

This first section begins a narrative that tells a story about the development of the study of face-to-face interaction. The first stage of this development was interaction process analysis (Bales, 1950). I begin with interaction process analysis because it was the first major attempt at systematic analysis of face-to-face group interaction. In turn, interaction process analysis proved to be hugely influential in stimulating research into face-to-face interaction. Indeed, I shall overview the role of interaction process analysis in, and its influence for, healthcare interactions later in the chapter.

As the 1950s began there was substantial sociological interest in theories of social systems and structures as seen in the publication of *The Social System* (Parsons, 1951). Robert Bales, one of Parsons' PhD students, had a keen interest in small groups and wanted to study face-to-face interactions in small groups. For Bales, however, small groups appeared more disparate and harder to generalise than full scale social systems such as countries (Bales, 1950). Parsons' influence became clear when Bales reconsidered small groups as "microscopic social systems", or more specifically "systems of human interaction" (Bales, 1950a, p. 257) to offset this problem of generalisation. In turn, Bales considered that there would not be a problem comparing small face-to-face groups to societies if they were compared as systems of interactions. In turn, Bales aimed to develop a systematic method of analysis for small group face-to-face interactions that could classify and explain the interactions and behaviours within. Subsequently, Bales presented interaction process analysis (Bales, 1950b), which began the tradition of interaction systems approaches for studying face-to-face interaction. Interaction process analysis is a process analysis system rather than, for instance, a content analysis system because it focuses on the process of interaction and problems that might impede this process (Bales, 1950).

Bales' (1950) system for analysing small group face-to-face interactions considered interactions to be processes, which could be categorised by functions but also by the relevance of interactive behaviour for problem-solving (Bales, 1950). Bales was interested in problems because he believed that interactions required equilibrium to progress smoothly and accomplish aims or tasks. Before I characterise the types of functional problems that Bales considered it necessary to solve or avoid for a smooth interaction, I will discuss the categories that interaction process analysis used. There were 12 categories of interactive behaviour proposed for interaction process analysis, which were grouped into four areas of function (Bales, 1950). There are two Social-Emotional areas of a) positive reactions and b) negative reactions plus two Task areas of c) attempted answers and d) questions (Bales, 1950a, p. 258). Each area included three of the twelve categories for classifying interactive behaviour and every category had an inverse category in the opposite area. That is, category three in the positive reactions area was agrees while activity nine in negative reactions was disagrees (Bales, 1950). Now, being concerned with problem-solving meant that these categories for classifying behaviour corresponded to a functional problem for the equilibrium and aims of face-to-face interaction (Bales, 1950).

There were six functional problems proposed in interaction process analysis and they were as follows: Orientation, evaluation, control, decision, tension-management, and integration (Bales, 1950). To give an example of the way that problem-solving was conceptualised in interaction process analysis, categories four and nine relate to problems of control while categories two and 11 concern problems of tension-management (Bales, 1950b, p. 11). Categories two and 11 are a) shows tension relief and b) shows tension respectively, and interactions could risk being impeded if speakers could not skilfully avoid or solve these problems in their interactions. Indeed, to maintain equilibrium throughout the interaction process speakers must address the various functional problems as they arrive. An example that Bales offered on more than one occasion is of a group meeting to reach a conclusion on a single matter (Bales, 1950a, p. 259; Bales, 1950b, p. 11). To reach a conclusion, the group must proceed through the functional problems of, for example orientation; evaluation; and control (Bales, 1950a, p. 259-260).

In terms of methodology, interaction process analysis was a coding system and focused on the verbal units or processes that speakers produced, which ranged from a word to a sentence. Interactions could be coded either directly from the ongoing interaction by two observers trained to use interaction process analysis or from a transcript from an audio recording of the interaction (Bales, 1950). Typically, direct observational coding was performed, but transcripts were used to train observers in the skill of using interaction process analysis. Notably, while direct coding provided details such as posture, gesture, and intonation it was seen to omit as much as 23% of behaviour when compared directly to transcript coding (Psathas, 1961). Another approach was to code from the audio recording of an encounter, and this was considered to share a drawback with coding from transcripts, which was that the expressive features of speech and the postural and gestural behaviour were not coded (Waxler & Mishler, 1966). An observer would identify a process or unit of speech and then classify it, attribute it to its producer, and designate its target (Bales, 1950, p. 259). It was the observer’s judgement, then, to decide on the category classification for units of speech or processes and both observers would cross-reference their scores to establish inter-rater reliability (Bales, 1950). Observers would make attempts, however, to preserve the sequential positioning of behaviour for accuracy of representation and facilitating comparisons between coders.

Despite Bales' enthusiasm for interaction process analysis and its importance as an empirical method for investigating face-to-face interaction, there were critiques worth considering. One of these critiques comes from a proponent of a radically empirical alternative to studying interaction, and the other from the interaction systems analysis perspective. Number one comes from the language and social interaction approach of conversation analysis. Harvey Sacks, one of the founders, remarked in a 1964 lecture that "Bales has the notion that you can categorize [human behaviour] as it comes out, so that you sit and watch people as they are talking, and write down categories of what they are doing as they're doing it. That makes it into some kind of trick. There's no reason to suppose that you should be able to see it right then and there" (Sacks, 1992, vol. 1, p. 28). While not contemporary to the publications of Bales' manual, it is notable that Sacks would take issue with interaction process analysis 13 years after publication, and perhaps speaks to the extent of influence and uptake of interaction process analysis.

Sacks' contention was that interaction process analysis purported to make sense of interactions and their behaviour as they took place, rather than take time to develop a systematic understanding over time. Interaction process analysis, Sacks contended, was working with a set of categories and actions that could be considered to constrain and force interactive behaviours into closely bounded groups. Critique number two came from a researcher who would go on to develop a widely used alternative to interaction process analysis to study healthcare interactions. This critique of interaction process analysis would also come much later than its publication, which again demonstrates the influence and acceptance it had among researchers. That said, there was a critique that interaction process analysis was a poor fit for more unique or specialist types of face-to-face interaction. Roter was critical of interaction process analysis for healthcare interactions specifically, deeming it "largely insensitive to the unique communications of the practitioner-patient dyad" (Roter, 1977, p. 304). Roter's critique of interaction process analysis and related contribution to the field will be discussed in the next section where I consider interaction systems analysis and healthcare interactions.

Bales was working from a theory of social systems and social structures and was therefore attempting to fit a grand structural theory of society onto small face-to-face groups that varied in conduct and contexts. Interaction process analysis was designed to operate on this broader level of structural generalisability, and it consequently produced a standardised approach with a limited set of generic categories. While this standardised approach was influential and useful for generalising behaviour and comparing social structures, it might struggle with interactions that could vary significantly across cases. For instance, we can consider healthcare interactions, which imply a recognisable category of interactions that we might effectively standardise and generalise across. However, practitioners' appointments could differ between acute visits to an accident and emergency department, a routine health check-up, or an appointment to discuss cancer treatment. Naturally, a routine health check-up is significantly different from an acute illness visit and would almost certainly entail a different kind of interaction marked by both different aims and interactive behaviours. Despite the distinct business these interactions cover, they are on the face of it small group face-to-face interactions and belong to the category healthcare interactions. In the next subsection I will overview some of the work that used interaction process analysis to study healthcare interactions, and the modifications that were used.

2.1.2 Applying interaction systems to healthcare interactions

Interaction process analysis (Bales 1950) offered a method to study face-to-face interaction and was both highly influential and widely adopted but Bales himself cautioned that it was not a specialist measure for analysing the specific aims and behaviours of institutional interactions, such as practitioner-patient interactions. This, however, did not stop researchers using interaction process analysis to study healthcare encounters. One of the most notable cases was a project spanning five years at the Los Angeles Children's Hospital (Korsch & Negrete, 1972). This project took audio recordings of over 800 visits by 800 parents who brought their babies to an emergency clinic with an acute but treatable illness. In these encounters the parents were considered the patients, as babies cannot conduct their own treatment visits. The aim of the project was to investigate practitioners' communicative style and its effect on patients' evaluations of and satisfaction with encounters. Recordings of encounters were coded with a modified version of interaction process analysis (Bales, 1950). The existing functions of positive reactions, negative reactions, questions, and attempted answers (Bales, 1950) became positive affect, negative affect, neutral statements, and neutral questions (Fremon et al., 1971). While the change in functions was to improve goodness-of-fit between interaction process analysis and healthcare encounters, Bales' (1950) original 12 categories were used for the analysis.

While I do not consider it necessary to summarise the entirety of the findings from the full five years, there are some notable observations to report. To begin, friendliness on the practitioner's part was related to greater patient satisfaction, and the opposite was true for perceived unfriendliness (Fremon et al., 1971). Patients reported, however, that the highly specialised technical language that practitioners used was problematic, as 149 patients felt their baby's problem had not been clearly explained to them (Korsch & Negrete, 1972). The study also found similar issues, as 26% of patients reported failing to voice their primary concern due to perceptions of an unsympathetic and disinterested practitioner (Korsch & Negrete, 1972). Although 76% of patients ultimately deemed practitioner performance satisfactory, perceptions of unfriendliness, disinterest, or unfulfilled expectations were all linked to noncompliance or poor compliance with practitioners' advice and prescriptions (Korsch & Negrete, 1972). In terms of suggestions for healthcare practice, then, the project clearly demonstrated a relationship between sociable and friendly nonmedical talk and reported patient satisfaction. Indeed, the authors suggested that their observations could offer a straightforward way to improve both the standard of healthcare communication and patient satisfaction (Korsch and Negrete, 1972).

The relative success of the project on practitioner communication and patient satisfaction (Korsch & Negrete, 1972) encouraged further use of interaction systems approaches to study healthcare interactions, but not everybody used interaction process analysis as it was initially formulated (Bales, 1950). For one, Debra Roter was also interested in the relationship between practitioner-patient interaction and both patient satisfaction and patient compliance. As such, Roter (1977) set out to investigate an intervention designed to increase the number of questions patients asked their practitioners, with the hypothesis that this might be associated with increased satisfaction and compliance. A three-armed randomised controlled trial including intervention, contact control condition, and non-contact control condition was run. The experimental group received a ten-minute health education intervention that took patients through questions they might have, with the aim that patients ask their practitioners these questions. Placebo patients also received a ten-minute health education intervention to preserve the interactivity and structure of the experimental condition, but this only provided routine information about the emergency room facility (Roter, 1977). As mentioned in section 2.1.1 Roter was critical of interaction process analysis, judging it "largely insensitive to the unique communications of the practitioner-patient dyad" (Roter, 1977, p. 304).

Roter used an uncredited, and as such presumably her own, set of interaction categories that were tailored to practitioner-patient dyads. This set of interaction categories would go on to be dubbed the Roter interaction analysis system, albeit it was not yet named as such nor entailed all the categories of its later form. Patients in the experimental group asked twice as many questions as the placebo group patients, which was a difference of statistical significance (Roter, 1977). In addition, patients who asked more questions were seen to keep more faithfully to their appointments, which suggested active roles for patients might influence health outcomes. However, experimental patients exhibited more negative affect and lower satisfaction scores, which was coupled with reports of feeling less satisfied with appointments (Roter, 1977). In addition to the practitioner-patient findings, Roter also reported that “uncomfortable dissonance demands resolution through behaviour change” (1977, p. 303), which was congruent with Bales’ focus on problem-solving in small group face-to-face interactions (Bales, 1950). As such, it might be argued that Roter was important to both the development of theory in interaction systems research and the methods for their use. For one, Roter took interaction systems research away from the generic categories of interaction process analysis (Bales, 1950) and began to work with specific interactions in a specific context. As such, there was no need to try to fit a contextually specific interaction into generic categories, and interested researchers had an example for developing their own categories.

The Roter interaction analysis system would be developed substantially and, in Roter and Larson’s words, become “the most widely used single system of medical interaction assessment” (Roter & Larson, 2002, p. 243). At its core, the Roter interaction analysis system was fundamentally concerned with detailing and characterising interactive exchanges between patients and practitioners and their relationship with, and predictive validity for, interaction outcomes (Roter & Larson, 2002). There are 37 mutually exclusive and exhaustive categories in the Roter interaction analysis system (Joo et al., 2018), although this has sometimes varied, with 41 being reported in a recent Japanese study (Yoshida et al., 2021). In turn, Roter contends that the Roter interaction analysis system is sensitive to the particulars of distinct healthcare interaction (Roter & Larson, 2002). That is, Roter interaction analysis system scores were discriminative of the healthcare context of practitioner-patient interactions, for example distinguishing between the particulars of interactions with oncologists compared to interactions with general practitioners (Ong et al., 1998).

Quantitative assessment tools need to have sufficient reliability and validity, and over the years the Roter interaction analysis system has found inter-rater agreement of 0.85 in studies where Roter was an investigator (Roter & Larson, 2002, p. 245).

Unlike interaction process analysis, which typically coded interactions directly or from audio recording transcripts (Bales, 1950), the Roter interaction analysis system typically coded from audio or video recordings (Roter & Larson, 2002). As such, there were claims that a skilled coder can code a recording in only twice the time of the interaction, but this has been challenged by studies using the Roter interaction analysis system in other languages (Ong et al., 1998). Since the Roter interaction analysis system emerged from a modification of interaction process analysis it is unsurprising that similarities exist such as coding units as small as a single word provided that a coder can impute meaning (Roter & Larson, 2001). Although the Roter interaction analysis system was first used, in an early form, in 1977 it became widespread over the years. As such, the supporting evidence for the system accumulated later than alternatives such as interaction process analysis.

Research using the Roter interaction analysis system continues to pursue the line of research put forward in Roter's (1977) influential study of health education interventions. That is, subsequent research typically aims towards establishing the predictive validity of the Roter interaction analysis system for predicting outcomes based on communicative behaviour in practitioner-patient interactions. In addition, focus remains on the practicable benefits of health education and communication skills interventions for improving practitioner-patient interactions and subsequently patient and practitioner outcomes. Programmatically, the Roter interaction analysis system is interested in describing and evaluating practitioner-patient interaction to subsequently teach communication skills and improve the quality of practitioner-patient communication where predictive relationships to patient and practitioner outcomes are demonstrable. Having outlined the influential work of Bales (1950) and the subsequent development of interaction systems for healthcare interactions (Korsch & Negrete, 1972; Roter, 1977), the next section will evaluate the various interaction systems both from within and outside the approach.

2.1.3 Evaluating interaction systems approaches

As studies were beginning to show (Korsch & Negrete, 1972; Roter, 1977), interaction systems research was making inroads with healthcare interactions. By the early 1980s there was sufficient interest for a comparative review of their effectiveness in studying healthcare interactions. Interaction process analysis (Bales, 1950) was compared with the Roter interaction analysis system (Roter, 1977), and a third approach dubbed the verbal response modes (Stiles, 1979). I do not intend to dwell on the verbal response modes nor return to it and therefore will only outline it briefly. The verbal response modes focused on units of verbal communication and coded utterances into one of eight distinct categories ranging from disclosure to reflection (Stiles, 1979). As with interaction process analysis, transcripts were used for coding and utterances were coded for their grammatical form and their communicative intent; or literal versus pragmatic meaning (Stiles, 1979). Of the three approaches applied to the set of interactions the authors concluded that the verbal response modes had the least explanatory power for outcomes of interactions (Inui et al., 1982).

It was the Roter interaction analysis system that was observed to perform best, as it had higher explanatory power for patient compliance with drugs, patient knowledge, and was tied with interaction process analysis for patient satisfaction (Inui et al., 1982). With caution, the authors suggested that the Roter interaction analysis system might be the best interaction system for studying healthcare interactions because of its explanatory power and relative coding speed (Inui et al., 1982). That said, beyond individual performance categories the authors concluded that while these methods have value, they do not capture the holistic experience and business of practitioner-patient interactions (Inui et al., 1982). Importantly, the authors did not dismiss interaction systems and voiced their potential for meaningful insight about structural and linguistic features of potential relevance. Rather, they suggested that perhaps further descriptive materials or work would be required if the aim was to account for and explain healthcare encounters in their totality as interactions (Inui et al., 1982).

Beyond the overall explanatory power of these approaches, it had also been observed that when interactions were broken up into segments that the explanatory power of these approaches varied (Carter et al., 1982). In addition, the findings were not seen to corroborate previous results and the authors noted that historically the use of interaction analysis systems had been heterogeneous and unstandardised. To these points the authors added the critiques that these approaches focused on frequency and therefore undervalued potentially significant but infrequent behaviours and made outliers significant challenges to consistency (Carter et al., 1982). Moreover, the features of verbal communication that give language its expressiveness such as delivery and intonation were not accounted for by the systems, which stilts the account of the communication. As such, the authors considered that these limitations might make interaction analysis systems useful for generating hypotheses but perhaps not for accounting for and explaining healthcare interactions holistically (Carter et al., 1982). Since the Roter interaction analysis system went on to become the dominant interaction analysis system for healthcare interactions, I will evaluate this approach further before moving on to discuss an alternative approach to the study of healthcare interactions.

An obvious strength of Roter's approach was that it got away from the generic categories of interaction process analysis to study distinct healthcare contexts such as oncology, end of life, and chronic conditions (Roter & Larson, 2002). However, the Roter interaction analysis system was considered to face a familiar problem, which was that coding healthcare interactions into pre-formulated categories produced data that missed the context of the interactions (Charon et al., 1994). Indeed, there is an argument to be made from the language and social interaction perspective that the Roter interaction analysis system also misses the sequential context of healthcare interactions, which is important for understanding how the verbal communicative acts fit together and shows transitions between speakers (Heritage & Maynard, 2006). The lack of contextual information might be considered a trade-off for the latitude to study different specialisms, but it also hints at a related issue. Namely, that the Roter interaction analysis system might not capture all relevant elements of action or phenomena in healthcare interactions. For instance, in a study of disclosure and informed consent, the authors remarked that the Roter interaction analysis system only accounted for the content that the chosen codes can account for (Hlubocky et al., 2018). The results of Roter interaction analysis systems research were therefore suggested as likely to be highly specific but not particularly sensitive to the totality of the phenomena being coded.

By this point in time, interaction systems research had become well established for the study of face-to-face interaction. Subsequent researchers had developed the methods beyond the limited set of categories and meanings that Bales initially proposed. We had also begun to see the types of interactions studied broaden out to healthcare interactions where it provided valued findings about patient satisfaction and compliance (Korsch & Negrete, 1972). Moreover, rather than persist with Bales' (1950) more generic categories, researchers were developing their own specific alternatives to attempt better fit with their chosen interactional context and finding success (Roter, 1977). There were limitations, however, and chief among these was the use of prespecified categories that constrain the interactive behaviour by forcing it into a set of narrow categories with limited meanings (Psathas, 1995, p. 3). In addition, there was an argument made that interaction systems approaches struggled with the specificity of healthcare interactions, and more broadly prioritised frequency of conduct over exploration of less frequent but potentially insightful behaviours (Inui et al., 1982). With this evaluation of interaction systems approaches to healthcare interaction complete, the next section will cover the markedly different approach taken by critical interaction analysts.

2.2 Critical interaction analysis and the study of healthcare interactions

Another stream of research investigating practitioner-patient interaction also sought to address perceived problems with practitioner communication. Critical interaction analysts sustained the interest in social systems and structures such as was found in the work of Parsons (1951) and Bales (1950), but they set out to explain how these structures and systems could shape healthcare interactions. These researchers were interested in such issues as structural imbalance of power and degrees of participation that might diminish the patient's role and voice in their healthcare appointments. As such, their approach to researching healthcare interactions was distinctly different and not just for its critical agenda. For one, researchers eschewed the idea of systematically coding the interactions in favour of increased focus on verbal conduct and propositional content. There was no predefined set of categories to try and fit the varied range of face-to-face conduct into, but rather considerations of what structural or ideological features might be shaping or unfolding in the interaction. Whereas traditional interaction systems research could typically be considered to neglect the rich contextual information parties bring to healthcare encounters, except for the Roter interaction analysis system, critical interaction analysts consider context and interaction inseparable.

2.2.1 The voice of the patient and the biomedical practitioner

A concern that would spark a distinctly critical view of and approach to health and healthcare encounters was the medicalisation of society, including the concept of health itself (Illich, 1975). By medicalisation, these authors meant that the problems which individuals faced were increasingly met with therapeutic or pharmaceutical solutions (Illich, 1975; Waitzkin, 1984). The argument, here, was that in a similar manner to the sick role foregrounding the concepts of unmotivated deviance and societal roles (Parsons, 1951), social control by way of an ideology of economic production was produced and reproduced in medicalised health (Waitzkin, 1984). Indeed, the case was made that even healthcare encounters were subject to the medicalisation of health. That is, that patients' issues, which might arise from their social, structural, or personal situation were side-lined by a problem-solving approach to medical care that focused on biomedical solutions to return patients to their societal role (Illich, 1975; Waitzkin, 1979, 1984). Although this view did not become the mainstream position in the 1970s and 80s, it did contribute to a bold and critical movement that would investigate and critique healthcare approaches and encounters. This critical streak becomes quite clear when we consider that two key figures who I discuss in this section were activists as well as academics and practitioners. One of the two was a frequent proponent of Marxist critiques of health and healthcare encounters (Waitzkin, 1978, 1981), and ideology and power were therefore both fixtures in the critical approach to healthcare and its accompanying programme of critical analysis.

One of the clearest demonstrations of this critical analysis, focused on the problematizing presence of social structural context, came from Elliot Mishler. Mishler was an academic, psychiatrist, and activist at Harvard Medical School. In his influential book *The Discourse of Medicine* (Mishler, 1984) Mishler performed qualitative microanalysis on audio recordings of practitioner-patient interactions and subsequently characterised patients' and practitioners' agendas as distinct and often oppositional. Although patients and practitioners both exist in social contexts, only patients drew on and made available their lifeworld agenda of daily concerns. Conversely, practitioners stuck to a biomedical agenda that was concerned with technical problems of diagnosis and treatment (Mishler, 1984). Practitioner-patient interactions were therefore considered to be observably asymmetrical, as patients sought to involve their lifeworld concerns while practitioners pursued biomedical agendas towards technical problem-solving without meaningfully involving a patient's lifeworld perspective. I am using the term lifeworld here in the sense that Mishler did, which is to mean the lifeworld of patients or their lives outside of the lens of the biomedical. The world that patients live and function in outside of the appointment with subjective issues not seen through the prism of medical outcomes and factors. Mishler wrote of practitioners as "applied bioscientists" (Mishler, 1984, p. 11) and compared healthcare interviews to physiology experiments. It was not just pursuing conflicting agendas that was problematic however, as Mishler called attention to the structural features of healthcare interviews. Structurally, practitioners controlled the power of the interaction through initiating a question, receiving a patient's response, and moving on to another question or topic (Mishler, 1984).

Mishler contended that the voice of the patient, and associated lifeworld concerns, were suppressed by the practitioner throughout the practitioner-patient interaction. Furthermore, in what were termed unremarkable interviews, Mishler argued that the structuring and control of the interaction by the practitioner frequently interrupted the patient and limited their ability to influence the interaction (Mishler, 1984). While the work was avowedly critical in nature, it was not criticism for the sake of criticism, and *The Discourse of Medicine* (Mishler, 1984) contained suggestions for addressing these perceived problems. Furthermore, these suggestions would concern the actual interactions between practitioners and patients. The biggest suggestion made was that practitioners negotiate with patients to share the power more equally in the interaction. In turn, a key recommendation for reducing the power imbalance was to translate the biomedical into terms more amenable to patients' lifeworld perspectives (Mishler, 1984). In addition, suggestions that would become fairly common practice such as trying to ask open-ended questions and engaging in active and sustained listening were also made.

2.2.2 Ideology, power, and healthcare interactions as social control

Mishler was not alone in his argument that that practitioners both held and withheld the power in healthcare interactions. Howard Waitzkin, a physician, and sociologist also working in the USA, undertook a review of social sciences literature and concluded that practitioner-patient information giving was problematic (Waitzkin, 1985). Waitzkin contended that practitioners often underestimated patients' desire for information and therefore gave information in a highly controlled manner. Subsequently, two hypotheses were proposed with the first being that practitioners might withhold information to preserve interactional power, and the second that sociolinguistic class differences could problematise information giving (Waitzkin, 1985). That is, Waitzkin (1985) theorised that practitioners could both produce and reproduce uncertainty in their patients by withholding the specialist information they had privileged access to and therefore remain in control of the interaction. Furthermore, Waitzkin (1985) theorised that social class difference, along sociolinguistic lines of language and social structure as relational, would be relevant for information giving. Sociolinguistic patterns of communication were observed, namely upper-class practitioners typically gave more information, and well-educated/upper-class patients received more information (Waitzkin, 1985). However, the results of the relationship between withholding information, [need for] power, and uncertainty were inconclusive (Waitzkin, 1985).

Waitzkin (1989) continued developing the critical analysis of practitioner-patient communication, emphasising the importance of social context and both its macro level structures and micro level interactions. This development progressed into the thesis that the structure of healthcare encounters, and practitioners' language therein, focused so fully on diagnostic concerns that patients' social contexts and related problems outside the primary concern were side-lined. Practitioners seek to make patients amenable to the social context again by adhering to a technical, biomedical handling of patients' problems; therefore, making patients feel sufficiently able to continue or return to their social role. We can see, here, that this notion echoes Parsons' sick role (1951), which is perhaps unsurprising since it presented a paternalistic relationship between practitioner and patient. Being avowedly critical in their analysis and reading of practitioner-patient interactions, it follows that Mishler and Waitzkin would problematise such a structured and seemingly paternalistic healthcare encounter.

In the critical approach, healthcare encounters are affected by ideological notions of the social context much like how social context is governed by macro level structures. For instance, Waitzkin summarised three transcripts of healthcare encounters and observed concerns rooted in contexts of ideology. The two male patients reported concerns with gainful employment and financial earnings, for example, while the female patient was concerned about their ability to perform household work (Waitzkin, 1989, p. 233). Healthcare encounters therefore echoed macro level structures of ideological social context with Waitzkin (1989) considering both mechanisms for social control. It is worth remarking that Waitzkin held a doctorate in sociology, had been a physician, and was an activist who co-published a book in 1974 called *The Exploitation of Illness in Capitalist Society* (Waitzkin & Waterman, 1974). Waitzkin and Waterman argued that Parson's (1951) Sick Role, discussed in section 1.1, was a mechanism of social control (Waitzkin & Waterman, 1974). As such, it is perhaps unsurprising that Waitzkin took an openly critical approach to the practitioner-patient interaction.

2.2.3 Evaluating critical interaction analysis

Waitzkin ultimately aimed for a “critical theory of discourse that could convincingly interpret what happens in medical encounters” (Waitzkin, 1991, p. XIV). Judged by the metric of establishing a critical interpretive theory, then, Waitzkin could be said to have succeeded. Theories of healthcare encounters are useful things to have at a general level, and this is also true for SDM and patients’ preferences. However, theories are frameworks and do not serve the same function as empirical observation and fine-grained analysis. As such, criticisms of the critical interaction analysis programme came from proponents of a radically empirical alternative. Language and social interaction researchers, interested in the way that speakers would organize interactions and accomplish actions therein, contended that invocations of ideology and grand social structures of societal control presented a problem of interpretation. These authors argued that critical interaction analysts proposed strong, quite determinist causal relationships between macro social structures and the micro-processes of healthcare interaction (Heritage and Maynard, 2006). Therefore, they claimed it was difficult to draw systematic conclusions or highlight routine generalisable features of practitioner-patient interaction (Heritage and Maynard, 2006). In turn, these studies were not necessarily considered to hold strong in the face of issues of representativeness, reactivity, reliability, and replicability that often pose challenges for qualitative social research (Katz, 1983, Mishler 1991).

Two particular and related issues with critical interaction analysis, concerning its theoretical and ideological commitments, were raised by language and social interaction researchers. The first issue was how critical interaction analysts used their data, which were naturalistic records of healthcare interactions as they happened. Language and social interaction researchers believe that naturalistic healthcare encounter data allows us to study the way that healthcare interactions, and their institutional business, are organized and accomplished locally and in situ by patients and practitioners (Drew et al., 2001). Much like an interaction systems approach, then, critical interaction analysts were also argued to be taking rich interactive data and seeking connections to preformulated concerns rather than investigating the interactions for their own insights about healthcare encounters. That is to say, the view from language and social interaction scholars was that novel insights about accomplishing actions in healthcare interactions or organising a smooth interaction were side-lined as the data was fitted to something a priori or theorised (Pilnick & Dingwall, 2011). In the case of critical interaction analysis, it was ideological notions of power structures (Waitzkin, 1984) and in interaction systems it was prespecified categories of behaviour (Bales, 1950).

The related analytic critique of the critical interaction analysis also concerned the way that the data was used, and the role of the critical perspective. Language and social interaction researchers posited that the systematic study of the local organisation of healthcare interactions would be more instructive than critical considerations of ideology and societal power (Schegloff, 1997). Approaching healthcare encounters and practitioner-patient interactions so critically raised the possibility that analysts might prioritise seeking for faults in practitioners' conduct (Pilnick & Dingwall, 2011). Chief among these concerns was an idea that practitioner-patient interactions might be cast as dominance contests with patients silenced by asymmetrically privileged practitioners without exploring the possibility of co-constructive yet asymmetric interactions (Sharrock, 1979). While caution over the extent that criticism should drive research is justifiable, it is not sufficient grounds to dismiss the work or approach wholesale. Therefore, it is necessary to reiterate that the critical interaction analysis research overviewed was empirical research working with real cases of healthcare encounters to perform fine-grained qualitative microanalysis. As such, it would be inaccurate to suggest that, for instance, the critical interaction analysis research amounted to mere criticism. Additionally, it is worth noting that this critique of openly critical approaches was not exclusive to studies of healthcare encounters and was the subject of debate between eminent language and social interaction scholars (Schegloff, 1997; Wetherell, 1998; Billig, 1999).

It is also worth noting that although these critiques and analyses are grouped under the term critical interaction analysis, it was not the case that the field at large used interaction analysis methods. Indeed, the concerns with ideology and social structures often lend themselves to theoretical or conceptual and polemical works such as *Limits to Medicine* (Illich, 1975). The work of Mishler (1984) and Waitzkin (1984) were both clearly uses of interaction analysis and both lent into the qualitative microanalysis tradition that will be the subject of the next section. When we couple the polemical nature of the focus on ideology and the tradition of qualitative microanalysis, then it follows that there were critiques from other interaction analysts within this tradition. There was a critique of the critical interaction analysis from within the tradition by one of its main proponents, however, as Waitzkin later remarked that there was an unspoken criterion of choosing content that would appear typical but also eye-catching and attention grabbing (Waitzkin, 1990). As such, there was an admission that this analysis might not have been entirely representative of the general tenor of the healthcare encounters recorded for the project. In the same paper, the related point that it is difficult to interpret the reliability, representativeness, and validity of these critical and qualitative microanalytic studies of healthcare interactions was made (Waitzkin, 1990). Therefore, while this work stimulated much exciting discussion and did provide both instructive findings and an insightful view of the workings of practitioner-patient interactions there was an awareness of some important limitations.

2.2.4 Considering an alternative approach to studying healthcare interactions

Interaction systems analysis and critical interaction analysis similarly aimed at addressing problems of practitioner-patient interactions. Both approaches produced interesting findings relevant to healthcare encounters and practitioner-patient interactions. Naturally, each approach also has limitations, which I have discussed previously, but they have enriched our understanding of healthcare encounters and interactions especially the dynamics of interactions. From the language and social interaction perspective that I use for this research, critical interaction analysts made an insightful contribution to the understanding of healthcare interactions by virtue of its fine-grained analysis of real healthcare encounters (Mishler, 1984; Waitzkin, 1984). This is to say little of the conceptual and polemical critique that posed difficult questions about practitioners and healthcare encounters. The critical position of this research set it apart from many of the alternatives despite it producing findings consistent with those in alternative approaches. For example, the broad similarities in Mishler's (1984) distinction between practitioners' biomedical agendas and patients' lifeworld agendas and the task-focused and socioemotional behaviour conceptual framework that Roter and Hall (1989) would propose. Despite the suggestion of a developing body of valid research evidence across approaches, there remained a belief among language and social interaction researchers that another distinct approach would make an additive contribution.

Among the various critiques, the two approaches were subject to two shared criticisms from language and social interaction researchers about how interaction data was used and the role of context in the analysis. Both approaches were argued to make limited use of their data, which was typically naturalistic or at least direct recordings of practitioner-patient interactions. For interaction analysis systems, the issue was that interactive behaviour had to be coded into preformulated categories, whether generic (Bales, 1950) or medical (Roter, 1977). Therefore, the unique conduct of a healthcare interaction became a decontextualised idealisation with no connection between context and conduct (Charon, 1994). In addition, the commitment to problem-solving (Bales, 1950) or patient outcomes (Roter, 1977) presupposed a focus or perspective that was not consistently borne out in the data (Heritage & Maynard, 2006). With critical interaction analysis the data was often used in its naturalistic form with analysis of verbatim transcript extracts (Mishler, 1984; Waitzkin, 1989), which was roughly in line with language and social interaction research.

That said, the perceived issue was that critical interaction analysts were not focusing on the analytically tractable concerns and conduct that parties produced. Rather, the argument was that a critical agenda and ideological apparatus was imposed upon and smothered the concerns and actions that patients and practitioners made observable in their interactive behaviour (Schegloff, 1997; Pilnick & Dingwall, 2011). The sense from language and social interaction researchers was that the two approaches were pitching at similar aims with less difference than one might otherwise assume. Indeed, Pilnick and Dingwall (2011) suggest that critical interaction analysts and interaction systems researchers pursued "complementary but analogous" (Pilnick & Dingwall, 2011, p. 1376) programmes of investigating problematic practitioner-patient communication. Both programmes were deemed to miss the local interactive work that might reveal insight about the organisation and accomplishment of healthcare encounters because they focused on preformulated categories or prior stipulations (Pilnick & Dingwall, 2011; Heritage & Maynard, 2006).

The role of context in the data was the second issue seized upon by language and social interaction researchers. For instance, the argument was made that interaction analysis systems missed the context of interactions by forcing the behaviour into prespecified categories (Charon et al., 1994). That said, the lack of certain specific contextual information might be argued to balance out against the ability to discriminate between healthcare specialities and account for their business (Roter & Larson, 2002). By contrast, critical interaction analysts were said to invoke macro level contexts of ideology and social control that might not be borne out in the fine-grained detail of the talk by language and social interaction researchers

(Schegloff, 1997; Heritage & Maynard, 2006). This criticism, however, reflects the specific and ultra-empirical character of conversation analysis, and is one that critical analysts would certainly refute. Indeed, even within the tradition of language and social interaction research there are avowedly critical positions such as critical discursive psychology (Parker, 2002) and positions that argue for a synthesis of more critical and radically empirical approaches (Wetherell, 1998). As such and considering the insightful contributions that these approaches have made to the study of healthcare interactions and encounters, it is evident that there is not a singular approach to context that should be endorsed above others.

To date, interaction systems approaches had revealed instructive findings about patient satisfaction and compliance (Korsch & Negrete, 1972; Roter, 1977). As for critical interaction analysts, they had characterised tensions between the agendas of patients and practitioners (Mishler, 1984). However, there was still space for a radically empirical approach to the study of healthcare interactions. As such, a tradition of language and social interaction researchers went on to pursue another distinctive research agenda of qualitative microanalysis. This aim of this agenda was to bracket off issues of ideology, social structural theories, and categorical coding to focus on the local interactive work of patients and practitioners. This approach would be one that worked with both the specific context that interlocutors made relevant for that interaction (Goodwin & Duranti, 1992) and the institutional context of a healthcare encounter. Therefore, the research would investigate the concerns that patients and practitioners made relevant and the actions they could be observed as doing in the verbal exchanges. Since I have reported critiques from within these traditions earlier and wish to set up my own discursive psychological approach, this section detailed the perceived contribution that a language and social interaction approach might make prior to overviewing relevant literature.

2.3 The study of language and social interaction

This alternative approach, focusing on interactions as practical accomplishments of reasoning practically, is the language and social interaction approach. There are several approaches to language and social interaction research, but the two most relevant for my research are discursive psychology and conversation analysis. To provide an overview of the study of healthcare interactions this section focuses on conversation analysis, which was established before discursive psychology and has generated more research on healthcare interactions. Examples of discursive psychology studies are scarce, and the coverage of discursive psychology will primarily be confined to considering the additive value of studying healthcare interactions with discursive psychology. The case for using discursive psychology over conversation analysis will be made at the conclusion of this literature review where I can relate it to the extant conversation analytic literature. A more thorough account of both conversation analysis and discursive psychology will follow in chapter 3, where I discuss my methodological and analytical framework. I will begin this section proper by briefly overviewing conversation analysis in the following few paragraphs.

Conversation analysis is a qualitative approach to the study of human social interaction focusing primarily on the use of language for accomplishing social action and producing and maintaining social order (Sacks, 1992; Hoey & Kendrick, 2017). The development of conversation analysis derived from Harold Garfinkel's (1967) ethnomethodological thinking, which was concerned with how individuals employed common-sense knowledge and practical reasoning to both order social life and render it intelligible through situated practices. Conversation analysis took the ethnomethodological notion of social order as produced locally and in situ by members, by which he meant interlocutors, and aimed to demonstrate that social interactions concerned members producing "order at all points" (Sacks, 1992, vol. 1, p. 484). Members produce order at all points, so that interactions might exhibit this order and therefore be understood as ordered. Members are required to accomplish certain conditions in interactions and therefore interactions need to be ordered to permit members these accomplishments (Sacks, 1992, vol. 1, p. 485). Indeed, authors within this tradition argued that a "focus on practical reasoning emphasizes that members are - as a condition of their competence - rendering scenes intelligible, reasonable and accountable, that their world is a constant doing and achieving" (Turner, 1974, p. 10). As such, the approach that would seek to demonstrate order at all points, would have to be one that was constantly attuned to the production and reproduction of order in social interactions.

Harvey Sacks, and his colleagues Emanuel Schegloff and Gail Jefferson, developed conversation analysis from these ethnomethodological origins, and Sacks wished to understand "how activities get done methodically and reproducibly" (Schegloff, 1992, p XVII). Conversation analysis therefore developed an analysis of members' situated practices, practical reasoning, and inferences from available adequacies for producing and recognising intelligible social action (Goodwin & Heritage, 1990, p. 287). Sacks realised that records of talk-in-interaction such as recordings of calls to a suicide prevention centre afforded the study of "rules of conversational sequences" (Sacks, 1992, vol. 1, p. 3). It was through careful investigation of these rules that Sacks began to illustrate methodical and reproducible procedures whereby members employed specific practices to produce recognisable action (Sidnell, 2013). Sacks came to see that what one member said was responsive to what another had said previously, or that an action was responsive to a prior action. For example, beginning with hello would occasion another hello, with greetings therefore being actions responsive to other greetings (Sacks, 1992, vol. 1, p. 4).

Sacks', and his colleagues Emanuel Schegloff and Gail Jefferson' insight was that talk-in-interaction was organized by a turn-taking system, wherein "overwhelmingly, one party talks at a time" (Sacks, Schegloff, & Jefferson, 1974, p. 699). Interlocutors oriented to the turn-taking system to conduct intelligible interactions that accomplished actions and displayed orderliness. The turn-taking system (Sacks et al., 1974) described and characterised a systematics that demonstrated Sacks' claim of interactions not only exhibiting "order at all points" (Sacks, 1992, vol. 1, p. 484) but an order that members' constantly accomplish and orient to. The turn-taking system functions to allocate turns at talk, coordinating speakers towards orderly talk-in-interaction through completed turns at talk and places where speaker change can occur (Hoey & Kendrick, 2017). From this, conversation analysis developed its line of analysis towards the systematics of organization of social interaction and talk-in-interaction. Guided by the question of "why that now" (Schegloff & Sacks, 1973, p. 299), conversation analysts sought to identify, describe, and characterise the structure of talk-in-interaction as something orderly and mutually intelligible wherein members would demonstrate their understanding of this structure and its practices.

In addition to taking turns at talk, turns are sequentially organized, so that one turn or action makes a responsive second turn or action conditionally relevant and noticeable when absent (Schegloff, 1968, 2007). To accomplish action, speakers design their turns to project the recognisable second action such as requesting information with interrogatively formatted turns (Hoey & Kendrick, 2017). Particularly relevant for understanding, is the notion of repair, which is when speakers address breakdowns in intersubjectivity, and potential halting progressivity. A speaker can self-repair and address their own trouble in the production of their turn or another speaker can project difficulty with a turn and make relevant the action of repairing the breakdown (Gardner, 2008, p. 274). Conversation analysis therefore embodies an analysis whereby considering prior turns at talk, their projections, and speaker uptake one can investigate “the organization of action and… understanding in interaction” (Goodwin & Heritage, 1990, p. 288). These preceding paragraphs are a gloss and a thorough treatment of conversation analysis, the particulars of its application to institutions, and its relation to the chosen methodology of discursive psychology will follow in chapter three. In addition, it is useful to restate that discursive psychology receives less focus in this chapter because the institutional study of healthcare interactions has largely been dominated by conversation analysis.

2.3.1 Language and social interaction studies of healthcare interactions

Conversation analysis continued to develop research into “the organization of action and… understanding in interaction” (Goodwin & Heritage, 1990, p. 288). Concurrently, studies of social interaction in institutions were developing in observational (practitioner-patient communication, Byrne & Long 1976; Strong, 1979) and ethnomethodological (therapy, Turner, 1972; Wootton, 1977, and psychiatry; Coulter, 1973) research. By the end of the 1970s conversation analysis made its first foray into institutional social interaction (courtroom; Atkinson & Drew, 1979) and by the 1990s institutions had become a distinct component of the conversation analysis research programme (Drew & Heritage, 1992). Interests in the production and maintenance of social order, the use of language for accomplishing action, and the role of language in mutual understanding remained. This interest was supplemented by interest in identifying and characterising how the specific business of institutions was accomplished through social interaction and both if and how members orient to the institution as the specialised context wherein the interaction occurs and for the identities particular to the institutions (Gill & Roberts, 2013). Taken together, the main programme of conversation analysis, the interest in applying conversation analysis to institutional interaction, and the observational and ethnomethodological research investigating healthcare interactions spurred conversation analysts towards studying healthcare interaction.

The increase in specificity from institutional interactions to healthcare interactions generated a strand of medical conversation analysis (Gill & Roberts, 2013). The broad project of medical conversation analysis is to describe and characterise how practitioner-patient interactions are organized to provide a structure of produced orderliness, and how interaction sequences therein are organized to render recognisable medical business as intelligible in interactions. Robinson (2003) proposed, described, and characterised an overarching structure of social action wherein (a), a medical problem is established, (b), practitioners gather further information, (c), diagnosis is delivered, and (d), treatment is recommended (p. 30). Robinson (2003) argued that when presenting new problems, this structure functions to organize practitioner-patient interactions through the contingent progression of each sequential activity. For example, diagnosis requires sufficient information and is therefore contingent on gathering information, which is contingent on establishing patient's problem (Robinson, 2003, p. 47). Relatedly, patient participation and conceptions of asymmetric practitioner-patient interactions, is accounted for by "actions, activities, and projects of activities, and their constitutive relevancies" (Robinson, 2003, p. 51). Robinson and Heritage (2005) investigated problem presentation and observed a normative order to which practitioners and patients both oriented. Particularly, patients oriented to current symptoms as both necessary for presenting problems and transitioning to gathering information. Practitioners also oriented to current symptoms as transition-relevant by moving immediately to information gathering from current symptom presentation (Robinson & Heritage, 2005).

There are also actions and practices that members produce, which are consequential for the organization and therefore orderliness of practitioner-patient interactions. For example, the format of an opening question can occasion a response that henceforth shapes the sequential unfolding of the interaction. Heritage and Robinson (2006) distinguish between general-inquiry and confirmatory opening questions; with general-inquiry questions associated with longer and more detailed problem presentations. A study of an intervention to reduce patients' unmet concerns found that using the word "some" rather than "any" when asking patients "Do you have some/any other concerns you want to address today?" addressed up to 75% of patients' reported unaddressed concerns while "any" did not routinely address unaddressed concerns (Heritage et al., 2007). The negative polarity of "any" might impede the production of unaddressed problems. (Heritage et al., 2007). Robinson and Heritage (2016) studied up-front agenda setting, a communication skill designed to elicit exhaustive accounts of patients' concerns (Brock et al., 2011). Strikingly, Robinson and Heritage (2016) demonstrated that patients oriented to this practice as enquiring after new problems rather than exhaustive accounts of concerns. It is argued that because up-front agenda setting was produced adjacent to problem elicitation and presentation, the sequential position implicates further new problem discussion (Robinson & Heritage, 2016).

At this point it is worth considering how conversation analysis, as a representative of the language and social interaction approach, fares compared to the approaches previously covered. With interaction analysis systems there was much gleaned about the impact that communication styles and aspects of interaction had on patient outcomes, which were very useful for appraising practitioner communication (Korsch & Negrete, 1972; Roter, 1977). Furthermore, the Roter interaction analysis system became a powerful tool for healthcare communication intervention research (Joo et al., 2018), which had clear links to suggestions for practical improvements in the delivery of healthcare encounters. By contrast, conversation analysis studies tend to infrequently focus on interventions as the fine-grained qualitative microanalysis tends to forego the statistical analysis involved in establishing the strength of a relationship. Indeed, there would need to be a combination of a language and social interaction approach and an experimental or statistical one to accomplish such an aim (de Ruiter & Albert, 2017). As has hopefully started to become clear from this brief account of conversation analysis, its strengths lie more in the realm of identifying patterns, structures, and domains of organization (Schegloff, 2007).

Many of the concerns and foci of critical interaction analysis are outside of conversation analysis and discursive psychology’s remit as a result. While language and social interaction and critical interaction analysis can share the use of qualitative microanalysis, they put this analysis to distinct uses. My focus, for instance, could not easily answer questions about the role of social structures or the use of social control through ideological reproduction (Waitzkin, 1991). There may be opportunities to discuss the “voice of the patient” (Mishler, 1984) where it is seen to be borne out in the fine-grained analysis of talk, but it would not form a primary research question. In turn, the choice of language and social interaction is a decision to use one insightful but specific approach to the study of healthcare interactions. I decided that at this stage it was more useful to attempt to identify and characterise patients’ preferences as constructions (Elwyn & Miron-Shatz, 2010) and the interactive consequences of construction empirically before attempting intervention or critical studies.

2.4 Language and social interaction studies of decision-making

2.4.1 Elements of decision-making

There has been lots of language and social interaction research into some of the features of SDM with the following key aspects: Elements of decision-making, approaches to decision-making, decision-making practices, and patients' preferences. Before proceeding with the overview, I wish to note that in this section I use the term language and social interaction research to refer primarily to conversation analysis and discursive psychology; although it is possible to consider other strands of this approach such as critical discourse analysis. I do not refer to the Roter interaction analysis system, as this remains an interaction process analysis system, nor critical interaction analysis, as this does not have the grounding in ethnomethodology and ordinary language philosophy of most language and social interaction approaches.

A systematic review of language and social interaction studies of decision-making in healthcare encounters derived four decision-making elements and thirteen corresponding communication practices (Land et al., 2017). Decision-making elements were broaching decision-making, putting forward a course of action, committing or not (to the action put forward), and healthcare professionals' responses to patients' resistance or withholding of commitment (Land et al., 2017). Broadly, broaching practices were decision-relevant such as indicating a commitment point, eliciting patients' perspectives or preferences, or patients' disclosing a preferred treatment. Putting forward a course of action was the commitment point and made committing to or avoiding commitment relevant (Land et al., 2017). Typically, practitioners proposed one treatment option to reach commitment points. Even where only one option is feasible, single options were usually taken as being endorsed by that practitioner. Practitioners could also recommend against a treatment or list the options available to the patient. Upon reaching the commitment point, patients' next actions include committing, passively resisting by withholding commitment, or actively resisting treatment proposals (Land et al., 2017). If patients resist, practitioners can pursue commitment, with or without engaging with patients' stated issues; can modify or propose an alternative course of action; or can defer the commitment point to a future appointment. As such, patients can exert sufficient influence on the interactions as to prompt the practitioner to propose an alternative, even if it is only the option of declination or an equivalent course of action (Land et al., 2017).

The review scanned nine electronic databases and performed citation tracking to collect 5535 candidate publications, but only 28 publications met the stringent criteria for inclusion after screening (Land et al., 2017). As with chapter 1, it is worth acknowledging the Anglo-centric nature of the work being reported, as the studies reviewed were from North America, the United Kingdom, and Australia. The authors, however, admit that they had to exclude relevant quality works from other countries due to the focus on English language data (Land et al., 2017). This Anglo-centric perspective perhaps reflects a preponderance of English data in conversation analysis and discursive psychology, an issue discussed by some alongside the emphasis on classic data (Hoey & Raymond, 2018). Since there were 28 publications in total, we might express some caution as to how established we view the elements and the practices reported. Moreover, the publications concerned various illnesses or conditions and different healthcare settings, so it would not be straightforward to confidently establish the proposed framework. There is a distinct advantage, however, when we compare these findings to the majority of the SDM models discussed in chapter one, as the publications and their data are grounded in empirical observation and fine-grained analysis of real healthcare encounters and interactions. This empirical basis is present in the Implement-SDM model (Joseph-Williams et al., 2019) but less prominent or prevalent in others.

It is insightful, then, to compare the distinct ways in which elements of decision-making, as reported here, and models of SDM, in chapter 1, differ. For instance, the revised three talk model (Elwyn et al., 2017) has three stages of talk; team talk, option talk, and decision talk. The review findings focus more tightly on the mechanics of decision-making and an increasingly granular set of small but significant communicative practices. In turn, the authors propose more of a taxonomy that might inform or be adapted into a model of SDM and or practice. We see in the three talk model that the communicative practices are broader, and the focus is on a succinct model for clinical practice. Arguably, these two distinct approaches are getting at differing levels of granularity and therefore adding colour to different aspects of our understanding of SDM. The Implement-SDM model (Joseph-Williams et al., 2019), by contrast, sits between the two, appearing closer to the review findings due to its emergence from empirical work. Of course, the focus on the function of talk-in-interaction casts a distinct spotlight on the practices of communication in Land and colleagues' (2017) review. That said, the focus on observations of practice and its appeal to both greater complexity of SDM and variability of stages in situ share more in common with the review findings than previous models of SDM.

2.4.2 Approaches to decision-making

Another influential factor in decision-making that has been revealed by conversation analytic work is the approach that practitioners take to appointments. In a study that looked at oncology and diabetes consultations, practitioners were seen to approach decision-making on a continuum that spanned from more unilateral to more bilateral (Collins et al., 2005). Unilateral decision-making elides patient involvement, avoids patient contributions, and eschews patients' perspectives or discussions. Bilateral approaches, however, are contingent on patient involvement and build patients' perspectives and contributions into decision-making sequences (Collins, et al., 2005). Sequentially, bilateral decision-making provides interactional space and slots for patient responses not found in unilateral approaches. Bilateral decision-making is amenable to negotiation and considering both the medical necessity of treatment and the patient's perspective, while unilateral decision-making invokes medical necessity, precludes negotiation, and makes acceptance or declination relevant (Collins et al., 2005). Furthermore, the authors reported that approaches differed between settings, as ear nose and throat cancer consultations featured more unilateral decision-making approaches than diabetes consultations. A unilateral approach would be led entirely by the practitioner and as such would likely omit doing nothing from treatment recommendations, as that option could pose more risk than curative treatment. Despite bilateral approaches encouraging patient involvement, patients participated minimally in decision-making across the dataset (Collins et al., 2005).

Aspects of Collins and colleagues' (2005) broad typology of approaches to decision-making have been replicated elsewhere. In a study of primary care consultations for upper respiratory tract infections in Finnish municipal health centres, the authors primarily observed variations of unilateral approaches (Ijas-Kallio et al., 2010). Patients typically responded minimally or were occasionally silent around accepting recommendations but neither response impeded progressivity. Patients sometimes produced extended responses, such as positive assessments or negotiation initiations however, and these were often consequential. For instance, patients' positive assessments were seen to gloss decision-making sequences as more bilateral by virtue of including patients' perspectives and co-implicating patients in diagnostic reasoning (Ijas-Kallio et al., 2010). Initiating a negotiation sequence halted the appointment progress and deferred the decision-making point. Patients would, for instance, request further information and in turn exert their right to evaluate how acceptable treatment recommendations were. Although it was not overwhelmingly prevalent, there were occasions where negotiation sequences prompted re-evaluations of treatment recommendations by practitioners (Ijas-Kallio et al., 2010). One point worth considering, however, is that the unilateral-bilateral typology might look different depending on contextual variation. For instance, a study of antenatal screening in Hong Kong not only found that doing nothing was a viable option but that the patient might often be seen as a unilateral decision maker (Pilnick & Zayts, 2016).

2.4.3 Decision-making practices: Epistemic and deontic authority

Having overviewed the significance of the way that practitioners approach decision-making more broadly, language and social interaction research would proceed to remark on the decision-making practices that practitioners can draw on. In studying outpatient neurology, practitioners were broadly seen to use two formats to recommend treatments; either as an explicitly limited single recommendation or listing a menu of available options were seen as practitioners' common formats (Toerien et al., 2011). However, a spectrum of openness suggested that option lists can be designed and delivered as functionally comparable to single recommendations. This means that practitioners can exclude possible options, make clear that that they prefer a particular option, or describe options in a way that undermines them (Toerien et al., 2011). Despite scope for designing and delivering option lists as functionally comparable to single recommendations, they remain different formats with distinct interactional consequences. Of the two formats, recommending makes accepting or declining the relevant next action for a patient, while option listing makes the selection of an option by the patient relevant (Toerien et al., 2013).

In option listing, practitioners diminish their epistemic authority, or right to knowledge, by formulating a claim about available rather than advisable options. Therefore, there is interactional space for choice, an interactional slot to put forward one's preference, relative epistemic equivalence for choosing, and an open-ended decision-making slot (Toerien et al., 2013). In turn, patients need not perform potentially delicate actions such as rejecting a practitioner-preferred option or challenging practitioners' epistemic authority. Patients, then, have interactional space for decision-making participation that treatment recommendations constrain (Toerien et al., 2013). Interactional devices that occasion reductions in practitioners' authority whether epistemic or deontic, meaning the right to decide, are significant because treatment recommendations in the UK and the US are most frequently pronounced to patients (Stivers et al., 2017). Pronouncements stand alone among recommendation formats such as suggestions, proposals, offers, and assertions because they relinquish neither practitioners' epistemic nor deontic authority (Stivers et al., 2017). We might consider, then, that while offering patients options is an essential element of SDM (Makoul & Clayman, 2006) its interactional constitution can be hugely consequential for the functions and work it accomplishes. Indeed, the interactive consequences of treatment recommendations go beyond the formats that practitioners use to the ways that practitioners formulate and lead up to them.

Continuing to consider the possible role of deontic authority in decision-making means considering the ways that it might be interwoven with medical advice. For instance, findings from oncology consultations report a pattern whereby oncologists move from delivering diagnosis to recommending treatment (Fatigante et al., 2016). Whether diagnostic tests were ongoing, or results were conclusive, oncologists presented diagnostic information and the possible treatment options before advising a treatment option, therefore formulating it as logically consequential from the available diagnosis (Fatigante et al., 2016). Patients are therefore positioned as recipients of a logically informed recommendation and this constrains them by not affording interactional space for co-constructing treatment recommendations (Fatigante et al., 2016). We saw in Toerien et al.'s (2013) study how the epistemic asymmetry of a recommendation and its acceptance or declination dynamic similarly constrained patients. Further work identified how formulations of risk in treatment recommendations can shape decision-making (Alby et al., 2017). Oncologists formulated treatment recommendations as mandatory when recurrence risk, as stated by the oncologists in the interaction, was high, and as optional when recurrence risk was low (Alby et al., 2017).

In these cases, the oncologist would produce an utterance pertaining to recurrence or perhaps precautionary treatment (Alby et al., 2017, p. 1428). When a mandatory formulation of a recommendation was used, oncologists gave advice after diagnostic assessment, whereas advice preceded diagnostic assessment in optional recommendations (Alby et al., 2017). In mandatory cases patients had interactional slots for involvement but were pressured to accept or decline in situ whereas optional cases provided no slots for involvement but left patients to make choices autonomously (Alby et al., 2017). Therefore, risk formulations in recommendations were consequential for patient choice and patient involvement. In addition to presenting a treatment option as recommended (Toerien et al., 2011, 2013), a practitioner can also formulate this as mandatory and further constrain patients' involvement (Alby et al., 2017). At a similarly basic level the move from diagnosis to recommendation made an asymmetry of knowledge and authority relevant (Fatigante et al., 2016).

One of the most relevant notions of patient involvement for treatment decisions is resistance. Broadly speaking, treatment appointments are oriented to progressivity, with a view to acceptance on the way to deciding (Koenig, 2011). If one accepts an orientation to accepting a treatment recommendation as being necessary for progression to decision-making, then it is possible to consider resistance an agentic action (Koenig, 2011). When a patient resists a treatment recommendation, they halt progression towards a decision and open space for their own participation in negotiating which options are acceptable (Koenig, 2011, p. 1112). As such, we see that a normative expectation of patients accepting recommendations exists, but resisting these recommendations is a resource for patients to negotiate the option endorsed (Koenig, 2011). Similar action has been observed in paediatric healthcare encounters where resistance opens both a space and opportunity for patients or parents to negotiate treatment options (Stivers, 2006).

A key feature of language and social interaction findings is that they tend to concern generic or reproducible actions, as we can see with resistance in Stivers (2006), and Koenig's (2011) works. The significance of these negotiation sequences in paediatrics, then, is that patients and practitioners orient to them as a negotiation of resistance and acceptance respectively (Stivers, 2006; Koenig, 2011). This observation of resistance as an agentic action had also been observed in oncology and general medicine contexts. Costello and Roberts (2001) reported that patients resisted treatment recommendations via interactive actions such as silence, delaying responses, and minimal uptake. While resistance prompted negotiation in both contexts, treatment recommendations were only reformulated in general medicine consultations (Costello & Roberts, 2001). As such, resistance is not normatively tied to reformulation, but resistance is a resource for patients constrained by treatment recommendations that may open a negotiation sequence. Another example, then, of the complex interactional work involved in what might otherwise appear as an unremarkable aspect of the process of negotiation towards a decision.

To take stock of the coverage so far, the language and social interaction literature has built on the groundwork laid by the research programmes of interaction analysis systems and critical interaction analysis. For one, the systematic review of language and social interaction studies that revealed four decision-making elements and thirteen communication practices provided empirically grounded alternatives to our more conceptual models of SDM (Land et al., 2017). Additionally, we have seen evidence of distinct approaches to decision-making from practitioners and the specific interactional opportunities they afford patients in two countries (Collins et al., 2005; Ijas-Kalio et al., 2010). Relatedly, the insights about the distinct effect of listing options as opposed to recommending a treatment option and the interactional constraints and obligations they impose on patients is pertinent to our understanding of SDM (Toerien et al., 2011, 2013). That said, how patients frame and construct their preferences, an increasingly important part of SDM, is less intensively studied. In turn, the next section will overview the small but insightful number of language and social interaction studies that have investigated patients' preferences in situ.

2.5 Patients' preferences in decision-making appointments

A small number of analysts have investigated how discussions around patients' preferences are involved in the negotiation of treatment decision-making. In particular, the way that the respective rights to knowledge and deciding were negotiated around patients' preferences; and the ways that practitioners could paraphrase patients to encourage or challenge preferences. The following sub-section first reports on the interplay of epistemic and deontic rights relative to decision making and preferred treatment options first and then the ways that practitioners can respond to patients' preferences.

One of the dynamics that is crucial to SDM is the balance between knowledge and determination. Indeed, the interplay between epistemic and deontic authority, or alternatively, the right to knowledge (Heritage, 2012a, 2012b) and right to determination (Stevanovic,

2013) has been reported as interwoven with the production of sharedness in decision-making (Landmark, Gulbrandsen, & Svennevig, 2015). Deontic authority and responsibility for the decision were ascribed to the party whose epistemic authority was glossed as most relevant. In a way, we might consider the negotiation of deontic authority comparable to Collins and colleagues' (2005) continuum of unilateral to bilateral decision-making approaches. At the unilateral end, one party has complete deontic or decisional authority, while at the bilateral end this authority might be shared where appropriate.

For instance, in a study of Norwegian secondary care appointments the authors reported that the patient had deontic authority where preference and experience were seen as most relevant, and the practitioner when biomedical knowledge was most relevant (Landmark et al., 2015). Deontic and epistemic authority are types of authority that are primarily locally constructed in the interaction by speakers, rather than social forces that certain speakers carry with them. For instance, while we might presume that the practitioner automatically carries epistemic authority in a treatment appointment, the linguistic and discursive resources for constructing a claim to epistemic authority are equally available to patients. Deontic authority is particularly important for decision-making because it can ultimately relate to the party who gets to make the decision.

Patients often oriented to practitioners' epistemic authority as a way of diminishing their claim to deontic authority, citing insufficient or inferior knowledge bases to make such decisions. A prior study by Stevanovic (2012) observed that individuals could project insufficient access to specialist knowledge to avoid decisional responsibility for a joint decision. This was particularly evident when patients were ascribed deontic authority based on their previously stated preference, but they in fact oriented to the practitioner's superior biomedical knowledge and by extension right to determine (Landmark et al., 2015). By contrast, when the patient had deontic rights to an option that they did not prefer but the practitioner did, they provided partial agreement contingent on the practitioner ultimately making the decision (Landmark et al., 2015). As such, despite being offered the right to decide on treatment options, patients often relinquished this authority and did so by invoking and interweaving the respective epistemic and deontic authority of the practitioner.

Deontic authority was also relevant for how practitioners formulated treatment recommendations; and whether these were proposed as possibilities or necessities. For necessities practitioners strongly indexed their deontic authority to the decision while this was relaxed and turned over to the patient in the case of possibilities (Landmark et al., 2015). Notably, also, every presentation of an option in Landmark and colleagues' data was as either possibility or necessity. We can see, then, that deontic authority was mobilised as a decision-making resource by patient and practitioner alike in service of decision-making. With the historical move towards SDM, it is perhaps surprising that patients were observed to forego their rights to determination.

Practitioners were observed to elicit patients' preferences by formulating hypothetical preferences and treatment proposals (e.g., "if you think X, we can do Y"; Landmark, Ofstad, & Svennevig, 2017). Broadly, practitioners were observed to produce positively, negatively, and neutrally formulated hypotheses. These hypothetical formulations were typically produced when a treatment recommendation had been made but the patient had not accepted. If a practitioner was to formulate a hypothetical stance that went against their preferred option, then it was framed negatively. For instance, the practitioner might frame not waiting for a development negatively by characterising the patient as impatient in a formulation such as the following "but if you are very impatient, then I can't say to you that you can't have a baby" (Landmark et al., 2017, p. 2084). In turn, the option is available to the patient, but the practitioner has presented it negatively and potentially undermined the option. By contrast, when practitioners produced a hypothetical stance about their preferred option, they did so in positive terms. For example, waiting to check a blood test was framed as a demonstration of the patient's patience, and requiring only "a ↑bit of patience" (Landmark et al., 2017, p. 2084). Notably, this formulation featured a negative interrogative, which is significant because speakers have been shown to treat negative interrogatives such as "can't you" similarly to assertions rather than a traditional questioning interrogative (Heritage, 2002). As such, we can see the practitioners actively pursued acceptance of their preferred option in positive formulations and engaged in delegitimization with negative formulations in this study (Landmark et al., 2017).

Whether positively or negatively framed, practitioners' hypothetical formulations about patients' preferences were designed for preference elicitation (Landmark et al., 2017). That said, both positive and negative formulations pursued acceptance of practitioners' preferred options and constrained patients' involvement. Indeed, while hypothetical preference stances were ostensibly about an important aspect of SDM (Charles et al., 1997, 1999; Elwyn et al., 2012, 2017) they posited predetermined options for patients to accept or reject in practice. Perhaps unsurprisingly, considering the pressure to accept, undermining of alternative options, and interactional constraints, patients often produced non-committal responses (Landmark et al., 2017). This finding, then, is an instructive example of the disparity between a theoretical notion such as preference elicitation and the interactive in situ work that can be missed by standardised notions taken at face value. More specifically, Landmark and colleagues' work (2017) demonstrated what the disparity between the theoretical notion and the actual interactive work looked like in practice. This is an important clarification because a coding scheme would not uncover a disparity between attempting to elicit preferences and the lack of positive engagement on behalf of patients. As such, it was the fine-grained analysis of practitioners' interactive work that revealed what that disparity entailed, which opens possibilities for addressing it in the future. Having discussed the language and social interaction research into patients' preferences, I will proceed to evaluate the language and social interaction research on healthcare interactions in the next section.

2.6 Evaluating language and social interaction research

As with the other approaches overviewed in this chapter, language and social interaction had both strengths and limitations. A trait that straddled the lines between strength and limitation was language and social interactions' obvious focus on description and characterisation. Whether conversation analysis or discursive psychology, the primary analytic focus was on identifying, describing, and characterising the interactive conduct and social actions of speakers. As such, this work has significant insight value and can be especially instructive when we consider the mechanics of the social interactions that underpin healthcare encounters. By the same token, however, the work has less immediate power for interventions or judgements on the wide scale effectiveness of an intervention. One might think of the language and social interaction approach as a crucial or primary first step in addressing problems or proposing solutions for problems with healthcare encounters and practitioner-patient interactions.

I say primary because when we study or discuss healthcare encounters, we are dealing with something real conducted through real social interactions between real people rather than something theoretical or contrived. There are of course exceptions, but typically the business of the healthcare encounter is largely accomplished through verbal and vocal interactions, between patients and practitioners. To clarify, I mean that while gestural and embodied conduct is relevant for these interactions, the decision-making work is primarily driven by words and vocal sounds. It is therefore necessary to produce a body of research that can identify the conduct produced and accomplished in healthcare encounters. Furthermore, to contribute to the explanation of this conduct by describing the accomplishment in situ by reference to fine-grained interactive and discursive work and characterising the structuring and organization of that conduct by the speakers. This ultra-empirical focus, then, is a clear advantage of the language and social interaction approach, but it does mean that for example, experimental studies of effectiveness (Roter, 1977) or comparative coding of predictive validity and explanatory power (Inui et al., 1982) would be outside the remit of this approach. We might consider, then, that the ultra-empirical focus of language and social interaction research narrows the lens to such an extent that other approaches would need to be recruited to take further steps towards outcome or intervention research.

A critique especially pertinent to the critical interaction analysis approach is the way that conversation analysis especially does not move beyond the fine-grained analysis of conversational organization (Schegloff, 2007). With a focus on what is made observable in the talk-in-interaction and having distinct proof procedures for analytic claims, conversation analysis does not engage in considerations outside of the text. Again, then, we have an example of the narrow focus that persists throughout conversation analysis. The narrow focus, and the way that conversation analysis positions this focus, has been subject of debate even within the language and social interaction approach. Other language and social interaction researchers who have used conversation analysis in some capacity remarked that while the method provides a fine-grained technical analysis, this does not necessarily mean a scholarly analysis (Wetherell, 1998).

For the ultra-empirical analysis, there is a sacrifice of broader theoretical considerations and social explanations alongside any discussion of identity and power that cannot be overwhelmingly grounded in the data as a concern or production of the speakers (Wetherell, 1998). Again, the avowedly technical focus allows the research to produce insightful and high-quality fine-grained analysis, but the limitations are clear. If we consider the critical interaction analysts, then the programme they are engaged in has similarly qualitative microanalysis but also the addition of engagement with theoretical and ideological issues.

Indeed, if researchers were interested in the questions or problems of power or the broader relationship between healthcare encounters and social structures or forces, then it is reasonable to assume that they might prefer the more wide-ranging and seemingly holistic approach.

Despite the methodological and analytical frameworks of language and social interaction and interaction analysis systems research differing substantially, they do share in some similarities. For one, both approaches disattend to content in certain respects, as the language and social interaction approach focuses on action over content (Billig, 1999) and interaction analysis systems works with a set of preformulated categories (Roter, 1977). Furthermore, these two approaches are often engaged in similar tasks of evaluating healthcare encounters and interactions, but cling to their own perspective rather than establish collaborative programmes despite calls from figures in the respective fields (Roter & Frankel, 1992). Indeed, one of the critiques of conversation analysis has been the field’s claim to naivety (Billig, 1999) that has led it to privilege the disattending to content and subsequently function as an exclusionary approach. That said, this concern has dissipated over time as the field has become more interdisciplinary and collaborative (Barnes, 2019) and cases have again been made to collaborate between language and social interaction researchers and more quantitative or experimental approaches (Albert & de Ruiter, 2018).

Of course, the language and social interaction approach remains a distinctive one that yields highly particular findings, but ones that are amenable to the broader empirical contributions of cognate but alternative approaches. We might say, then, that to fully bring out the value of the research there needs to be more collaborative and interdisciplinary work. Without this edge towards collaboration the output of language and social interaction might not find its place in the bigger picture understanding of healthcare encounters as they pertain to decision-making. Although it is crucial to emphasise that this issue is bidirectional and other approaches must integrate this ultra-empirical fine-grained microanalysis of language and social interaction to bolster their claims and contributions to our understanding of healthcare encounters and interactions. I note also, that perhaps due to the relative outsider status of language and social interaction in the mainstream of healthcare research, there has not tended to be as much critique of this position as vice-versa. In turn, much of this evaluation comes from either my perspective as author of this overview or figures within the tradition who recognise its limitations as a singular approach (e.g., Billig, 1999; Wetherell, 1998). With this consideration of some of the limitations of language and social interaction research, I shall move on to outline the gaps I perceive in the SDM and patients' preferences literature.

2.7 Gaps in the literature and unanswered questions

Despite the sustained interest in SDM from both academic and practice perspectives, there has only been so much work on patients' preferences. Now, this research has often been illuminating and contributed to our bigger picture of SDM and patients' preferences, but it has naturally left gaps. I would argue that there are three significant, but related, gaps that require addressing to come to an understanding of patients' preferences that works best for SDM. The first gap is what patients' preferences as constructions (Elwyn & Miron-Shatz, 2010) look like empirically as they feature in healthcare encounters. Second is how patients go about constructing preferences in an observable manner and what kinds of strategies and approaches are used in this process of construction. Finally, there is the question of the consequences of patients' preferences in situ, which is the gap that Landmark and colleagues (2017) have begun to address with their work on practitioners' handling of patients' preferences. I will further discuss these gaps below before I provide more detail about discursive psychology and reprise the discussion of the gaps with regards to how discursive psychology can contribute to addressing them.

When we consider these gaps together, it is likely the case that they result from the low number of studies investigating patients' preferences in a way that focuses on interactivity and construction. Outside of Landmark and colleagues' (2017) work, I could not find research that engaged with preferences as primarily verbal constructions empirically. That is not to discount the good work that is being done on a theoretical level, such as the focus on stages of talk and taking preferences from initial to informed (Elwyn et al., 2017). In addition, the Implement-SDM model (Joseph-Williams et al., 2019) began to partially address this gap by providing a model of SDM based on empirical analysis of actual decision-making encounters. Promising work on patients' preferences in situ is also taking place in intervention development research. For instance, one study reported that the inclusion of a preference assessment before the decision-making point was reported to lower decisional conflict and may have prompted patients to discuss their preferences more fully with their practitioner (Shirk et al., 2017). Although I consider the language and social interaction approach to be most immediately valuable, by virtue of its scope for documenting and characterising real interactive behaviour, there remain questions to be answered.

For instance, the work by Landmark and colleagues' (2017) while hugely insightful for understanding the gap between ostensible SDM behaviour, such as preference elicitation and checking, and its interactive appearance in situ shows us the ways that practitioners respond to preferences. These findings alone are instructive and novel contributions to the way that we understand SDM and patients' preferences, however there is still space for a focus on the work that patients put into their preferences and the construction process. Indeed, if we want to better understand what a discussion about preferences that might lower decisional conflict (Shirk et al., 2017) looks like or see examples of initial or informed preferences (Elwyn et al., 2017), then we need research that is designed to work with the constructed nature of patients' preferences (Elwyn & Miron-Shatz, 2010) and the interactivity involved in construction. Put simply, I believe there remains a clear need for research that identifies patients' preferences as unique constructions in situ and characterises the forms that these preferences can take. If we are to take patients' preferences as a prominent essential element of SDM (Makoul & Clayman, 2006), then we need to be able to refer to real examples and analysis of patients' preferences as they appear and function in healthcare appointments.

A related second gap in the literature is research on how patients' preferences come to be constructed within a healthcare encounter or treatment discussion. When discussing patients' preferences as constructions in section 1.5, I overviewed the research on preference reversals (Lichtenstein & Slovic, 1971, 1973), which is a long-standing example of preferences being anything but fixed. To return to that discussion, preference reversals are an example of a substantial literature with a sustained focus on how preferences get constructed via cognitive processes (see Lichtenstein & Slovic, 2006 for an overview). Again, this research contributes to a larger understanding of the possible explanations for or routes to preference construction and findings such as preference reversals are useful despite methodological or theoretical differences between approaches. As such, this research is certainly valuable and lends another kind of support to the claim that patients' preferences are constructions that can stand alongside language and social interaction research.

I do, however, consider the absence of research documenting and explaining the ways that the construction of preferences occurs in verbal interaction to be noteworthy. Having examples, and an understanding, of the ways that patients actively construct their preferences in decision-making discussions would be useful for two reasons. First, it is easier to track and respond to the verbal construction work than internal processes of cognitive computation, which could help with the dynamism of encounters. Second, if practitioners can recognise that a patient is in the process of constructing a preference, then they would be well positioned to ensure that there is meaningful engagement with and impact of that preference.

The final gap would be the way that patients' preferences are influential for the patients' decision-making process and treatment decision. In section 1.5.3 I discussed some of the problems that patients' preferences and SDM faced in relation to implementing or utilising patients' preferences. Crucially, patients' preferences do not exist in isolation and to understand the impact of patients' preferences on decision-making, we need to observe and interrogate preferences as they feature in healthcare encounters. Returning to Landmark and colleagues' work (2017) since it is the primary example of this research, we have an example of the consequences of patients' preferences, and it is a striking one. The observation that practitioners would steer patients towards institutionally preferred treatment options and undermine alternative preferences certainly provides one candidate explanation for the limited influence of patients' preferences on treatment decisions (Landmark et al., 2017). Indeed, the disparity between what is ostensibly SDM behaviour, and the in situ interactive work is a spur to further work that might reveal similar barriers to patients' preferences influencing treatment decisions. As the suggestion appears to be that patients voicing their preferences is insufficient to influence treatment decisions, there is a clear gap for research that can demonstrate the interactive consequences of patients' preferences in treatment appointments.

Although I have been discussing conversation analysis here, this is not the only approach that has left this gap around patients' preferences. Indeed, the argument that patients' preferences are constructions was made within the mainstream of SDM by one of its main proponents (Elwyn & Miron-Shatz, 2010). Eleven years have passed since the publication of the paper making the argument for constructed preferences and there have been contributions from various research traditions and approaches, which point towards useful suggestions and insights. Taken together, however, they do still leave a gap in the research that remains to be filled and this suggests to me that a novel contribution such as a discursive psychological study would enrich our developing understanding of patients' preferences. As this section concludes, I will now transition and make a clearer statement as to why I chose to use discursive psychology for my research.

2.8 Why use discursive psychology to study patients’ preferences?

Thus far, my overview of the language and social interaction research has focused on conversation analysis and its application to healthcare interactions. As such, there is a question to be asked: Why did I not choose to use conversation analysis instead of discursive psychology? My answer to this question includes the following reasons. The first reason is that discursive psychology as it is practiced by major proponents such as Potter, Edwards, and Wiggins is distinct from discursive psychology as it first appeared. Potter and Wetherell’s (1987) *Discourse and Social Psychology* set out a vision of discursive psychology that drew on the analytic framework of conversation analysis, but also concepts such as interpretive repertoires (Gilbert and Mulkay, 1984) and ideological dilemmas (Billig et al., 1988) from the sociology of scientific knowledge and rhetorical studies respectively. By contrast, contemporary discursive psychology has recently been characterised as: “an approach that applies a conversation analytic method and perspective to issues that are typically seen as individual, cognitive, and psychological” (Edwards & Potter, 2017, p. 498). As such, it did not make sense to suggest stark differences between the analytic frameworks of conversation analysis and discursive psychology. Now, having acknowledged the similarities between conversation analysis and discursive psychology, the second reason for my choice of discursive psychology is the key difference between the two approaches.

Discursive psychology is obviously interested in psychology, but more specifically in the ways that psychological concepts and terms feature in talk (Potter, 2005, p. 739), which is less clearly a focus in conversation analysis. Indeed, conversation analysis is more interested in questions of structure, organization, and the mechanics of conversations as social interactions (Schegloff, 2007). My research is interested in SDM, but the focus is on patients’ preferences, which in addition to being constructions (Elwyn & Miron-Shatz, 2010) are also psychological phenomena. Moreover, my research also focuses on the fine-grained analysis of talk-in-interaction, and the constructive power of language in accomplishing action that are hallmarks of language and social interaction research. When we consider that preferences as constructions are responsive to information and options given in situ and develop in appointments (Elwyn & Miron-Shatz, 2010), we consider points that are amenable to discursive psychology. In turn, it is logical that my research would gravitate to language and social interaction approaches, and that I would choose the one with the focus on psychology in interactions.

To reprise the gaps in the literature that I outlined earlier, there are reasons to believe that discursive psychology can contribute to addressing them. For one, I mentioned that although we can now speak of initial and informed preferences (Elwyn et al., 2017) and empirical examples of practitioners challenging patients' preferences (Landmark et al., 2017), we do not have a clear picture of patients' preferences. Indeed, even the definitions of patients' preferences tend to be general and quite vague such as "what patients want from their healthcare" (Street et al., 2012, p. 168). We do, however, have a claim that patients' preferences are constructed in situ (Elwyn & Miron-Shatz, 2010) and evidence that preferences are malleable and interactive (Lichtenstein & Slovic, 1971, 1973). Therefore, using discursive psychology's focus on both construction as an interactive act and psychology as an interactive resource would allow for similarly fine-grained analysis into the work of constructing a recognisable preference. Moreover, it would also allow for the characterisation of patients' preferences as constructions alongside the provision of examples of both constructed preferences and strategies for constructing them. Both insights would be instructive in developing our understanding of patients' preferences empirically, which is crucial to grounding the overwhelmingly theoretical and conceptual understanding of SDM that we currently have. In addition, there would be a clear link to the work of Landmark of colleagues' (2015, 2017) for an additive contribution to a small but detailed programme of analysis.

One obvious caveat is that discursive psychology cannot answer these questions alone, especially in a single piece of research. That said, discursive psychology can contribute to this area by extending the examination of the interactive consequences of patients' constructions of preference in situ. Using discursive psychology affords me the opportunity to identify patients' preferences in treatment appointments, as they appear and in the fullness of their interactive and decision-making context. This provision of context alongside examples of real preferences and analysis of the forms they take would provide a bundle of rich information to our understanding of patients' preferences and SDM. It is not the case, then, that a discursive psychological investigation would provide a narrow contribution to knowledge despite it being a narrow and specific approach to the study of language and social interaction. Altogether then, I argue that this is a window of opportunity for an underutilised approach to language and social interaction that would build on existing findings and make specific novel contributions that enrich our understanding of patients' preferences and SDM.

2.9 Chapter summary

This chapter told the evolution of the study of small group face-to-face interactions from beginnings in social structures theories through to radically empirical analyses of conversational structures. One striking continuity between these stages of evolution is the shared attention to fine-grained analysis from distinct traditions. For example, interaction systems research drew upon grand sociological theories of social structures but systematically recorded and rigorously coded each act in face-to-face interactions (Bales, 1950). Another evolution arose from adapting the earlier interaction systems approach to better fit healthcare encounters and discriminate between the specific context of medical specialities (Roter, 1977). As researchers moved into more qualitative investigations of healthcare interactions, there were two markedly different approaches that I reviewed. The first was avowedly critical and drew on similarly grand social structural theories as the earlier interaction systems research to explore how social structures would shape and constrain healthcare encounters (Mishler, 1984; Waitzkin, 1985).

By contrast, the second approach was radically empirical and ignored the ideological considerations of the critical researchers to focus on how patients and practitioners were responsible for structuring and accomplishing their face-to-face encounters (Sacks, 1992). All the traditions have their own strengths and limitations and make distinct contributions to the broader understanding of healthcare interactions. Indeed, taken together they are developing a broad understanding of healthcare encounters that can further our understanding of the way that decision-making occurs in treatment appointments. That said, my decision was to pursue the radically empirical tradition and to choose one of its approaches that has been less commonly applied to the study of healthcare interactions. Therefore, I conclude this chapter by reiterating that I shall use discursive psychology to investigate the way that patients' preferences appear as and are a feature of post-diagnostic prostate cancer treatment appointments. Chapter 3 will follow by reporting my methodological choices, my data collection process, and my analytical framework and procedure.

Chapter 3: Methodology

Chapter overview

This chapter will provide more contextual information about the research site and what typically happens in prostate cancer treatment appointments. Having overviewed the treatment appointment process and its position in the treatment decision-making trajectory, I will proceed to cover data collection, sampling, and recruitment. A discussion of ethical considerations follows the data collection section before the chapter focuses on the analytic framework of the research. Ethnomethodology is covered first, as the theoretical and analytical basis for conversation analysis and discursive psychology. Subsequently, conversation analysis and discursive psychology both receive sections detailing their intellectual foundations and analytic principals. The chapter concludes with an account of the analytic procedure used for this thesis.

3.1 Prostate cancer treatment appointments

Prostate cancer is the most diagnosed cancer in men (Cancer Research UK, 2020), and the second highest cause of cancer mortality, in the UK (Cancer Research UK, 2020). There is, however, a high survival rate, as seen in recent 5- and 10-year rates respectively (86.6% and 77.6%; Cancer Research UK, 2021). Indeed, providing that the cancer has not spread throughout the body, then patients can receive curative treatment. Prostate cancer is interesting in this regard because there are a range of treatments such as internal and external beam radiotherapy, surgery, and brachytherapy. Of the available options there is no "gold standard therapy for prostate cancer" (Zeliadt et al., 2006, p. 1871) and no superior treatment for cancer-related mortality (Xiong et al., 2014). In turn, it has been suggested that treatment for localised prostate cancer ought to be responsive to patients' preferences rather than purely clinical factors (Sommers et al., 2007). As such, post-diagnostic prostate cancer treatment appointments are a strong candidate to explore how SDM takes place. The expectation, then, is that treatment discussions in prostate cancer treatment appointments might be rich sites of patient preference and by extension SDM work.

Prostate cancer treatment appointments typically take place after a diagnostic discussion with a clinical or medical urologist. Patients present to general practitioners with symptoms, which may not indicate prostate cancer, and the general practitioner will perform initial examination. Typically, a general practitioner will either administer a digital rectal examination or perform a prostate specific antigen blood test. A digital rectal examination involves the general practitioner checking the prostate gland for signs of abnormalities with their finger. Prostate specific antigen blood tests can indicate possible prostate cancer if they reveal unexpectedly high prostate specific antigen levels. In each case, the general practitioner will refer the patient to a urologist. A urologist might then offer a clinical diagnosis of prostate cancer and refer the patient for further testing. The further tests for patients are typically prostate biopsies such as a transrectal ultrasound, which involves threading a needle through the rectum (NHS England, 2018). A transperineal biopsy is the other typical biopsy and a needle is guided through the skin behind the scrotum (NHS England, 2018). Subsequently, patients might have a magnetic resonance imaging scan or computerised tomography scan to establish whether the cancer has spread and to stage the cancer. Staging cancer involves factoring the size of the tumour, whether cancer cells have spread to the lymph nodes, and whether cancer has spread further into the body (Cancer Research UK, 2019).

Ideally all of this takes place prior to an appointment with the patient, but in a system like the NHS, scheduling all these tasks means some can be incomplete. This is relevant for our data because the treatment discussions did not always take place in ideal conditions with all stages complete. A doctor will usually inform the patient of their diagnosis and provide information about grading, staging, and whether the cancer is treatable. Subsequently, clinical nurse specialists (CNSs) will ask patients about this information and discuss it further with patients. It is important to note that treatment appointments do not necessarily entail a treatment decision. Due to their proximity to diagnosis, it is possible that the multidisciplinary team has not discussed suitability for treatment options. A multidisciplinary team is a collection of specialists that typically includes oncologists, CNSs, pathologists, radiologists, and surgeons (NHS England, 2018). The multidisciplinary team will discuss the stage and grade of the cancer, its size, and whether it has spread alongside the patient’s general health when deciding treatment suitability.

Patients are then given their Gleason score, which range ranges from six to ten. While pathologists calculate Gleason scores, a doctor or specialist nurse will usually tell patients their score. Gleason scores are calculated by examining cell samples taken during biopsies and adding together the two most common grade cells. Cell samples are graded between 3-5 depending on how aggressive and likely to grow they appear. Three is the least aggressive and the Gleason grades that feature cells graded as 3 are the least aggressive grades (Cancer Research UK, 2019). Gleason grades 1-3 are slow to moderate growing cancers, while 4-5 are quick growing and more aggressive cancers (Cancer Research UK, 2019). Two critical pieces of information for decision making are therefore a) how far the cancer has already spread, or the cancer's stage, and b) how fast growing the cancer appears to be, which is the Gleason score.

Treatment appointments are the interactions where patients receive their options for treating or living with cancer and relevant associated information. In turn, treatment appointments are sites of behaviour directly relevant to and consequential for decision-making. Patients have the opportunity also to raise any questions or concerns they might have or respond to information they may not entirely understand. Most relevant to this research however is that these appointments are a place for patients' preferences to take shape in response to the information and options available. In receiving treatment information, asking questions, and being offered options there is a time for patients to begin formulating how they wish to proceed. The key professional party is the CNS who is the representative of the multidisciplinary team and therefore knowledgeable about the multidisciplinary team's decision-making process. Clinical nurse specialists also offer support to patients and occupy an interesting position between patients and the institutional machinery for treatment decision-making. In the treatment decision making appointments recorded for this research participants had typically already met briefly with a consultant urologist to receive news of their diagnosis and an initial suggestion of the treatment strategy recommended by the multidisciplinary team. Immediately following this they are invited to meet for longer with the CNS for an opportunity to ask questions about their diagnosis and to discuss their treatment preferences.

It is necessary to explain that the treatment discussions recorded for this research are not the final stage of decision-making. Indeed, patients are typically sent home after these appointments with written information, such as a pack of booklets and leaflets, and advised that they have time for further consideration. However, if there has been indicative agreement to a treatment option, institutional arrangements for this proceed such as the making of appointments, booking of operating theatre space and so on. Final consent to treatment is formally collected immediately prior to its commencement which could be several weeks after the appointment recorded for this research. In turn, while we might expect patients and practitioners to both be oriented to the need to eventually decide, we would not expect patients to arrive and make an immediate decision. Treatment decision-making as arranged in and understood by NHS England, then, is a distributed affair and difficult to capture in totality. In my research I collect data on one very important occasion, potentially the most important occasion, according to the advice of my patient and public involvement panel.

The CNS role is also a topic that deserves proper explanation to better contextualise the research. In the context of NHS England, the CNS has been seen as having a critical role overseeing the holistic care of cancer patients since the 2004 National Institute for Clinical Excellence guidance on supportive care in cancer. Clinical nurse specialists can have evidence-based expertise in domains such as types of cancer, treatment specialisms, and patient population groups (National Cancer Action Team, 2010). In addition, CNSs inform patients about the specifics of treatment options such as the benefits and risks they entail (National Cancer Action Team, 2010). The CNS role, then, is one that is pivotal to patients' supportive care but crucially for this research, also to their decision-making process. Despite the general competencies, the precise role of the CNS will differ between both hospitals and cancer multidisciplinary teams therein. In our specific context of prostate cancer CNSs play a major role, with treatment decision-making appointments up to four times longer, up to an hour, than those typically held with a medical doctor. Patients, then, can spend far more time with their CNS than their doctor, and would work through many key aspects of their care and decision-making. Particularly interesting for the literature, is that the role of CNSs in decision-making has not been prominently studied in the language and social interaction research.

3.2 Data collection and management

3.2.1 Ethical approval process

While the university did not need to grant ethical approval, as this was the role of various NHS organisations, they were required to approve the project. Project approval was granted on March 23rd, 2018 and preparations were subsequently made for ethical approval. To work with an NHS foundation trust, I required ethical approval from the NHS research ethics committee, the health research authority, and the health and care research Wales bodies. The chosen NHS foundation trust also had to confirm capacity and capability to deliver the research. Ethical approval was part of the integrated research application system and this was accompanied by the health research authority qualitative protocol development tool. The protocol and the integrated research application system form together comprised the research proposal reviewed by the research ethics committee, health research authority, and NHS foundation trust for the research site.

Prior to submission, the protocol was reviewed by a lecturer in communication and social interaction and a consultant clinical psychologist. Both reviewers affirmed the value and novelty of the research while contributing insightful revisions. Ethical approval also required study documents, all of which were reviewed by the health research authority, research ethics committee, and NHS foundation trust research and innovation department. Furthermore, as patient and public involvement is central to NHS research, former and current prostate cancer patients also gave feedback between April and August of 2018 prior to submitting my project to the relevant NHS bodies. Indeed, the patient and public involvement feedback was important for ensuring the research was designed with a sensitivity to patients' concerns and impressions and subsequently conducted in an appropriate manner. Patients received a project summary and example study documents. All patients endorsed the project and provided astute suggestions for refining study documentation, which rooted the study in the concerns and experiences of prostate cancer patients. The most influential of the study documentation suggestions were emphasising the potential of the research to improve delivery of care, providing a clear timeframe for data archiving, and attempting to avoid impersonal language.

Three patients advised on the significance of treatment decision-making appointments for them and the right way to approach potential participants at such a sensitive moment in their lives. For instance, patients agreed that notification in advance, via post, would be required, and that a sensitivity to the possibility that patients might be anxious was important. Although patient and public involvement and external peer review were not addressed specifically to ethical considerations, these processes both informed an ethical sensitivity and stimulated particularly attentive detail to the delicacy of the research design and subsequent implementation and conduct. The patient and public involvement informants had concerns about de-identification, confidentiality, and anonymity, which I discussed with them face-to-face and via email; and gathered their suggestions to best attempt to address their concerns. Following approval and access, frequent communication between the research site and the chief investigator and local principal investigator has maintained up-to-date information and ensured prompt responses to requests. Moreover, the chief investigator produced annual reports for the two years that the project ran with the cooperation of the NHS foundation trust. Per patient and public involvement, all participants also received a write up of the study findings that was tailored to the participant group while findings of a practicable, applied nature were shared with the NHS foundation trust.

This research has three participant groups, all with dedicated study documents containing standardised study information but tailored to their participation, namely prostate cancer patients, patients' companions, and CNSs. Consent forms were also standardised and asked for the same permissions. Namely, consent to audio record the appointment, to use anonymised data extracts for publications and presentations plus teaching university students and medical students and staff, and to securely archive recordings and transcripts for up to ten years. Consent forms asked for these permissions on an opt-in basis, so participants could consent to the extent that they felt comfortable. All study documents included contact details for the local principal investigator [1]and the chief investigator while information sheets contained information about withdrawing participation from the research. The study documents that patients received are available in appendix A, for the information sheet, and appendix B for the consent form. Appendix C contains the information sheet for patients' companions while appendix D is the patient companion consent form. Clinician information sheets are in appendix E and clinician consent forms are in appendix F.

3.2.2 Overview of ethical issues

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[1] Dr. Mike Rennoldson acted as local principal investigator in addition to his role as Director of Studies while Charles Baker acted as chief investigator.

The main ethical issues were related to the confidential nature of medical data and records on one hand and the sensitivity on the patients' side of the potentially difficult interactions on the other. For one, it was crucial to ensure that identifiable information about patients was anonymised and omitted. Furthermore, that confidential information that comprised part of patients' medical files were de-identified and stored securely. This concern was particularly pertinent since the intention was to archive consent forms and recordings for up to ten years and offer a form of open access, albeit not in the sense of making them widely available. Rather, the intention to make the audio recordings, with identifiable information obscured in the recordings, available to other researchers with appropriate ethical approval. In turn, I arranged for a secure archive system that could store both the recordings and study documents separate from each other. Another ethical concern was the potential intrusiveness of the research. While it would have been more intrusive to set up cameras, the patient was informed that a digital recorder will be present and visible. Beyond the intrusiveness of recording devices, however, there was a sense of intrusion into potentially tough emotional and otherwise private moments. As such, I was mindful of being alive to the possibility that patients, or their companions, could find themselves overwhelmed or upset in the appointment.

To help address this issue, I attempted to clearly inform patients about the nature and scope of the research including how it would be conducted. I was careful to avoid influencing the patients' appointments and ensure they were not left with lingering doubts or concerns about the research and their contributions to the research specifically. A key component of this communication was informing patients of the extent of their involvement, precisely what will happen to their recordings including storage and all usage. Furthermore, informing them of their rights to decline participation and withdraw their permission during and after the appointment up to a clearly defined cut-off date. One other important step to addressing these issues was conducting the research in a way that minimised the potential for ethical problems. For instance, being sensitive to any delicate moments in the recordings and swiftly anonymising data while moving them from the digital recorder to the secure storage system.

3.2.3 Consent to sensitive data collection

A two-step recruitment process was necessary to conduct the data collection strategy. First, CNSs needed recruiting so that they could subsequently recruit prostate cancer patients and their companions. The director of studies, as local principal investigator, approached CNSs about participation eligibility and interest. It is important to note that the NHS requires the director of studies to be named principal investigator and responsible for data collection in PhD research. Clinical nurse specialists saw tailored information sheets, consent forms, and spoke with the local principal investigator about what participation entailed. Six CNSs ultimately consented to participation, and thereafter assumed responsibility for recruiting patients and their companions and recording their appointments. Clinical nurse specialists were identified as participants, and patient recruitment leads, because they are responsible for conducting treatment appointments with newly diagnosed prostate cancer patients. The local principal investigator briefed the CNSs on the data collection process and recruitment strategy before passing on an encrypted digital recorder and study documents leaving the CNSs to conduct recruitment. Clinical nurse specialists were asked also to include a written notification of the possibility of being invited to take part in research which would involve recording appointments in appointment letters. The director of studies acting as local principal investigator provided a link between hospital and university for any questions, contributions, or concerns that they might have.

Patient participants were men awaiting prostate cancer treatment appointments at the research site. Notification included contact details for the researcher and information about opting out of recordings. All patient participants were identified by participating CNSs. Participating CNSs approached men attending the hospital for treatment appointments to ask whether they were interested in participating. Members of patients' clinical care team used their professional judgement to decide whether it was appropriate to approach about participation, paying particular attention to visible distress or discomfort. Interested patients were assured participation was voluntary with no expectations of participation and no consequences of declination. Patients were provided an information sheet by participating CNSs, who also took questions. Patients wishing to participate were then provided a consent form, informed of their right to cease participation without explanation, and, although data would be retained, to withdraw from the study. Further to explaining the research and participation requirements, participant information sheets detailed all prospective uses of data including archiving and using anonymised extracts for teaching and publishing. Consent forms requested permissions for all uses so participants could consent to the extent that they were comfortable.

As patients' companions were often part of the interactions to be recorded, they were also asked about participation. Patients' companions were approached concurrent to patients and were therefore party to the discussion between CNS and patient. Tailored information sheets and consent forms were provided for companions, who also had the opportunity to ask questions and raise issues with the CNS. Of course, companions declining participation would stop the recording since their data would have been collected without their consent in such cases. That said, no companions declined participation and only one patient declined, which meant that their appointment was not recorded. Beyond the presence of companions as a possible source of support, they can have important roles in decision-making appointment business and do form part of the patient-side of these interactions. As such, it was not just procedurally appropriate to record companions but intellectually useful in capturing how companions help patients navigate treatment appointments.

Prospective patient participants were considered for inclusion if they had recently been diagnosed with prostate cancer, were aged eighteen years or older, and were discussing treatment at the research site. Patient companions were included if they were accompanying the patient for the purpose of attending the treatment appointment. If prospective participants lacked capacity to give informed consent to participate, and/or lacked fluency in spoken and written English to understand study information, they were excluded. If all parties consented, the CNS took the treatment appointment as standard but asked patients to confirm their name and date of birth upon beginning the recording. On occasion, the CNS recorded a patient's name and date of birth when it was not asked in the recording. Patients and companions were not tasked to do anything for the recordings, nor was there any follow-up obligation. Initial recruitment began in November 2018, but the first recordings were taken on January 14th, 2019. Here it is key to state that CNSs were making recordings in addition to their usual institutional tasks, and patients were not approached sequentially, which constrained their ability to give time to research recruitment. Recordings were made with three Olympus digital recorders; one DS-3500, one DS-5000, and one DS-9500. The digital recorders were circulated between the CNSs for making audio recordings.

As a cancer consultation would typically be a personal and private experience it follows that there existed potential for distress. Therefore, I was mindful of the possibility that patients, should they become distressed, may want to stop the recording after giving consent. Participants were able to stop the recording, either temporarily or definitively, and to withdraw their consent to participate after the recording or later after the appointment. Crucially for participants, their CNSs, as the principal source of psychological care during their treatment, were well placed to offer support. There were no reports of concern at participation to CNSs nor were there any requests to withdraw data or consent after participation.

3.2.4 Data management

Treatment appointments are sensitive interactions, particularly in these instances, where participants were discussing a prostate cancer diagnosis. In the interactions being recorded, patients and companions were informed about the severity of their cancer and the available treatment options. A total of 22 recordings were made with an overall sample size of 22 prostate cancer patients, 6 CNSs, and 20 patient companions. Recordings varied in length with the shortest running five minutes and 37 seconds and the longest being one hour fourteen minutes and 43 seconds. The individual durations of the recordings are listed in table 4 below, and the total time of the combined recordings is 09:54:32. I explain how I came to choose the extracts used for analysis and their representativeness of the dataset more broadly in the subsequent two paragraphs on selecting and coding data. Participant demographics were not recorded as this was not deemed criterial to the research, although some but not all participants were asked by their specific CNS to give their date of birth during the recordings.

Table 4: Recording duration in minutes

Recording title	Recording duration in minutes
Recording 1	16:28
Recording 2	10:08
Recording 3	16:05
Recording 4	05:37
Recording 5	26:30

Recording 6	42:41
Recording 7	20:40
Recording 8	1:14:43
Recording 9	10:04
Recording 10	38:55
Recording 11	36:41
Recording 12	41:58
Recording 13	24:34
Recording 14	18:22
Recording 15	23:13
Recording 16	21:16
Recording 17	25:05
Recording 18	32:30
Recording 19	38:10
Recording 20	20:37
Recording 21	22:43
Recording 22	27:32

I coded my data in line with standard practice for discursive psychology, which is to first familiarise myself with the recordings and transcripts before making notes on stretches of talk (Wiggins, 2016, pp. 118-119). These stretches of talk were revisited in greater detail as I focused on spotting candidate actions and phenomena in them. Once I had spotted more than one stretch of talk containing an action or phenomenon, I compared them one against another. The comparison process led me to identify actions and phenomena that appeared in stretches of talk across the dataset. I then extracted and gathered the stretches of talk featuring those actions and phenomena into collections that described the patterns they demonstrated. After establishing collections of extracts I categorised the actions and phenomena into sub-collections that would comprise the analytic foci of my three empirical chapters. For instance, my collection for chapter 4 concerned preference construction and was comprised of three smaller sub-collections. These sub-collections were Accounting for a firm preference; Constructing preferences: Cognitions, emotions, and mental states; and Constructing preferences: The invocation of prior experiences. As these collections and sub-collections were derived from all available recordings, they are representative of the dataset used. The extracts that make up the collections and sub-collections were numbered, labelled, and given line numbers in preparation for analysis.

My dataset was diverse, as recordings varied in the decision-making content they contained. This variation reflected participants' distinct positions in the decision-making process rather than cherry-picking, which was consequential for the preference work involved. There were recordings that featured extensive and distributed preference work, which meant some recordings were sampled multiple times. By contrast, other recordings dealt with decisions in progress and therefore contained less preference work and fewer preference formulations. These decision focused recordings were still sampled, however, to demonstrate the heterogeneity and distribution of patients' preferences. Patients' preferences were constructed in different ways, took distinct forms, and were not always discussed extensively. Indeed, the focus on patients' preferences varied across chapters despite being developed through the same rigorous process of coding and collection building. Chapter 4 and the focus on preference construction came from identifying the psychological phenomena of patients' preferences and characterising the construction strategies used. With chapter 5, I focused on the handling and receipt of patients' preferences after close inspection of the stretches of talk that featured preference construction and preference formulations. Chapter 6 was different because I noted a surprising prevalence of laughter and then subsequently came to understand the tacit ways that laughter could help manage and construct preferences. I cover these points in more detail throughout the thesis, particularly in the opening sections of my three empirical chapters and reflect on them in my discussion.

Research data was subject to strict regulations and permissions as part of the ethical agreement with the NHS foundation trust. Access to data was restricted to the chief investigator and their supervisory team with exceptions granted for auditing and review purposes. All recordings being made with an encrypted Olympus digital recorder meant that recordings were saved as .ds2 files, which only open in DSSPro transcription software. Digital recorders were password-protected, and passwords were only known to the chief investigator, local principal investigator, and participating CNSs. Recordings were subsequently transferred to the university's centralised secure storage system and were then deleted from the digital recorders. No copies of recordings were stored outside of the centralised secure storage system, except for when required for presentations. In the event of using data for presentations, the audio recordings would be clipped to match data extracts, stored in a password-protected folder, and securely transported on an encrypted USB flash drive. Transcripts would exclude identifying information, with the recordings altered to silence these utterances, and the pitch of participants' voices would be shifted up or down semitones for anonymisation.

Recordings, transcripts, and consent forms were numbered rather than named and all were stored in separate folders in the centralised secure storage system. All data analysis activity took place on a password-protected computer on university grounds or remotely through the secure virtual private network Pulse Secure and university host NTUAnywhere. Furthermore, except for printing anonymised extracts for data sessions, all analysis was mediated via the centralised secure storage system to minimise concerns around confidentiality. In terms of physical security, the chief investigator passed the digital recorders to the local principal investigator, who securely transferred it to the CNSs. The CNSs then passed the digital recorders between themselves for recordings and upon completion stored the digital recorders in a locked room. The local principal investigator collected the digital recorders from the CNSs, securely transferred it to the chief investigator who transferred recordings to the central secure storage system. After deleting recordings, the digital recorders were stored in a locked drawer, in a locked room, on university grounds.

While audio recordings were one of the great innovations of conversation analysis, video recordings have become increasingly commonplace (Heath et al., 2010). Video recordings offer unique insights about embodied conduct (Streeck et al., 2011) and were considered for this research. Ultimately the decision was made to take audio recordings. One reason was the continued belief that audio recordings offer a faithful or at least "good enough record of what happened" (Sacks, 1992, vol. 1, p. 622) for analysis. Moreover, discursive psychology and conversation analysis both continue to use audio recordings for research, including healthcare interactions. For instance, in studies of patient resistance in diagnostic testing (Zhao & Ma, 2020), the delivery of weight loss interventions by general practitioners (Albury et al., 2018), and the appearance of diagnostic categories in psychiatric interviews (Weiste et al., 2018). Although audio recordings do not afford considerations of embodied conduct, they do offer a naturalistic account of the vocal conduct of the treatment appointments. In turn, it remained possible to describe and characterise recognisable preference talk, the construction of patient preference, and the organization of treatment appointment discussions. The primary reason however was sensitivity to patient and public involvement informants' concerns about de-identification, confidentiality, and anonymity. As the research asked patients to volunteer access to, and a record of, a highly sensitive life experience, all efforts were made to assuage their concerns, and this was easier with audio recordings.

Beyond sensitivity to patient and public involvement informants' concerns, there is an empirical basis for the concerns that informants raised. There exists a body of research that demonstrates voice identification as an ability is fallible and suggests voice identification accuracy is diminished compared to visual recognition (McAllister et al., 1993; Stevenage et al., 2011). For instance, voice recognition is subject to significant interference compared to visual identification (Stevenage et al., 2011), poor detection of speaker change has been reported (Fenn et al., 2011), and low success rates for identifying a target voice among distractor voices were observed (e.g., Kerstholt et al., 2004, 2006; Öhman et al., 2013a, 2013b). Given, then, the evidence that voice identification research suggests identification is difficult, I was confident in the assurances given to participants about non-identification. There are, of course, ways to show visual data in outline that reduce the possibility of identification. That said, when coupled with auditory information, the data presents two possible sources of identification information. In turn, the singular use of audio recordings and single possible source of identification information was considered to better engender confidence[2].

3.2.5 Open data

One aim of the research was to archive the data collected. The purpose of data archiving was multifaceted and begins with the opportunity to study audio recordings of treatment appointments without requiring data collection. In this case, the burden of participation on patients is diminished and access to healthcare interaction data is made more easily available. For the research agenda I am staking out, the intention is that the archival data allows more researchers to study SDM and patients' preferences. Nottingham Trent University confirmed they could provide an archive for anonymised recordings and electronic consent forms to be securely stored in designated folders with access restricted to the chief investigator and their supervisory team. Data archiving was an optional element of participation, and this was communicated clearly to prospective participants in study documents. Data archiving was

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[2] I am grateful to Dr Harriet Smith for providing me with relevant information on voice identification

proposed for a period of ten years following study completion, which study documents also clearly stated. As research data will be stored in Nottingham Trent University's centralised storage service for active research data for five years following study completion, the transition to archiving will be straightforward. During patient and public involvement, correspondents were mindful of de-identification, confidentiality, and anonymity issues. However, except for mentioning General Data Protection Regulation and advising against archiving in perpetuity, correspondents had no objections to data archiving.

A descriptive metadata record for datasets will be created, using the DataCite schema, in Nottingham Trent University's open institutional repository to ensure discoverability. A Digital Object Identifier (DOI) will be 'minted' so that the data can be cited in future outputs. This is a mediated service and access to the data will be made available upon request, subject to agreed conditions of access and terms of data usage. All data will be preserved for a minimum of 10 years after the end of the project. As the archive is institutional, it will be held by Nottingham Trent University with a request procedure for mediated access. Academics requesting access to the data would have to provide their details and credentials as well as the reasons for wanting access to the data and how they intended to use it. The Nottingham Trent University library research team then contacts me or my supervisor to ask for permission to share the data with that academic. In the event I or my director of studies leaves Nottingham Trent University, further instructions about how to manage access to this data will be provided. Ultimately, however, the library research team would refer the request to the Associate Dean for Research and School Research Committee for their permission to share that data. This, therefore, minimises the impact of staff turnover and guarantees long-term access to and custodianship of the data[3].

In archiving the data and transcripts, the intention is to be transparent and aspire to the highest standard of research. Although Open Science (e.g., The Center for Open Science) is a bigger issue in experimental and statistical psychology (Maxwell et al., 2015) this does not diminish the need for language and social interaction and qualitative researchers to assist in addressing shortcomings in scientific practice. Qualitative researchers encounter an ethical issue of participant sensitivity with open data due to the way that the data generated has

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[3] I am grateful to Jane Bonnell for extensive discussions about the university's storage and archival systems and assistance in setting up access to these systems.

stronger real-world implications and experiential content than the artefacts of experimental procedures. For instance, sharing accounts of adverse psychological experiences or recordings of therapy sessions makes much more potentially sensitive information about a person public than a collection of reaction times. Conversation analysis and discursive psychology perform well on transparency, and this is because of two related reasons. One reason is the subsequent analyses of phenomena that engender corroboration and empirical generativity (see Heritage 1984, 1998, 2002). The other reason is the reanalysis of published findings that probe critical evaluation and discussion of previously accepted claims (see Lynch & Macbeth, 2016; Drew, 2018). Owing to their shared intellectual lineage, and overlapping analytic frameworks, discursive psychology shares in these practices. A 2020 editorial on discursive psychology argues that it "is aligned with the strive for open science in that readers can undertake their own examination of the transcripts and their analyses" (Huma et al., 2020, p. 324).

3.3 Theoretical and analytical framework

The analytical and theoretical framework informing this research traces its lineage from developments in American sociology through to the linguistic reinvigoration of social psychology. Now a recognisable approach to the study of psychology and talk-in-interaction; discursive psychology has many intellectual forebears. The following section is subsequently concerned to introduce the approach of discursive psychology as "a package of topic, method, and theory" (Edwards, 2012, p. 427). Moreover, it expands on ethnomethodology and conversation analysis as central influences on and components of the theoretical and analytical framework of discursive psychology. There are no proprietary methods for ethnomethodological analysis, which is the intellectual and analytic basis for conversation analysis and discursive psychology, and the thesis will focus on discursive psychological and conversation analytic methods. Rather, an ethnomethodological appreciation of the centrality of "mundane interpretive processes" (Arminen, 2008, p. 186) to the sense-making work of both analysts and interlocutors informs the analytic mentality. It is therefore necessary to reprise the brief discussion of the ethnomethodological mentality and outline such notions as accountability, indexicality, reflexivity, and the documentary method of interpretation as relevant for the thesis. As conversation analysis developed out of ethnomethodology, and discursive psychology out of ethnomethodology and conversation analysis both, there is value in discussing all three approaches.

This research is a discursive psychology project but draws extensively on conversation analysis as a key part of the analytical framework. In turn, the analytic thrust of this thesis can be considered in two parts. A primarily conversation analytic section and a discursive psychological analysis. Conversation analysis is used to describe the structures of social action that underpin the institutional business of prostate cancer treatment appointments. In particular, the ways that talk recognisably about patients' preferences occurs, and how the related phenomenon of option talk unfolds. Furthermore, conversation analysis shows the methodical and reproducible ways that intelligible prostate cancer treatment discussions are accomplished. The conversation analysis-driven section therefore describes the observable structures of social action underpinning the institutional business of prostate cancer treatment appointments, with a focus on the business of patients' preferences. Conversation Analysis is used to describe and characterise the normative order of the treatment appointment, and to detail the formation and location of talk recognisably about patients' preferences. Moreover, I use conversation analysis to account for the organization of recognisable preferences talk so that it constitutes mutually intelligible sequences of preferences-implicative action.

The discursive psychology analysis demonstrates the ways that psychological concepts of preference are constructed and how they are implicated in the practices underpinning or accomplishing the institutional social actions of treatment appointments. The discursive psychology focuses on patients' constructions of preferences as practical, situated, and constructive resources consequential for the institutional business of the treatment appointment and social action therein. Moreover, this analysis addresses the ways that psychological concepts and states are deployed as discursive practices shaped for the specific business of formulating or constructing, accounting for, and making relevant or involving patients' preferences within the institutional context of treatment decision-making and the sequential and structural contexts of treatment discussions and decision-making conversations. The intention of this cumulative analysis is to display how parties to treatment appointments render these interactions "intelligible, reasonable and accountable" (Turner, 1974). Furthermore, how patients' preferences as interactive psychological constructions "are shaped for the functions they serve, in and for the nexus of social practices in which we use language" (Edwards, 2012, p. 427) particular to the institutional context of prostate cancer treatment appointments.

Discursive psychology and conversation analysis both overlap and complement each other by drawing on similar intellectual and analytical foundations. As such, discursive psychology has been called "an approach that applies a conversation analytic method and perspective to issues that are typically seen as individual, cognitive, and psychological" (Edwards and Potter, 2017, p. 498). That said, discursive psychology has a clear focus on psychological matters, and stance on cognition, that conversation analysis does not share. Conversation analysis concerns the fine-grained study of talk-in-interaction and its sequential and structural organization as recognisable ordered interactions. While discursive psychology retains an interest in the production and organization of talk, it is focused more on the action-orientation of talk (te Molder, 2015). The combined analytic foci, then, allow me to build a rich account of the interactional business of treatment appointments. In turn, giving me the scope and tools for the organization and production of recognisable decision-making talk and the construction of patients' preferences and their subsequent action-orientation. I believe that an understanding of ethnomethodology is beneficial for understanding both conversation analysis and discursive psychology for two reasons. The first is the intellectual context of these approaches, being that they both arose from initial developments in ethnomethodology. Second, the terms and concepts of ethnomethodology were largely absorbed by and then subsequently reappeared in various forms in conversation analysis and discursive psychology.

3.3.1 Key underpinnings of ethnomethodology

The now-classic statement of EM was Harold Garfinkel's *Studies in Ethnomethodology* (Garfinkel, 1967), which largely collected work conducted earlier. Garfinkel set out to demonstrate that although social order was a valid object of inquiry, the intelligibility of social actions and their place in the production and sustainment of social order should not be taken for granted (Hammersley, 2018). *Studies in Ethnomethodology* is appropriately named to distinguish the particularity of EM. That is, although referring to a sociological approach, ethnomethodology is the subject of investigation (Lynch, 2007). Ethnomethodologists study the methods and methodic ways with which individuals produce and maintain social order as observable, and therefore reportable, and intelligible (Turner, 1974). Garfinkel demonstrated the ways that interlocutors produce social order locally and in situ through their mastery of natural language and production of social actions (Garfinkel, 1967). Interlocutors draw upon the resources of commonsense knowledge, practical reasoning, and culturally available inferences to produce and order their social reality. Therefore, for interlocutors the social reality, its order, and indeed "their world is a constant doing and achieving" (Turner, 1974, p. 10).

As there are no proprietary steps for ethnomethodology, the instructive way to characterise it may be through an explication of some key terms and concepts. In turn, I will offer brief characterisations of accountability, reflexivity, indexicality, and the documentary method of interpretation. Before I begin, it is important to clarify that accountability, indexicality, and reflexivity are held to be intrinsic, inherent, and incarnate properties. Now, accountable conduct is simply conduct which may be accounted for irrespective of whether one must account for that conduct. That is, accountable conduct is not the conduct that individuals are held responsible for, but rather conduct that can be understood or can stand as intelligible. Indeed, the term accountability refers to the relationship between how conduct can be described and its intelligibility as conduct (Peyrot, 1982). As accountability is inherent, it follows that one does not make conduct accountable by accounting for it post-hoc, but rather an accountable meaning and accountable features either inhere in that conduct or they do not (Peyrot, 1982). If not immediately intelligible, then accountability can relate to explicability such that conduct is both understandable and expressible (ten Have, 2002). To be accountable, then, conduct must have "the potential for being understood" (Peyrot, 1982, p. 271) rather than be accounted for by the producer or explained to the recipient.

For reflexivity, members' productions afford or are taken as being constitutive of that which they account for. That is, the scene, account, or social world "is in part made up of, the talk" (Turner, 1974, p. 10) and can be said to denote how that scene or account stands in relation to itself (ten Have, 2002). For Garfinkel, reflexivity may also be considered the incarnate property of action and to stand as the relationship between the action, and its methodical production, and the process whereby it is made accountable and amenable to interpretation (Lynch, 2000). With reflexivity, then, being incarnate entails that "descriptions of the social world become, as soon as they have been uttered, constitutive parts of what they have described. To describe a situation is to constitute it"" (Coulon, 1995, p. 23). Reflexivity, then, does not refer to a conscious act, such as a term like reflection might suggest, but rather the inherent link between conduct under description and its existence out there in the world as observable and describable conduct.

Ethnomethodology transformed indexical expressions, the linguistic idea that certain expressions are dependent on their context of use for meaning (Bar-Hillel, 1954), into the notion that all conduct, including all language, is indexical (Garfinkel, 1967, p. 33). Indexicality changed from relationships between expressions and context-specific meanings to relationships between all conduct involved in the organization of the conduct being studied (Peyrot, 1982). All conduct is inherently indexical, because all conduct is part of the local and in situ production of social reality and its ordering (Garfinkel, 1967). Garfinkel stated that indexical conduct is "self-organizing with respect to the intelligible character of its own appearances" (1967, p. 33). All conduct being indexical requires interlocutors apprehend the quiddity (Garfinkel, 1988) or just-thisness of conduct and its uniquely occasioned context-specific meaning.

One key resource for interlocutors to apprehend the just-thisness of conduct and the practical accomplishment of accountable ordered social reality, is the documentary method of interpretation (Garfinkel, 1967; Mannheim, 1952, as cited in vom Lehn, 2014). The documentary method of interpretation involves identifying a pattern underlying a series of appearances, or conduct, where each appearance is also a document of that pattern (Garfinkel, 1967). That pattern, however, is identified by reference to the individual appearances, which means that the pattern and the appearances stand in relation to each other as mutually determinable. As the pattern gives meaning to the appearances, and the pattern is meaningful through its relation to the appearances, the documentary method of interpretation demonstrates indexicality. This last point is a useful reminder that these ethnomethodological terms and concepts are not just inherent but also interrelated. Having reached the end of this brief account of key ethnomethodological terms, I will move on to characterise conversation analysis as a development from ethnomethodology that would focus squarely on talk-in-interaction.

3.3.2 Key underpinnings of Conversation Analysis

Conversation analysis is a qualitative microanalytical approach to the study of social interaction. Conversation analysts investigate talk-in-interaction for its role in the production of social action, accomplishment of understanding, and orderly organization of interaction and the actions therein (Psathas, 1995). The interest in order comes from the founder Harvey Sacks, who built upon Garfinkel's (1967) interest in order as practical accomplishment and Goffman's (Goffman, 1967, 1983) interest in studying social interaction (Heritage, 2001). Sacks proposed that social interactions exhibit "order at all points" (Sacks, 1992, vol. 1, p. 484). Furthermore, that this order was locally produced in situ by interlocutors and normative in that interlocutors orient to it and the related norms. Conversation analysts study recordings of "naturally organized ordinary activities" (Garfinkel, 1988, p. 106) to investigate interlocutors' local production and orderly organization of social interaction in mundane and institutional settings. Perhaps the clearest demonstration of the conversation analytic interest in order and organization is *A Simplest Systematics for the Organization of Turn Taking for Conversation* (Sacks et al., 1974).

In this early paper, Sacks Schegloff, and Jefferson put forward the turn-taking system, which would prove to be the mechanism with which conversations were ordered and organized for intelligible and accountable conduct. The turn-taking system is an illustration of how social order is both a produced and a normative order. Order is produced per the expectation that "one party talks at a time" (Sacks et al., 1974, p. 699), and is normative in that interlocutors orient to this expectation and the possibility of sanctions for eschewing the norm (Sacks et al., 1974). The turn-taking system involves two components, turn-constructional units and turn-allocational techniques, and rules governing their use (Sacks et al., 1974). Turns at talk are built from turn-constructional units ranging from phrases to sentences, which carry entitlement to speak. The first interlocutor to speak claims the right to take the present turn. Each turn-constructional unit also projects a recognisable point of possible completion that is required for speaker change.

Possible completion points occasion transition relevance places where speaker change can occur through turn-allocational techniques. The turn-allocational techniques are other selection by current speaker, self-selection by other speaker, and self-selection by current speaker (Sacks et al., 1974). Allocation techniques are hierarchically organized, with current speaker self-selection being the least preferred outcome. Current speaker selecting other speaker designates next speaker and privileges the right to the turn. Other speaker self-selection is subject to no such designatory privilege (Sacks et al., 1974). The turn-taking system exemplifies Sacks' aim of transforming "our sense of 'what happened', from a matter of a particular interaction done by particular people, to a matter of interactions as products of a machinery." (1984, p. 26). That is, the turn-taking system is a context-free and generic machinery but also context-sensitive and therefore able to underpin orderly social interaction methodically and reproducibly (Sacks et al., 1974).

Talk-in-interaction is sequentially organized, in service of order, intelligibility, and action; and it is the organization of sequences that comprise this sequential organization so central to the conversation analytic enterprise and its empirical generativity (Stivers, 2013). Turn-taking is one such organizational resource for sequential organization, and it is in the orderly production of turns that we observe sequence organization. When inspecting the openings of calls to a suicide prevention centre, Sacks noticed that certain utterances occasioned a particular utterance in response. From this noticing, Sacks ascertained that the first utterance, or first-pair part action, made relevant a second-pair part action (Sacks, 1992, vol. 1, p. 3-12). The organizational machinery of first-pair parts and second-pair parts is conditional relevance (Schegloff, 1968) and its organizational structure is an adjacency pair (Schegloff, 2007, p. 13). Conditional relevance functions to project a recognisably expectable second-pair part upon completion of a first-pair part (Schegloff, 1968). Conditional relevance is the relationship between two pair-parts such that if the expected second-pair part is not produced it is noticeably absent (Stivers, 2013). For instance, greetings expect return greetings and invitations project acceptance or declination (Stivers, 2013). Adjacency pairs demonstrate the extent of "order at all points" (Sacks, 1992, vol. 1, p. 484) and that the order is produced and organized by interlocutors as "a constant doing and achieving" (Turner, 1974, p. 10).

Another form of organization is structural organization, which is a type of sequential organization but distinct from sequence organization (Schegloff, 2007). Structural organization is concerned with how sequences of talk-in-interaction are organized into the larger framework of coherent interaction (Robinson, 2013). To this, it is important to clarify that overall structural organization can relate as readily to a single unit of interaction as it can a body of units (Schegloff, 2007). Per Schegloff and Sacks (Schegloff & Sacks, 1973), and later Schegloff (Schegloff, 2011), a local and an overall organization can exist, and exist in such a way that they provide for and shape each other. For instance, the work of structural organization depends upon the provision of space for the organization that local organization provides (Schegloff, 2011, p. 378). The local organization, by contrast, is shaped by reference to the overall structural organization of coherent interactions, turns-at-talk, and sequences of interaction among others (Schegloff, 2011, p. 378). As with sequence organization, such as in adjacency pairs and the conditional relevance of second-pair parts, interlocutors orient to structural organization as both relevant to and consequential for their interaction (Schegloff, 1992).

Repair is the organizational domain and related machinery for addressing problems of speaking, hearing, and understanding (Schegloff et al., 1977). As with coherent sequences of action, shared understanding is central to the production and maintenance of orderly, organized social reality as incoherence risks disorder. Interlocutors recognise the necessity of shared understanding and display their candidate understandings in talk-in-interaction. When interlocutors produce or encounter a trouble source, they address it through the machinery of repair (Schegloff et al., 1977). Interlocutors produce a repair initiation that indicates the upcoming repair procedure, and subsequently work to achieve a repair solution (Kitzinger, 2013). Repair can be self-initiated or other-initiated, these differing in implementation and interactional import. A preference exists for self-repair over other-initiated (Schegloff et al., 1977) and self-initiated, often self-implemented in the same turn constructional unit, is the most common format (Kitzinger, 2013). Other-initiated repair marks the preceding utterance as a trouble source therefore requiring a repair solution and interrupts the ongoing sequence. Self-initiated repair requires no such external marking and interruptions are typically localised to the turn-in-progress (Kitzinger, 2013).

Talk-in-interaction being vehicular of action, it follows that there is much emphasis in conversation analysis on action. We see this emphasis in the two notions of action formation and action ascription, sometimes action recognition, (Levinson, 2013). Action formation concerns the conversational practices that produce a recognisable action; an action that the recipient can demonstrably understand as having been produced by the conversational practices of the speaker (Schegloff, 2007, p. 7). The question of action formation is the question of what interlocutors' talk can be recognised as designed to achieve. The means for ascertaining the answer are inspection of interlocutors' treatment of this talk in the surrounding, and their uptake in subsequent turns. Action ascription is the corresponding notion and entails interlocutors attributing an action to another's prior turn (Levinson, 2013). Turns at talk might propose various actions by virtue of their sequential placement but there are organizational restraints upon actions. For instance, action is constrained both by sequence organization, such as adjacency pairs and their projected seconds, and overall structural organization such as openings and closings (Levinson, 2013).

Talk-in-interaction being conducted through turns at talk, and talk being vehicular of action and shared understanding, requires turns be designed for specific actions. Turn-constructional-units comprise turns, and linguistic features comprise the resources interlocutorss use to design and build turns (Drew, 2013). One aspect of turn design is its relation to sequence organization, as interlocutors often design turns to fit contiguously with the prior turn (Sacks, 1987). Interlocutors might respond with a change of state token such as oh to indicate something newsworthy (Heritage, 1984) or a well-preface to indicate a dispreferred response to an utterance (Pomerantz, 1984). As interlocutors ascribe action to prior turns (Levinson, 2013) and build understanding through successive pieces of documentary evidence (Garfinkel, 1967, p. 78) it is crucial that turns are designed to produce accountable actions. Turn design relates to action formation and ascription through the ways that turns projecting actions are designed to project actions in particular accountable terms (Drew, 2013). For example, Curl (2006) showed how interlocutors formulate offers of assistance as do you want or either conditional or declarative grammatical forms. Each grammatical form is recognisably an offer of assistance, but the turn is designed for a particular sequential position (Curl, 2006).

One final organizational domain is preference organization, and it is crucial to stress that the technical concept of preference in conversation analysis is distinct to the vernacular sense of preference, and the psychological sense of preference this research investigates. Lerner (1996, p. 304), characterises preference organization as methods and practices, observable and recognisable, primarily turn-constructional and sequence organizational in nature, that inhere in the structures of social actions that inform talk-in-interaction. To consider all language indexical (Garfinkel, 1967) necessarily entails that a preference for action may be discerned only in the local sequential environment of its production or implication. To perform the seen but unnoticed preferred action, one must recognise the design of an action (Boyle, 2000). Turn-constructional practices relate to how interlocutors design turns as responsive to the inherent preference of an action for a particular response. Pomerantz (1984) for instance, demonstrated how disagreement with self-deprecation is constructed in a preferred turn shape while agreement is constructed in a dispreferred turn shape. In terms of sequence organization, interlocutors can organize their interaction to elide the possibility of a dispreferred action. For example, a pre-sequence, such as a pre-request can occasion the response that an invitee is unavailable and therefore need not produce a dispreferred rejection responsive to an invitation (Lerner, 1996).

From the beginning of Sacks' work, conversation analysis developed with the study of audio recordings of everyday (Schegloff, 1968) and institutional talk-in-interaction (Sacks, 1992, vol. 1, pp. 3-12). This interest was as incidental as the focus on talk-in-interaction itself, providing Sacks some possibility of accounting for the methodical and reproducible ways that activities were accomplished (Schegloff, 1992, p. XVII). However, both topic and resource soon assumed centrality, with Sacks' early rationale of audio recordings providing "a good enough record of what happened" (Sacks, 1992, vol. 1, p. 622) providing a theoretical tenet around which to organize data collection and analytical strategies. The analytical framework of conversation analysis stipulates "naturally occurring, interactional phenomena" (Psathas, 1995, p. 45), as it inspects talk-in-interaction as it happens, in routine situated contexts, for the interactive ordering and organization of social reality. There is also a rich body of conversation analysis research using video recordings to analyse embodied conduct as part of the production of action and social order (Heath et al., 2010; Streeck et al., 2011). Whether audio or video however, recordings afford repeated inspection, detailed transcription, and documents of interlocutors' displayed conduct and understandings.

3.3.3 Key underpinnings of Discursive Psychology

Discursive psychology is an approach to talk-in-interaction and psychology, both for and in interaction (Potter, 2005). In particular, discursive psychology is interested in how interlocutors put together talk-in-interaction, the role of ostensibly psychological language and concepts, and what talk-in-interaction achieves (Potter & Wetherell, 1987; Edwards & Potter, 1992). Conversation analysis, and ethnomethodology, were both central influences on discursive psychology, and in turn, both share this focus on talk-in-interaction and practical accomplishment. Distinct to discursive psychology, however, and its unique intellectual focus is the study of psychology as interlocutors' concerns. That is, psychology is understood as a practical interactive object and a subject for analysis rather than being purely explanatory (Potter, 2005; Potter & Edwards, 2013). Discursive psychology draws on conversation analysis and ethnomethodology in particular, but also on linguistic philosophy and ordinary language philosophy such as that of Austin (Austin, 1962), Wittgenstein (Wittgenstein, 1953), and Ryle (Ryle, 1949); constructionism (Berger & Luckmann, 1966); the sociology of scientific knowledge (Gilbert & Mulkay, 1984), albeit diminishingly relative to its earlier statements, (Ashmore, 1989); and rhetoric (Billig, 1987). This section will not give a historical account of the development of discursive psychology, as this has been done expertly elsewhere (e.g., Potter, 2010; Wiggins, 2016). Overviews of ethnomethodology and conversation analysis have been included as they feature prominently in discursive psychology and are central to the theoretical and analytical framework of this research.

Discursive psychology is a highly particularised approach to psychology, “a package of topic, method, and theory” (Edwards, 2012, p. 427). A central interest of discursive psychology is constructionism and discursive psychology may be considered a constructionist, particularly relativist, enterprise (Edwards et al., 1995). Social constructionism as discursive psychology considers it, entails that interlocutors’ social world and social reality therein is constituted by their social practices (Wiggins, 2016). Relatedly, constructionism in discursive psychology is epistemic rather than ontological (Edwards, 1997), which means it pertains to the constructive capacity of talk-in-interaction. Derek Edwards characterises this sense of epistemic social construction as concerning “the constructive nature of *descriptions*, rather than the entities that (according to descriptions) exist beyond them” (1997, p. 47-48; emphasis in original). This epistemic constructionism leads to the discursive psychology principle that talk is both constructed and constructive (Wiggins, 2016, p. 9). Constructed herein refers to how interlocutors construct their talk out of various linguistic resources, including psychological, linguistic, and categorial materials (Wiggins & Potter, 2008). Constructive ties directly into “the constructive nature of descriptions” (Edwards, 1997, p. 47-48) as interlocutors’ worlds and the concepts, constructs, and notions therein are the constitutive product of interlocutors’ talk-in-interaction (Wiggins, 2016).

Action orientation is one central tenet that distinguishes discursive psychology from much other work preoccupied with language and its importance. As Derek Edwards wrote “language is *primarily* a medium for the accomplishment of social action” (1991, p. 518; emphasis in original). Discursive psychology is not preoccupied with propositional content, and diverges from the information transfer, or telementation, view of language (Harris, 1981). The telementation view of language being that language functions to transparently transfer information between interlocutors (Harris, 1981). For Edwards, any such cognitive, informationist, or propositional functions of language is “predicated upon that essential and primary social nature” (1991, p. 518). The intellectual lineage of discursive psychology follows on more closely from speech act theory (Austin, 1962). Briefly, speaking comprises noise, vocabulary, grammar, and meaning that together forms a locutionary act. Performing a locutionary act also conveys an action such as asserting or denying, which is an illocutionary act. By performing an illocutionary act, one consequentially performs a further perlocutionary act such as persuasion (Austin, 1962). In discursive psychology the “focus is squarely on language *use*” (Potter & Hepburn, 2007, p. 166, emphasis in original) or talk-in-interaction. Talk-in-interaction is taken as the arena for talking psychological concepts, notions, and states into being that other approaches may consider talk to reveal straightforwardly to analysts.

Discursive psychologists understand that talk is not context-free and, like psychology, appreciate the contextual sense in which it is situated. Talk is situated sequentially, in that utterances precede and follow other utterances within larger sequences of talk-in-interaction (Potter & Edwards, 2001). Furthermore, talk is occasioned by this sequential situation, such that interlocutors orient to what an utterance projects as relevant, such as acceptance or declination following an offer (Potter & Edwards, 2001; Schegloff & Sacks, 1973). The second sense of situation is an institutional one, and this pertains to the possibility of the institutional setting as providing a particular framework for talk. This situation is similarly driven by interlocutors, in that it is about the ways that interlocutors make the institution relevant and implicate and accomplish its specific institutional business (Potter, 2005). Third, talk is taken as rhetorically situated, which is to say that interlocutors’ talk has a rhetorical organization such that particular choices have specific interactional importance per their selection. For instance, interlocutors might produce a particular account or remembering to defend against claims of stake (Potter, 1996) or to provide a version that stands to counter an alternative, such as an assessment (Edwards & Potter, 1992; Pomerantz, 1984).

As in conversation analysis, discursive psychology typically studies recordings of “naturally occurring, interactional phenomena” (Psathas, 1995, p. 45) and both audio and video recordings are used to generate data. Discursive psychology also uses Jeffersonian transcription conventions (Jefferson, 2004). The broad preference is for an untouched record of exactly what happened in a non-contrived social interaction. Sources of data other than naturally occurring or naturalistic social interactions are poorly fitted to the theoretical and analytical framework of conversation analysis and discursive psychology. There has been debate over the stances of terms such as naturalistic or naturally occurring data, and interviews as data gathering techniques (cf. Speer, 2002; Lynch, 2002; Griffin, 2007; Potter & Hepburn, 2005b), but I choose to use the term naturally occurring data.

Interviews for instance, do not provide the naturally occurring data of interlocutors' mundane talk-in-interaction, being instead a social scientific venture that necessitates investigation as a distinct interactional object itself (Potter & Hepburn, 2005). There is no recourse to idealised sentences, as perhaps in linguistics, or experimental control of linguistic performance, per psycholinguistics, as this is not where one discovers the ordered structure of social reality (Garfinkel, 1996). Using other sources of data problematizes the interpretive gap between research interest and the claims and discussions staked thereupon (Edwards, 2012). In other words, the gap between how patients and practitioners enact the process of SDM and preferences and how they talk about them is huge. Conversely, the gap between the recordings of patients and practitioners' enactment of SDM and preferences and the enactment of these phenomena in situ is small.

Before summarising the analytic procedure that I used for my analysis, it is necessary to formally state my research questions. My overarching research question is the following: How do patients' preferences shape treatment discussions in decision-making appointments? This question can be broken down into a set of 5 smaller research questions, however.

1. What form do patients' preferences take in prostate cancer treatment appointments?
2. How do patients' construct preferences in situ as interactive phenomena?
3. How do clinical nurse specialists respond to patients' preferences?
4. How were patients' preferences consequential for the decision-making business of treatment appointments?
5. How, if at all, was the production of laughter relevant for patients' preferences and decision-making?

I wish to expand on the last of these research questions because it was not one that I anticipated asking when I designed the research. Of course, I was not presupposing my research questions, but I did imagine that I would be able to investigate patients' preferences on account of the preference-sensitivity of prostate cancer (Zeliadt, 2006; Shirk et al., 2017). The focus on laughter, however, to the extent that it formed one of my three analytic chapters was unexpected. During the transcription process I noticed that laughter was surprisingly commonplace and that both patients and CNSs would laugh. Indeed, most surprising was the observation that CNSs did not appear to treat laughter as proscribed, whether it was responsive to the patient or produced to invite laughter. Reciprocal laughter, then, was observed alongside patient and CNS-initiated laughter and at a greater frequency than I would have expected. As such, my analytic chapter on laughter was the one that most closely resembled the practice of "unmotivated looking" (Psathas, 1995, p. 45). By unmotivated looking, I mean that laughter emerged as a topic of analytic interest because I recurrently noticed the production of laughter, first more generally and subsequently around side or treatment effect talk. With a substantial number of cases, I began to wonder whether the production of laughter might be relevant for either or both patients' preferences and SDM.

In discursive psychology, a research question is typically concerned with a topic or form of interaction before progressing into the specific foci of the work as the data collection and familiarity with the data progresses (Wiggins & Potter, 2008, p. 80). As such, we can see how my interest in SDM and interactions between CNSs and prostate cancer patients led me to my specific research questions. My research began with a topic and developed iteratively with the concept of unmotivated looking (Psathas, 1995, p. 45), as I was led by the recurrent phenomena that appeared in the data, which led to the accumulation of collections of phenomena. That is, while research questions are informed by the topic of research such as patients' preferences in this case, they take shape in response to emergent findings. Indeed, this research began with an interest in SDM and prostate cancer appointments before a proper research question developed; and subsequently, smaller research questions arose to better account for the topics and analyses the research focused on. It would, of course, have been possible to pose a greater number of questions to attempt a comprehensive investigation of patients' preferences. I was aware, however, that this posed a higher risk of the research losing focus and therefore being spread thin with few and shallow analyses. In turn, my decision was to retain my focus on the construction and subsequent treatment of patients' preferences and the emergent focus on laughter as possibly preference relevant.

3.3.4 Summary of analytic procedure

Having outlined the intellectual lineage that discursive psychology traces to its inception, and characterised conversation analysis and ethnomethodology as particularly relevant forebears, this section describes the analytic procedure underlying the claims advanced in this thesis. To begin, I will discuss the process of transcription and related familiarisation with the data. Subsequently, I will cover the work of noticing phenomena and building a collection for the purpose of analysis. This will be followed by a characterisation of the actual work of the analysis and its various foci. Finally, I conclude this section with a note on the analytic approaches taken throughout the empirical chapters.

Before analysis could begin, I was required to transcribe the audio recordings to have textual aids for my analysis. All transcription was initially performed in the verbatim style common to other forms of qualitative social sciences research. After the verbatim transcription I often revised transcripts in line with a modified version of Gail Jefferson's transcription conventions (Jefferson, 2004). This modification differs in the granularity of prosodic detail and extent of interactional symbols it provides. As such, it works up a more representative version of the data but stops short of providing an exhausting representation of all possible prosodic details or non-standard renderings of pronunciation.

In cases where data was a candidate for analysis the provision of prosodic and interactional detail was necessary to characterise the data as faithfully as possible. Once an extract was chosen, I would often attempt a closer take on Jefferson's conventions (Jefferson, 2004) with the caveat that judgements on pronunciation and timing were my own subjective readings. My reasoning behind the differing degrees of transcript detail was that the transcripts were textual accompaniments and aids to the data proper, which were the series of recordings. As such, while I obviously wanted an accurate textual rendering of the data, I would still use the data itself to guide my analysis. That all said, Jefferson's (2004) conventions are a core feature of the history and practices of conversation analysis and discursive psychology, and I shall provide more detail about them and subsequent developments.

Jefferson's transcription conventions not only capture what interlocutors have said but also a close sense for the way that interlocutors produced their vocal conduct. To accomplish this representation of vocal productions the Jefferson's conventions utilise a series of symbols and a style of notation sometimes referred to as "'comic book' orthography" (Jefferson, 1983, p. 3). This style is so-called because it renders words in the style that they are spoken rather than the traditional orthographic way. In terms of rendering what interlocutors said in the manner that they produced it, examples include me rather than my and d'ya rather than do you. Beyond pronunciation, the Jeffersonian conventions also include a set of symbols for the representation of prosodic and vocal features, which include using degree signs to indicate quiet or low volumes ° ° and arrows to signify notable rising or falling intonation ↑ ↓. A copy of Jefferson's transcription conventions is included in the appendix G for reference.

As mentioned previously, I chose not to transcribe every recording in line with full Jeffersonian conventions. Not fully transcribing the entirety of the data in complete Jefferson's conventions is not unheard of in discursive psychology (Wiggins, 2016, p. 99) and I consider this to have been sufficient and appropriate for my research. As mentioned previously, I largely decided to use this lighter take rather than focus on furnishing all audible prosodic features. Of course, some extracts demanded more extensive use of the conventions because the prosodic features were interwoven with the analytically interesting material. The decision to provide more interactional detail when using a certain extract for analysis was taken because that stretch of talk was particularly interesting and relevant. When discussing her conventions, Jefferson said that the features she transcribed were included simply because "it's there, plus I think it's interesting" (Jefferson, 2004, p. 15) while Jefferson also acknowledged that there were other features that went unrecorded. This interest, then, deserved to be represented as faithfully as possible to reflect both the analytic claims being made and eye-catching features of the audio data. Of course, the caveat is that my decisions were led primarily by importance for analytic claims, which in turn led to more sparing use of extensive transcription conventions.

As mentioned, the analytic procedure began by listening to the audio recordings and subsequently transcribing them with a simplified version of Jeffersonian transcription conventions (Jefferson, 2004). Following transcription, recordings were cross-referenced for accuracy and analytic sufficiency. Transcripts were then read for further familiarity with the data and in turn, initial noticings of phenomena linked to decision-making and patients' preferences. Analysis was iterative and cumulative, with the final analytic claims advanced on the grounds of the entire dataset of recordings. Preliminary analyses were worked up over the course of transcription to both satisfy procedural requirements and begin noticing phenomena that might subsequently shape and direct the analysis. Initial noticings were noted in the transcripts by adding comments to the word documents, and questions were posed of the phenomena noticed. As noticings began to span recordings, word documents were created for those phenomena that recurred across the recordings alongside of their place in the transcript and interaction. When phenomena were sufficiently recurrent to suggest their commonplace status in the dataset, collections were established, and candidate analytical sketches were developed.

Once established as collections, and formulated as candidate analytic sketches, I engaged the questions that I had posed of the phenomena in the initial noticings. For the conversation analysis-informed work, collections of phenomena were analysed for the organization of the phenomena, how participants understood it, and how it was accomplished interactively. Collections of phenomena were not restricted to discrete actions such as requesting or questioning, as the analysis focused also on the local and structural organization of stretches of preference-implicative talk. That is, sequences of talk-in-interaction pertaining to patients' preferences were analysed for their coherence as fitted sequences, and relatedly their appearance as recognisable sequences of talk about patients' preferences. For discursive psychology, the interactions were analysed for how psychological themes, states, and phenomena were used for and within these appointments. Primarily, how preferences were constructed as accountable, consequential phenomena and psychological topics and resources were drawn upon in the management of constructed preferences.

I developed, refined, and completed all the analyses, albeit with the luxury of taking analytical preliminaries to data sessions organized by my supervisors and me. Data sessions, and supervisor feedback too, afforded me the opportunity to crowdsource candidate explanations for phenomena and receive feedback on my analytic claims in their incipient state of development. At this point, it is important to clarify that I did have to decide when it was appropriate to use conversation analysis as opposed to discursive psychology and vice-versa. In practice, given the overlap of the approaches, they were applied simultaneously and the analysis that emerges foregrounds one or other approach as appropriate to the issue at hand. As such, I have referred to analytic sections and chapters that were primarily conversation analytic or discursive psychological focused.

3.4 Chapter summary

One of the driving aims of SDM research in recent years has been the translation of a conceptual model into practical actionable steps (Elwyn et al., 2012). As I discussed in chapter 1, this had some success, but patients' preferences both as an empirical phenomenon and as interactive constructions remain challenging for these proponents. In terms of theoretical models, the three talk model is the most promising and its treatment of preferences as moving from initial to informed across stages of talk is a thoughtful one. The Implement-SDM model (Joseph-Williams et al., 2019) has made the most progress towards a model faithful to clinical practice by providing empirical evidence for the three talk model (Elwyn et al., 2017) and expanding our picture of decision-making appointments. Taking the Implement-SDM model (Joseph-Williams et al., 2019) as a plausible candidate for the current model under pursuit allows us to see the focus on preferences and the gap between conceptual and practical.

The implement-SDM model (Joseph-Williams et al., 2019) largely follows the three talk model in dealing with initial preferences during team talk, evolving preferences through option talk, and concluding at decision talk and informed preferences (Elwyn et al., 2017). Theoretically, this stepwise pathway through the decision-making process with its space for preferences as dynamic and evolving phenomena makes sense and sounds both reasonable and intuitive. That said, however, it ought to have become clear by now that on one hand the cognitive work reported to be involved in preference construction, and on the other the conversational and discursive practices of construction make this process far from simple. Despite offering a more immediately accessible alternative, the language and social interaction approach is unsurprisingly also not simple. As such, there is a clear need to expand on the coverage of patients' preferences in SDM models in a way that better reflects the complexities of both getting to informed preferences and making them consequential for decision-making. I argue that a combination of conversation analysis and discursive psychology is well placed to make this contribution to research.

Having outlined the analytic procedure used in the empirical chapters, the next chapter will be the first of three analytic contributions and shall focus on the act of patients constructing preferences in situ in their appointments. Subsequent analytic contributions will first concern the receipt of preferences during and following their construction, and second, the role and function of laughter in relation to patients' preferences and decision-making business.

Chapter 4: The interactive production of patients' preferences as a constructed phenomenon in treatment appointments

Chapter overview

Across chapters 1-3 I have argued that patients' preferences should be understood as a crucial component of SDM. Furthermore, that patients' preferences are not ready off the shelf but are unique phenomena that patients interactively construct in situ. As such, it is necessary to investigate how patients' preferences get constructed in the treatment decision-making encounters. Discursive psychology can help reveal what a constructed preference can look like but also what consequences it has for the decision-making encounter. As discussed in chapter 3, I was required to decide when to use discursive psychology and conversation analysis simultaneously or distinct to one another. In turn, while this is a discursive psychology chapter, the first analytic section is largely conversation analysis inflected. Alongside this reveal would be the practices that patients and clinicians draw upon and the ways that they are used to attempt preference construction. In this, the first analytic chapter, I begin to examine this notion of preferences as constructed and the action of constructing a preference in post-diagnostic prostate cancer treatment appointments. A brief reminder of the notion of preferences as constructed will restate the context for the chapter and set the scene for the analysis proper. The chapter will then focus on the ways that patients' preferences get worked up and constructed rather than simply plucked from the brain at the first instance of being asked.

4.1 Patients' preferences as constructions

To restate the position that patients' preferences are constructed phenomena requires an acknowledgement of the following points. For one, preferences are rarely fully formed and ready to go off the shelf. Rather, individuals are made aware of their options, receive relevant information, and compare the alternatives (Lichtenstein & Slovic, 2006). Indeed, even when preferences are considered elicited, they come to elicitation through a process of construction (Tversky & Thaler, 1990). As such, there is a responsive and context-sensitive element to preferences. It is difficult, but not impossible, to think that patients would routinely come to appointments with certainty in a preferred treatment option. With a disease such as prostate cancer, which has no gold standard treatment (Zeliadt et al., 2006), it might be particularly unlikely that one option is staunchly endorsed from the moment of diagnosis. Although, there must obviously be exceptions for factors such as fear or previous experiences that can cast options as unfavourable, as we will see in the analyses to follow.

Further to these aspects, and particularly pertinent for sensitive treatment decisions like prostate cancer (Zeliadt et al., 2006), is the point that patients' preferences are not logically transitive and therefore preferring A to B and B to C does not guarantee preferring A to C (Elwyn & Miron-Shatz, 2010). Therefore, we have a phenomenon that we cannot take for granted as pre-existing, nor even as fixed throughout the consultation or series of consultations. Preferences are then, both the most important single element of SDM and the one most tricky to pin down and make consequential for the ultimate decision. The premise of this project is that patients' preferences are constructed (Elwyn & Miron-Shatz, 2010). Indeed, that context, information exchange, and options available have a role to play in preference construction. That said, the notion that patients' preferences are the result of cognitive inner workings that transpire inside their heads is problematic (see Slovic & Lichtenstein, 2006; Tversky & Thaler, 1990 for examples of this work). This is problematic for analysts and clinicians alike, as neither group has particularly much access to patients' inner cognitive workings.

Taking this approach allows us to "look to see how it is that persons go about producing what they do produce" (Sacks, 1992, vol. 1, p. 11). That is, to see what a patient's preference looks like in practice rather than general or abstract terms. In addition, a focus on language use or talk-in-interaction and the observable conduct of appointments has a practical advantage over the more internal or cognitive routes. For one, it avoids the problem of having limited, if any, access to the inner workings of a patient's head. Beyond this, the preferences that patients construct throughout the course of the encounter are the ones that will be taken as consequential regardless of what details might be purported as distinct from the internal preference. Clinicians can do little with a suggestion to focus more attention on what's inside a patient's head. By contrast, the availability of what is said in these encounters might make the proposed approach more amenable to refinements and improvements. One further issue that clinicians may face, but could attempt to tackle, is the reflexivity of patient interviewing. That is to say, and especially with the standardised treatment of patients' preferences, clinicians may be likely to assume the normal way to elicit preferences is to ask the patient. Perhaps, then, coupling a focus on what interlocutors say specifically in these appointments and a suggestion to look beyond straightforward elicitation questions might be instructive.

One of my research questions was how, if at all, patients interactively, and perhaps collaboratively, construct their preferences; and this was because an answer is crucial to any understanding of patients' preferences as constructions (Elwyn & Miron-Shatz, 2010). In turn, we might package it as a key instance of conduct that clinicians ought to look out for to improve the inconsistent involvement of patients' preferences in decision-making. It is crucial to note here, however, that while decision-making research can focus on decision-making as an event, focusing on if a singular shared decision was made, this is not the way that NHS England understands decision-making. Rather, within the context of NHS England, especially with non-acute illness visits, decision-making is understood as distributed across time and appointments. In turn, we do not find a constant stream of preferences being constructed and formulated nor an ever-present push towards a firm decision. Rather, we see orientations to decisions at different stages and talk that reflects these distinct orientations. This point is one that ought to become clear throughout the chapter and will be revisited in the discussion.

The first analytic section will explore the process of accounting for a firm preference and therefore begin by considering a straightforward example of a patient constructing a preference. Section 4.3 will investigate the work of drawing on cognitive, emotional, and mental states or phenomena when constructing preferences. In the final analytic section, remembering as a discursive act and appeals to prior medical experience will be the focus of the analysis. Further to the specific foci of each analytic section, there are two broader takeaways from this chapter that are worth foregrounding, and the first is that patients' preferences were indeed observed to be interactive constructions that developed in situ. Second, there was substantial variation between preferences both in terms of the form they took and the ways that patients constructed them.

4.2 Accounting for a firm preference

For the first analytic section I will focus on providing examples and a characterisation of the interactive production of patients' preferences as something they construct. To do this, I examine three extracts where the patient expresses an ostensibly firm preferred treatment and then accounts for this preference. All these preferences are presented for the fact that they become preference construction projects after the formulation of a choice. In turn, the preference as a stated option is often clearer, but we can then observe the interactional conversational work that makes the choice a unique constructed preference. This, then, offers a relatively straightforward example of what a constructed preference can look like and an intelligible characterisation of the way that one can be built interactively. I will also note that of the 21 appointments, only five featured formulations of firm preferences. By contrast, six preferences were judged not to be firm, and in 10 cases the decision was either awaiting ratification or had been made by the patients' main clinician. When I write of firm preferences, I do not refer to a discrete class of preferences but rather those preference formulations that are hearable as firm such as by ruling out an option or indicating a decision-in-waiting.

Extract 4.1 (recording 6)

```
COM:                                        [d]o you think we [need
        [to ]sit and think about it=
CNS:    [-ry]                        =oh ABSolutely I mean I don’t wa-
        -nt you to make a decision today I’ve got to be honest I’ve
        got to pop out and get a lo[t of]
PAT:                               [I do]n’t think we’re monitoring
        it that’s (.) that was out the question soon as he mentioned
        that in there as one of the options=
CNS:    ((stammering)) ↑O:k that that’s fine
PAT:    I already knew that straight away
CNS:    ((stammering)) ↑that’s absolutely fine that is your choice I
        mean uh: ((stammering)) I assume the own- only reason why
        name redacted offered that to you is becuz there’s only one
        core=
PAT:    =yea[h]
CNS:        [o]f the disease .hhh however (0.3) you know it’s
        ultimately your choice
```

In the extract above, the patient's companion has asked about the procedural aspects of the decision-making process and the CNS both affirms the companion's projection and goes further in saying that they do not wish to rush the couple. Orienting to the topicality of making the treatment decision, which involves choosing the preferred option (Charles et al., 1997; Elwyn et al., 2012), the patient rules out one of the treatment options initially offered (line 6). The format is initially soft, as the loose cognitive formulation "I don't think" is used to imply that the option of active monitoring is dispreferred. Far from being the definitive article, "I don't think" is implicative and allows the preference to take shape in a form less abrupt than a declarative. The patient goes on to produce an idiomatic formulation "that was out of the question" (line 7) that moves forward significantly from the subtler formulation offered in the turn prior. Indeed, the use of an idiomatic or figurative phrase can signal that the speaker is producing something that has a generality and sense of cultural familiarity that makes the phrase difficult to challenge (Drew & Holt, 1988). In the same turn the patient upgrades their stance with an extreme case formulation (Pomerantz, 1986) "soon as he mentioned that in there" (lines 7-8).

This combination of idiom and extreme case formulation has the effect of glossing the production as difficult to challenge due to its generality (Drew & Holt, 1988), sense of finality and therefore having the last word (Drew & Holt, 1998), and the implication that the option of active monitoring is unacceptable (Pomerantz, 1986; Whitehead, 2015). We can see evidence of the strength of formulation in the CNS's uptake, which is a stammer that produces no utterance followed by a concession of acceptance. This first extract is interesting because there is an initial indication of waiting that soon transfers into a firm preference against one option. We see in this first extract that while there may be an indication that decision-making is considered distant, a firm preference can be constructed. Furthermore, the preference is for avoiding something rather than favouring a treatment option, which is not uncommon as four of the five following extracts also present preferences this way. In this extract, we also see examples of distinct aspects of preferences as constructions such as cognitive language, idiomatic phrases, and live shifts between positions; for instance, from "I don't think" to "out of the question". Other extracts will show similar productions and devices but also various other actions and resources.

Extract 4.2 (recording 10)

1 PAT: yeah (.) erm .hhh he's told me that I can have treatment (.)

```
2              which is err radiotherapy (0.8) and err removal
3    CNS:      mk[ay]
4    PAT:        [th]ere was another one but I can't remember what that was
5              (0.2) it was three=
6    CNS:      =err hormone th↑erapy treatment maybe
7    PAT:      possibly I don't know
8    CNS:      °no: ok°
9    PAT:      erm I have opted for the removal
10   CNS:      >mm hmm<
11   PAT:      to get rid of it all together >and that< (.) he's told me
12             about the consequences [and] side effects=
13   CNS:                             [yep]             =ok=
14   PAT:      °so°=
15   CNS:      =and I'm >just gonna< elaborate on that a bit further then .h
```

In analysing the above extract, I will show how the patient constructs an ostensibly legitimate informed preference at the beginning of their appointment. This extract comes early in the encounter and the patient's first turn is a response to the CNS checking the patient's understanding of their prior encounter with another clinician. In response (lines 1-2), the patient produces a piece of reported speech (Holt, 1996) where the doctor categorised them as fit for treatment and provided two treatment options to choose between. This report implies that the patient was presented with a binary choice, but in line 4 the patient remarks that there was a third option, which might provide inoculation against either traducing the other clinician or ignoring them. Per classic early discursive work (Edwards & Potter, 1992) remembering is a discursive act and there are several potential resources that might be ascribed explanatory coherence. In this case, however, it appears plausible that the patient simply does not remember given the lack of gaps and pauses. A small insertion sequence follows as the CNS offers a candidate third option, but the patient maintains they cannot recall this information. Indeed, the patient claims not to know and therefore positions themselves as occupying the less knowledgeable end of an epistemic gradient (Heritage, 2012a, 2012b). In turn, the patient positions themselves as insufficiently knowledgeable to affirm the CNS's candidate third option.

In response to the patient's "possibly I don't know" (line 7) the CNS effectively collaborates to close the expansion. By proffering an acknowledgement token "no" and "ok" as receipt the CNS indicates no further topical treatment option talk. It is possible that this response demonstrates the CNS's treatment of "possibly I don't know" as closing the discussion of treatment options. It is in the subsequent turn that the patient voices their preference "to get rid of it all together" (line 11), one that has clear hearable implications for surgery with the removal of the prostate central to a prostatectomy. In putting the decision-implicative choice first and then accounting for this via the dimension of preference, there is a link between deliberation and decision (Elwyn & Miron-Shatz, 2010). In being "rid of it all together" the patient formulates a clear preference to both excise the disease and everything related to the disease in an intensified production. The patient having constructed their preference, then goes on to account for their choice by providing an upshot formulation (Heritage & Watson, 1979) of their previous appointment. In addition, the patient's account reports that side effects and consequences were discussed, which suggests that the patient is voicing an informed preference in line with contemporary SDM thinking (Elwyn et al., 2017; Joseph-Williams et al., 2019) possibly and warding off the CNS pointing this out.

This extract is distinct from the first in that a decision has purportedly been made, and the accounting for that decision constructs the preference. Furthermore, unlike the previous extract, the patient is responding to more traditional elicitation questions about their prior encounters. Here, then, we can see both a position in the appointment, the very beginning, and a sequential context that differs substantially, which speaks to the variability of the construction of preference. In the next extract we can see a similarly firm preference formulation but with another distinct focus. The next extract, then, features a greater focus on the legitimisation of the choice behind the patient's preference, illustrates the use of SDM terms, and demonstrates a characterisation of progress through the structural organization of the conversation.

Extract 4.3 (recording 18)

```
1   PAT:     they've explained that: ((lips smack)) erm I have erm ess-
2            -entially erm cancer (0.5) erm: (      ) erm at an inter-
3            -mediate level[ whi]ch is four plus three=
4   CNS:                   [yeah]                    =mm hm=
```

```
5   PAT:     =and (.) ma (0.2) prostate=
6   CNS:     =mm hm
7   PAT:     erm (0.2) I was given choices about what (.) options I
8            [can:] (0.2) do .hh and my option is to have thee surgery
9   CNS:     [yeah]
10  PAT:     (.) and to remove it [(.) er]m .hh and they were just going
11  CNS:                          [°yeah°]
12  PAT:     through (0.2) er:m (.) some of the (0.2) pre-op (0.3) err
13           (options) post-[op]
14  CNS:                    [ye]ah
15  PAT:     aspects that I need to be aware of
16  CNS:     yeah °ok°
```

Again, above, we have an example of a straightforward preference being voiced early in the appointment, but this time coming without a traditional elicitation question. The CNS has asked the first substantive question of the encounter, which is to check the patient's understanding of their previous appointment. Once the patient has produced an upshot formulation (Heritage & Watson, 1979) of their diagnostic information they segue, unprompted, into reporting the stage of the appointment we might call option talk (Elwyn et al., 2017). In this report, the other clinician is presented as performing the necessary steps for SDM of offering choice and providing relevant options (e.g., Charles et al., 1999; Elwyn et al., 2017), reporting the treatment options as "options I [Can:] (0.2) do" (lines 7-8). As such, the patient can be seen as articulating in service of legitimising the choice for surgery. By moving through an articulation of the conditions of SDM the patient also suggests that they have accrued sufficient information. In turn, despite coming early in the appointment, the preference is presented as an informed rather than initial one (Elwyn et al., 2017).

In characterising the previous appointment, the patient also refers to aspects they "need to be aware of" (line 9), which implies that procedural aspects beyond performing surgery were provided, and a potential choice or preference might have been voiced in the previous appointment. The production of this preference is marked by the patient's footing (Goffman, 1981) as they claim, "and my option" (line 8), with ownership over the choice and by extension deontic rights (Stevanovic & Peräkylä, 2012) to the decision-making implication. Despite reaching what might be heard as a transition relevance place (Sacks et al., 1974), the patient continues their turn by developing their preference in line 10. Indeed, while surgery is the preferred treatment, the preference is "to remove it", and therefore something only achievable through surgery. As such, the preference makes clear that there is one treatment appropriate for the decision. Moreover, the preference being cast as an informed preference therefore glosses it as decision implicative (Elwyn et al., 2017) in lines 6 and 9 where the patient reports on a decision relevant information exchange. The patient therefore constructs a firm preference from a clear upshot of their previous appointment and makes known that this preference is decision implicative.

This first analytic section has provided examples of patients constructing firm preferences that both clearly endorse an option and pertain to decision-making. Extracts 4.2 and 4.3 were clearly oriented to a decision as having been made or awaiting ratification. As such, these preferences were stated outright and formulated as being informed preferences that follow appointments reported as being consistent with SDM. In extract 4.1, there was a similarly bold preference statement, but one that ruled out non-curative treatment. Indeed, extract 4.1 began with a question about waiting prior to deciding and therefore showed an orientation to decision-making as something to follow. We can see then that there are patterns that unify projects of constructing preferences, but also variability in how their construction and orientation appear in the appointments.

Although the three extracts above appeared to be from the respective patients' first post-diagnostic appointments, there will be cases in the analysis where the decision-making context may shift because of positioning in the trajectory. That said, even these simple constructions offer points of entry for parties to the interaction and can be explored further in service of a mutually agreed upon informed preference. Of course, this straightforward preference construction project is not the whole story. In the next section, the analysis will investigate more complex cases of patient preference construction. I note that this research was badged as discursive psychology, but the first analytic section has been largely conversation analysis inflected. The reason for this more sequential focus on displayed orientations and conversational resources is that it often reflected the firm preferences patients would account for. Beginning with a focus on emotional states and cognitive processes, the next two analytic sections more obviously evoke discursive psychology.

4.3 Constructing preferences: Cognitions, emotions, and mental states

In this section the analysis progresses to consider some of the more complex cases of patients constructing preferences. While the first section demonstrated patients' projects of constructing a preference, this section begins to focus more fully on the discursive and psychological resources involved in construction. To be specific, these preferences are ones that turn on the use of emotion categories, cognitive invocations, and mental states. Two of the extracts come from appointments where the patient had chosen a preferred treatment, while the third concerns information about one possible treatment option. Therefore, two of the extracts present a sequential context of an incipient decision while the other is more distant from decision-making. With these two sequential contexts, we can investigate the construction of preferences across the appointment.

Extract 4.4 (recording 11)

```
1   CNS:     any questions prior to ya leaving
2            (0.5)
3   PAT:     nah I thin[k]  e[rm]
4   CNS:                [n]o [(u]nclear)
5   PAT:     I think I'm good I think I'm good at the moment thanks=
6   COM:     =↑yeah I think you feel relieved cos you've made the de[cisi]
7   PAT:                                                           [yeah]
8   COM:     -on
9   PAT:     [yeah] I've made my deci[sion] now and erm=
10  CNS      [yeah]                  [yeah]           =(unclear)=
11  PAT:     =obv[ious]ly you you you want it gone [as simple as th]at
12  CNS:         [yeah]
```

One thing that will become apparent with this extract is that it comes at the end of an appointment and appears less obviously concerned with preference construction. Indeed, the patient had stated their preferred treatment option earlier in the appointment, and as such my analysis will focus not just on the formulation of a preference, but the importance of the work that builds up to the preference. Indeed, the work of constructing a preference, from the sequential context that leads into it to the stated preferred treatment are all part of the preference as a unique interactive construction. Towards the end of the consultation the CNS poses a yes/no interrogative (Raymond, 2003) to elicit any potentially unaddressed concerns. Notably, they use the less successful "`any`" rather than some, which might not perform the elicitation (Heritage et al., 2007). In turn, the patient declines the CNS's offer to field further questions with a loosely type-conforming rejection "`nah`" (Raymond, 2003), and then begins to account for the declination. Accounting for the declination, as a potentially dispreferred action (Pomerantz, 1984), involves two pieces of discursive work.

For one, the patient relays a cognitive and temporal formulation that indicates they have reached a particular juncture and are satisfied at this time (Button, 1990). Notably, the temporal formulation comes in the second reformulation (line 5) and upgrades the initial turn to render the intelligibility of the declination as localised to this late stage of the appointment (Button, 1990). Relatedly, the temporal formulation softens the potentially dispreferred action of declining further specialist information; the patient simply reaches a point of satisfaction near the end of the appointment. The patient's companion proceeds to affirm the patient's account and expand it with the same cognitive notion of inner workings. Here we see the second discursive act as the companion makes use of an emotion category (Edwards, 1997) and ascribes a sense of relief to the patient. In ascribing relief to the patient, the companion makes relevant an emotional reaction rather than a cognitive one (Edwards, 1997), such as claiming to know everything necessary for undertaking surgery for instance. Both the emotion category work and the temporal formulation are consonant with each other in inoculating the patient from anything other than reaching an understandable state of relief and satisfaction near the end of their appointment.

The patient affirms the attribution and upshot offered by their companion by stating that they have made a treatment decision (line 9). Again, the patient offers a temporal formulation to take the turn beyond a minimally acceptable affirmation and localise the actions; the need for further questions does not exist in this space (Button, 1990). The construction has come close to its conclusion (line 5), the patient is ascribed a primarily emotional response and subsequent state (line 6), and the immediate environment is one that has a decision requiring no further questions (line 9). Having declined the CNS's initial offer and accounted for this action, the patient provides their preference in line 10. The patient begins their turn with "`obviously`", which has rhetorical value in implying that the following utterance is something that nobody would reasonably quibble with. With the grounds having been laid, the patient remarks that they "`want it gone`", which might read as deceptively simple considering the clarity of expression and almost stock sounding nature of the preference. However, the preference cannot be divorced from the work that has gone into laying and constructing the foundations. The desire to get "`it gone`" follows from the lack of necessity for further questions, the emotional state of relief rather than, say, inquisitiveness, and the sequential location of close to the end of the appointment. Not to speak of the rhetorical flourishes of "`obviously`" (line 11) to begin the preference and "`as simple as that`" (line 11) to close it out as something near enough self-evident.

This analysis has shown the importance of considering patients' preferences as more than a named treatment option or generic response to an elicitation question. It is necessary to understand parties talking about decision-making or decisions, not simply the decision negotiation process. The reason for understanding talking about the decision is that this is part of the decision-making process and can serve as local interactional context for preference work such as in this extract. Indeed, the discursive work that goes into the decision process talk is necessary for laying the groundwork of a clear preference formulation. Talking about the decision here is necessary also because the decision might not have been ratified and the patient referred, so the talk is valuable in firming up the preference and presupposing a commitment.

Extract 4.5 (recording 1)

```
 1  CNS:     do you have any questions around that because I know she's p-
 2           -robably gone through a bit of it with you and I don't want to
 3           go over too much of the ground if you've-
 4  PAT:     no no er:m she explained erm quite a lot=
 5  CNS:     =yeah=
 6  PAT:     =about the (.) about well about both=
 7  CNS:     =yeah=
 8  PAT:     =so yeah ye[ah]
 9  CNS:                [mm]
10  PAT:     mm mm mm I think I'm pretty much kn:ow=
11  CNS:     =know a bit mo[re]
12  PAT:                   [wh]at
13  CNS:     ye:ah
14  PAT:     erm each one involve[s]
15  CNS:                         [e]eah
16  PAT:     a::nd (0.2) and I'm already thinking (.) along one
17           track=
18  CNS:     =right=
19  PAT:     =y'know to go down
20  CNS:     °ok° right so on- with the surgery though erm it is
```

21 an overnight stay >roughly< we try and get you home following
22 day .h most patients seem to go home after the following day
23 .h and as that’s home with a catheter

The previous extract demonstrated a patient’s firm preference formulation “`want it gone`”, and the use of an emotion category (Edwards, 1997) as accounting for this preference. In the above extract, the focus again shifts as the patient builds up a preference through the construction of a mental state and does so in a markedly distinct way. This extract begins with the CNS asking after the information that another clinician gave to the patient, ostensibly to avoid repetition. Although the question solicitation sequence was grammatically a yes/no interrogative (Raymond, 2003), the patient goes further in response and characterises an appointment in which they were well informed about their two possible treatment options. Between lines 6-9, the patient and CNS produce a sequence of possible completion and speaker transition (Sacks et al., 1974), both abstaining from claiming speakership rights beyond these short utterances. Perhaps orienting to the CNS abstaining from self-selection (Sacks et al., 1974), the patient proceeds to offer a hedged entitlement to knowledge about the treatment options.

We can track the development of a claim to sufficient understanding across the patient’s sequence from lines 4 to 14, at which point the patient has constructed a working understanding that stands to preclude the necessity of asking further questions. In the first instance, the patient reports in lines 4 and 6 that the other clinician provided substantial explanation. As such, the patient has been subject to much expertise, and the clinician’s category entitlement to specific knowledge (Potter, 1996, p. 114). That is, the patient reports on substantial information exchange delivered by one who is treated as entitled to have such knowledge (Potter, 1996, p. 114). Indeed, this knowledge might colloquially be termed medical knowledge due to the entitlement to ownership of that knowledge that clinicians have (Sharrock, 1974). From this start point the patient proceeds to make it known that there are two treatment options, which is useful for building their entitlement. Two options limit the extent of specialist knowledge necessary to develop an informed preference and minimises the notion that the patient might not be sufficiently informed.

There is an interesting exchange between lines 10-11 where there appears to be a mismatch between the patient’s formulation of their epistemic position and the CNS’s reformulation.

While the patient appears to be working up a firm claim of knowledge “`pretty much know`”, it is notable that the CNS reformulates the patient’s claim as qualified in latched speech as “`a bit mo[re]`”. Here, then, the patient appears to be positioning themselves as higher up the epistemic gradient K+ (Heritage, 2012a, 2012b) and therefore closer to the CNS. By contrast, the CNS appears to be positioning the patient on a shallower K- epistemic gradient (Heritage, 2012a, 2012b). On the face of it, this reformulation and mismatch is potentially troublesome, but it does not appear to provoke trouble as the sequence progresses. We can see the patient continue their unfolding sequence as the CNS responded with receipt and acknowledgement tokens (lines 15 & 18).

Sequentially, the patient moves from the report of the expert informing, and almost category entitlement by proxy (Potter, 1996), to a claim of knowledge with the invocations of thinking and knowledge in line 10. Plausible candidate explanations for the non-definitive nature of the formulation are the early position in the appointment and the delicate nature of an entitlement constructed out of information exchange. Line 14 clarifies the patient’s project further, as they make clear that they have reached a working level of sufficiency for treatment information exchange. It is in line 16, after the earlier work, that we see the more obvious preference statement. A preference statement would necessarily have to come at this later point to successfully accomplish a sequential project of building an epistemic entitlement. Indeed, the patient starts this turn with a stretched “`a::nd`” (line 16) to link the upcoming production to the preceding project, while also projecting an upcoming utterance and therefore claiming speakership rights (Sacks et al., 1974).

In formulating the preference statement, the patient produces a pre-announcement of the preference (Terasaki, 2004). Here the patient refrains from declaring a preference outright but does imply an incipient preference with the utterance “`I'm already thinking`” (line 16). The construction of a mental state via this cognitive phrasing is also interesting coming off the back of the public working up of information exchange. We can see from the CNS’s next turn that they acknowledge the incipient preference for surgery and go on to inform the patient further on the procedure. Therefore, the CNS does not treat the preference as hedged but rather an actionable choice. There are two features of this formulation worthy of comment. For one, the pre-announcement coupled with the track metaphor allows a non-committal position. Institutional mechanisms, such as the multidisciplinary team, can provide barriers that preferences cannot circumvent, or the need for further referrals or appointments. As such, a move like the patient makes can sound out any potential barriers while also making known that an incipient preference is taking shape. There is, therefore, a bidirectional set of possible responses to pursue depending on the expected response to the utterance.

This analysis is insightful because it reveals another way that patients can construct preferences. That is, the construction of a preference as something hinted at rather than named outright. Through the production of cognitive language and constructions of mental states the patient can build an ostensibly intelligible, per the CNS's demonstrable uptake, picture of a preferred treatment. Awareness of such a construction project is noteworthy because it suggests the potential of an almost unspoken preference that certainly is not commensurable with elicitation style preferences. Furthermore, this style of construction is in stark contrast with the following extract, which has a firm preference that the patient does much to make overwhelmingly clear to the clinician.

Extract 4.6 (recording 6)

CNS: sorry it's probably me[(unclear)]
PAT: [no it's no]t that I just can't do
needles (.) I ah I I g ((sighing)) I faint over at needles=
CNS: =h(h)uoh=
PAT: =blood tests and the whole lot I'm=
CNS: =OH DO [YA]
PAT: [ph]obia I take after me mum bless her=
CNS: AWW:::=
PAT: =I've took after her all the time I (0.2) when I had my
COM: (he's well aware of the [erm)] [(unclear)]
PAT: [biop]s[y I I wen]t I went and
had it in me hand=
CNS: =aww did ya bless [you]
PAT: [and] I just don't do needles

… 16 lines omitted

CNS: WELL Y'KNOW=
PAT: =I know=
CNS: =>WITH THEM< WE'RE JUST TALKing about the options anyway you
don't have to think about anything yet or decide a-
an[ythi]ng at this point these are just me .hhh being very
PAT: [yeah]

Up to this point the patient has been asking about hormone therapy treatment and the line of questioning has led the CNS to orient to a breakdown in shared understanding (line 1). Despite the CNS apologising for a perceived loss of intersubjectivity the patient disaffirms this candidate understanding in overlap, closing off the project prior to any further sequential work. In this space, the patient puts forward their reason for the question and begins their preference construction work. The patient's utterance is glossed as something accepted and unspectacular through their minimisation "`just can't`" (line 2), which gives a matter-of-fact air to the admission. In the next line there is marked disfluency coupled with an affective display, sighing, that suggests trouble in formulating the production. Such displays might be understood as adding to the factual quality of the production (Potter, 1996). Having made the trouble associated with needles visible, the patient goes on to intensify their response with an extreme case formulation (Pomerantz, 1986). This extreme case formulation is considered possible, as we have no means of verifying whether the patient does "`faint over at needles`" (line 3). The CNS receives this information with laughter particles that might be heard, it is not entirely clear, as containing a change of state token (Heritage, 1984, 1998), and therefore suggesting that the information provided is novel (line 4).

These laughter particles might show that the CNS orients to the extreme case formulation as non-literal (Edwards, 2000) and the turn as less than entirely serious (Holt, 2013). The patient continues along this minimisation project by providing a routine, and therefore mundane, example of scenarios involving needles in "`blood tests`" (line 5). Having performed this foundational construction work, the patient rounds off their production with a generic "`the whole lot`" (line 5) that might be hearable as the final item in a three-part list (Jefferson, 1990). With the CNS latching their speech in lines 4 and 6 it might be the case that the CNS orients to the patient's list as weak, and thereby not providing the emphatic completion that a three-part list would otherwise provide (Jefferson, 1990). The CNS produces a clearer change of state token (Heritage, 1984, 1998) but this time in the grammatical form of a yes/no interrogative, albeit possibly hearable as rhetorical, and with increased volume more clearly indicative of surprise. As the CNS's speech was latched, and it was not clear that the patient had reached a transition relevance place (Sacks et al., 1974), the patient continues their truncated turn in line 7.

The patient reports that they have a phobia, presumably of needles, and this provides a psychopathological explanation for the earlier extreme case formulation of fainting at needles (line 3). Adding something psychological, indeed an anxiety disorder, escalates the patient's stance from merely dispreferred to an outright barrier. In the same turn the patient remarks that they take after their mother and this report is rhetorically useful for invoking the immutability of heritable traits. That is to say, the patient mobilises a barrier to getting over the phobia that is glossed as particularly resistant to more generic or dispassionate appeals from the CNS and companion. Indeed, coupled with the reference to phobia, the patient essentially attempts to close off the entire issue as out of the question. The CNS has already produced two change of state tokens in response to disclosures about needles, which suggests they may have been unaware of this information. At that moment there would be no immediately available resource for checking the patient's claims, which positions the CNS lower down on a shallower epistemic gradient (K-; Heritage 2012a, 2012b).

The patient then compounds this by reporting on something that the CNS has no way of verifying, and which is so firmly in the patient's lifeworld domain (Mishler, 1984) that it might not even be considered their place to seek such verification. Rhetorically, then, the patient is mobilising resources available to them in such a way as to construct a position of authority over the CNS from which they can frame their preference as something constructed across contextual specifics and broadly inaccessible to the CNS's influence. We see this work borne out successfully after a further sixteen lines, at the end of the extract, at which point the CNS pushes to move away from decision-making implications and reiterates that this is simply a discussion of options. In essence, then, the patient has constructed a preference that is more complex than simply refusing the hormone treatment without explanation and in doing so has made the preference more robust.

Something immediately apparent from this section is, again, the variability of the forms that preference construction can take. Indeed, extract 4.4 concerned a strikingly simple preference, but one constructed through a mixture of specific temporal formulations and explanatory emotion categories and ascriptions. By contrast, the second extract does not voice the preferred treatment, and instead builds on entitlements to knowledge and the reported speech of clinicians' category entitlements to prepare the ground prior to announcing their preferred treatment. Perhaps most complex is the third extract, which works on establishing the severity of an adverse reaction to an aspect of hormone therapy treatment.

While this reaction, encompassing claims to a phobia, would be sufficiently complicated for a CNS to navigate the patient goes further. The phobia is presented as being associated with the patient's mother and mundane experiences of medical procedures requiring needles. As such, the CNS ultimately finds themself in the position of halting the sequence and restating that this is merely a discussion rather than anything decision implicative.

This section has built on the previous one by expanding our frame of reference, and providing examples, of another distinct way that patients can construct their preferences. As such, it continues to work towards addressing the research aim of identifying what patients' preference might look like as constructions. Relatedly, although the sections do differ in the way that they showcase construction, they share in that unifying pattern, that these are preferences that come to be constructed. I wish to note that by constructed preference I mean a project of construction that potentially takes in several discursive acts and elaborate conversational resources that can be distributed across long stretches of talk. For example, in the extract that begins section 4.4 the patient produces emotion categories (Edwards, 1997), remembering as a discursive act (Lynch & Bogen, 2005), and epistemic entitlement by appeal to prior medical experience among other acts. Having moved from projects of construction centred around accounting for firm preferences to preferences that turn on cognitive and emotional invocations and formulations, the final section will consider the role of prior experience in constructing patients' preferences.

4.4 Constructing preferences: The invocation of prior experiences

Having examined emotional and cognitive states and invocations in the previous section, this section will focus on the role of prior experience. As such, the focus remains on discursive and psychological resources available to patients in appointments. Furthermore, it also continues to develop the characterisation of patients' preferences as unique interactive constructions that this chapter is concerned with. Although the extracts in this section are typically longer, especially the first one, the focus is squarely on preference construction that turns on prior experiences. To be specific, the production of longer multi-turn extended construction sequences that take time to invoke prior experiences. Extract 4.7 draws on a surgical complication that is mobilised comparably to the dispreferred option of surgery. By contrast, the second extract turns on an experience from the patient's prostate cancer biopsy that they will potentially experience again if they undergo surgery. The third extract shows discussion of prior experience at a different sequential position, which has implications for the discursive action it performs. We can see already, then, that both the sequential context and invocations of experiences themselves can be consequential. Furthermore, that this approach can show the variability that can make patient's preferences a challenge for clinicians not just to identify but to render consequential and influential for decision-making and, crucially, a shared decision.

Extract 4.7 (recording 1)

```
 1   CNS:     I've seen that she's put down oncology and I'm not- I don't
 2            think- the decision for oncology is that because of you're
 3            sort of leaning towards oncology- oncology is where they do
 4            the radiotherapy
 5   PAT:     yes I am (.) le:aning to[ward]s the: radiotherapy treatm-
 6   CNS:                             [yeah]
 7   PAT:     [-ent] rather [than surgery]
 8   CNS:     [yeah]        [is there any] reason why
 9   PAT:     erm (.) I'm a bit nervo[us abo]ut having (0.2) erm surg-
10   CNS:                            [mm mm]
11   PAT:     -ery down in that area I don't like the sound of y'know po-
12            -ssibility of cutting through .h erm ne:[rv]es
13   CNS:                                             [mm]
14   PAT:     in that area roun- the y['kno]w going round the prostate
15   CNS:                             [yeah]
16   PAT:         y['kno]w so they I get y'know I don't get the sensation-
17   CNS:          [yeah]
18   PAT:     -s not having an orgasm things like th[at] I mean that that
19   CNS:                                           [mm]
20   PAT:     wo:rries me
21   CNS:     yeah
22   PAT:     going forward (0.8) erm I: e: it's a long time ago but I had
23            a: (.) vasectomy and I know it['s] different area I was one
24   CNS:                                   [mm]
25   PAT:     (.) of erm (0.2) one in about fifty thousand whose vasectomy
26            went very very wrong
27   CNS:     right
28   PAT:     (alright) I bled internally
29   CNS:     ye::ah
30   PAT:     I was off work for ten week[s i]n massive amount of pain
```

CNS: [m m]
right
PAT: right I’ll never forget that
CNS: no
PAT: right that’s
(1.0)
PAT: up here
CNS: right
PAT: and I do not want (0.8) anything like that happening
CNS: no
PAT: I kno:w y’kno[w]technology impro:ves y’know and >that< et
CNS: [mm]
PAT: cetera .hh but y’know basically you try telling my head that
CNS: yeah [yeah] ok
PAT: [it’s] it’s har- it’s a hard one to get round that is
CNS: I know
PAT: (and and/erm erm) I don’t like the: risks of the surgery
CNS: right
PAT: I’d rather go for something (.) a lot less invas[ive]
CNS: [inv]a-
-sive yeah
PAT: and as the lady was saying y’know these days with the advanc-
-es in radiotherapy
CNS: mm mm
PAT: right there’s an equal chance=
CNS: =mm mm=
PAT: that the t- both (.) treatments are about equal chance of
success
CNS: they are right
PAT: so I’d rather not put myself through the invasive surgery
CNS: ok (.) so I see both sides so I know aha for me=
PAT: =mm=
CNS: =the surgery works really well yes
PAT: yes
CNS: erm and erm yes you do lose things like your erections but t-
hey do work towards sparing nerves .h to enable spontaneous
erections if they’re able to

Patients can voice preferences that appear fully formed, and capable of being captured in a single turn or sentence. The issue, however, is that while the preferred treatment may be captured in a single turn, the actual constructed preference can often take a far longer form and follow the initial snapshot of a response to an elicitation question. Part of what distinguishes preferences as constructions (Elwyn & Miron-Shatz, 2010) is that they are more than an endorsement for a treatment option. Rather, a constructed preference is the total of the interactive work and discursive devices that go into ultimately endorsing a treatment option. As such, it is important to demonstrate the scope for and potential scale of interactive work that can, and does, go into the work of constructing a preference and rendering a preference as constructed. In this extract, the patient works up a specific example that has drawn on entitlements through past experiences, discursive and communicative resources, and emotion categories in service of a strong dispreference for surgery. The first four lines here showcase the CNS checking a candidate patient preference. In line one the CNS can be seen as doing a noticing and thereby reporting on the actions of a junior doctor who saw the patient for a diagnostic discussion and preliminary treatment discussion prior to this appointment.

This noticing affords the CNS a way into checking the purported preference and provides a basis for the patient to respond. Furthermore, the CNS uses the phrase “`decision for oncology`” (line 2), which implies that the patient has come to the point of, at least preliminarily, agreeing a decision for radiotherapy treatment. The CNS then offers a candidate account for this decision which is that the patient might be “`leaning towards oncology`” (line 5) positing that it might rather be an incipient preference beginning to take shape. Despite implying both that the patient has a developing preference, and might have decided, they cut themselves off to provide a characterisation of oncology. The CNS’s question takes a longer form but can be recognised as a yes/no interrogative at its root, which projects a yes to affirm the request for confirmation embedded in the question (Raymond, 2003). A type-conforming yes affirms the CNS’s preference-implicative “`leaning towards`” (line 5). However, the patient begins to formulate a contrastive preference by way of tagging surgery to the end of the turn, while selecting the word rather has clear preference implications.

With the checking question answered the CNS asks a follow-up question that functions to elicit a reason for this "`leaning`" and, by extension, a preference underpinning or accounting for this leaning. A preferred treatment on record, the patient provides the reason for their expressed preference for radiotherapy over surgery. In so doing, the patient invokes an emotion category (Edwards, 1997) of being "`a bit nervous`" (line 9). The emotion category is thereby given explanatory power (Edwards, 1997, p. 191) in the account and sets up an unfavourable or dispreferred account of the prospect of surgery. There is also a future tense attached to the prospect of surgery, which suggests that the prospect alone of surgery is worrisome. As such, the patient begins to firm up the preference and this is rhetorically useful for implying the possibility that surgery in the future would cause worry.

Continuing this construction project, the patient refers euphemistically to surgery "`down in that area`" (line 11), which is a scenario that radiotherapy avoids. Therefore, radiotherapy also avoids the emotion category ascribed to surgery, and in turn the cause for being "`a bit nervous`" (Edwards, 1997). Beyond the emotion category ascription, the patient uses the language of risk and contingency when formulating a specific issue "`possibility of cutting through .h erm ne:[rv]es`" (lines 11-12). This formulation is notable because it is a risk specific to robot-assisted radical or laparoscopic prostatectomy, and therefore is a category-bound activity of a surgeon and their patient (Jayussi, 1984; Sacks, 1992, vol. 1, p. 40-41). This boundedness of the activity means that, again, it cannot be encountered during radiotherapy. As the CNS elicited this preference, they orient to the necessary suspension of typical turn-taking conventions to allow the patient to continue their telling (Sacks et al., 1974).

Within this extended telling the patient is continuing to weave together the flexible emotion category, and the bounded activities and consequences of surgery in one package, as ostensibly inseparable for useful rhetorical grounds. In lines 16 and 18 the patient continues to work up a specificity, going from the fuzzier experiential notion of losing "`the sensation`" (line 16) to "`not having an orgasm`" (line 18), which adds detail to the concern previously expressed. The patient's account becomes firmer and increasingly stable as a particular version, or preference (Potter, 1996). That is to say, the patient adds detail and specificity to their previous euphemistic formulations and build towards a clearer picture of an aspect of surgery relevant to preference. All the while the patient is maintaining the interweaving of the emotional and the practical, with the embodied notions of lost sensation (lines 16 and 18) described as something “`that wo:rries me`” (lines 18 & 20).

Worry being an emotional state that can be linked to being nervous. Both emotional productions, then, are consonant with each other and therefore provide a coherence and reliability to the account in process. As such, the patient is working towards an objection to surgery on emotional grounds, but an objection that is beyond challenge. The interweaving of the practical embodied fear of “`not having an orgasm`” (line 18) and the personal emotional state of worry ground and support each other. By this point, then, the patient has been building their preference on the grounds of, and interplay between, emotion categories and emotional states (Edwards, 1997) and specific aspects and potential risks of surgery. Going forward, the patient develops their preference further by appealing to a prior medical experience, thereby raising a lifeworld contribution, and mobilising remembering as a discursive act (Edwards & Potter, 1992; Lynch & Bogen, 2005), a pattern we saw earlier in section 4.2.

Although the patient leaves a point eight of a second pause in line 22, which might be heard as a spot for speaker transition (Sacks et al., 1974) they go on to begin a new turn. In so doing, the patient projects an upcoming story formulation with the temporal formulation “`a long time ago`” (line 22). Revealing that this projected telling occurred in the past indicates lasting relevance as opposed to being fresh in the patient’s recent history (Button, 1990). The second function of this temporal formulation is that the distance afforded by it is a resource itself, and the patient can be seen both as sufficiently distanced from the event to deny recency bias, and by making the concession to the passage of time the patient closes this avenue of rebuttal to the CNS. With a “`but`” immediately after the temporal formulation the patient begins to further work up the relevance of the telling.

The first act is to reveal that they “`had a: vasectomy`” (lines 22 and 23), which establishes a previous experience of surgery. In turn, the patient establishes a base for surgery as a possible source of worry or nervousness. As with the concession to the procedure being “`a long time ago`” (line 22) the patient also acknowledges that the procedure was a “`different area`” (line 23). Once more the patient acknowledges a possible point of contention and possibly gets ahead of the CNS while also offering inoculation through casting them as someone aware of potential weak points in their argument (Edwards & Potter, 1992, p. 154). At this juncture the CNS continues to sanction the suspension of turn-taking conventions, offering minimal acknowledgement tokens to allow the patient to continue. Immediately after the concession, the patient makes a statistical invocation that uses the numerical value to appeal to the unlikelihood of the misfortune they outline in the following line.

While the statistical likelihood is striking for its appeal to unlikelihood, it also has something of an upshot in that the patient might be considered unlucky, which is hard to challenge or undermine due to its subjectivity. Additionally, the patient provides repeat intensification to emphasise the severity of the misfortune. As with the earlier progression from the euphemistic “`in that area`” to “`going round the prostate`” (lines 11 and 14), the patient again moves from a more general to specific issue, adding detail as they go. In line 28 the patient proffers an understanding-checking “`alright`” before revealing that their misfortune was internal bleeding. Another temporal formulation (Button, 1990) follows to make known that the patient had to miss ten weeks of work following the vasectomy (line 30). The intelligibility of this formulation is that the typical annual leave allowance in the UK does not exceed an average of 5.6 weeks for full-time workers (Department for Business, Energy & Industrial Strategy, 2020). This complication, the intensifiers preceding its announcement, and the noteworthy timescale all cohere in this multi-turn sequence to provide an interlocked candidate reason to be nervous about surgery. Moreover, the introduction of a lifeworld concern in taking extended time off from work allows for the “voice of the patient” (Mishler, 1984) to become visible and material for the decision-making discussion.

The relevancy of this experience, this lifeworld concern, is compounded in the declaration that the patient will “`never forget that`” (line 33). Of course, this ties together the previous implication that the long time that has since passed is no barrier to the significance and impact of this experience. The declaration that the patient will “`never forget`” (line 33) is noteworthy because forgetfulness is a common excuse in response to having failed to do something. Indeed, “Cognitive actions like remembering and forgetting are of a piece with other communicative actions like answering questions, telling stories and demanding explanations for problematic conduct.” (Lynch & Bogen, 2005, p. 239). To claim then that one will never forget something is striking because it mobilises the discursive notion of remembering as practice rather than process (Edwards & Potter, 1992) to preclude the possibility that this experience, and therefore dispreference for surgery, would ever slip their mind. Going further, the patient remarks that the internal bleeding is "`up here`" (line 37), which is not immediately clear because of the audio-only nature of the data. One plausible candidate for "`up here`" (line 37) however, is that the patient gestures to their head thereby implying that the memory is locked in. Such an explanation would follow the preceding declaration that the experience will never be forgotten. In this case, the patient would be mobilising both the discursive resources of remembering as communicative and the inaccessibility to others of something so entrenched as to have a place in the patient's mind away from the externalities of the interaction.

The patient thereafter begins a transition to a broader message that they "`do not want (0.8) anything like that happening`" (line 39). Despite the preceding work building on a vasectomy experience the patient is now making clear that any surgical mishap or complication would be dispreferred. This broadening of the focus allows for the patient to ward off any projects that might seize on the specificity of the experience to hold the surgery here as sufficiently distinct. As in line 40, the CNS acknowledges this turn with a "`no`" that suggests a display of understanding beyond simple recipiency, perhaps responsive to the patient's checking-implicative "`right`" repeated on lines 33, 35, and 37.

When working up the story formulation the patient offered some concessions, in lines 22 and 23, that functioned to close off counter claims that either too much time had elapsed or that the surgery would be markedly distinct. This restatement is relevant because the patient again begins an inoculation project as they concede that there have been improvements in technology since the time of their vasectomy (Potter, 1996). In so doing they are working to dismiss any possible counter claim of wilful ignorance about or acting uncharitably to developments in surgery and the efficacy and benefits associated with this advancement. The concession is made in general terms and rounded out with a generic "`et cetera`" that therefore stands in contrast to the discursive work that follows. After a sustained inbreath the turn pivots on a "`but y'know`" that proceeds to the patient situating their preference as inaccessible.

The patient does this by drawing a mind/body distinction (Descartes, 1998) in a way, as the head is presented as an arbiter held distinct from the body. Although the body might be convinced, the head, and by extension all its cognitive processes and inner workings, remain to be convinced. A rhetorical move is apparent too, as the “you try” ascribes an accountability for sufficiently selling the surgery treatment in a manner amenable to the patient’s head. Naturally, this is glossed as rhetorically difficult in response to the working up of the internal bleeding as an unforgettable experience (line 33). In response, the CNS produces a longer turn but the patient treats their own turn as incomplete and overlaps the CNS by their second utterance, rendering the turn a glorified acknowledgement token. That said, the acknowledgement tokens might be a mirror to the developing intensity of the patient’s extended telling and case against surgery.

In overlapping and cutting off the CNS it is the patient’s project to outright give voice to the inferable difficulty at getting past the stated reasons for being nervous about surgery and the associated risks. The patient, in essence, offers an upshot of the entire construction sequence, which has built this preference as something difficult to surmount or disregard. Once more the CNS offers an acknowledgement of understanding, which is not cut off at this occasion. From this upshot, the patient explicitly names the risks of the surgery as dispreferred, which is a clear statement of preference. Moreover, the production is hearably similar to “I don't like the sound of y'know possibility of cutting through .h erm ne:[rv]es” (lines 11-12). Risk is a relevant production also for the fact that the earlier statistical likelihood invocation might imply that the patient is in some way an unlucky person.

Responsively, the CNS offers a continuer “right” that demonstrates attentiveness without staking a claim to speakership rights. Building on the preference statement, the patient follows with another, clearer statement of preference in line 49. Indeed, rather is a word that is familiar to formulations of preferential choice. Notably, there is both a subject for the preference, in being invasive, and a preference for the subject to be “a lot less invasive”. The rhetorical organization of this turn has two-layers then, and this guards against modulated counters or competing versions of the preference that might undermine the patient’s position. We see the patient’s argument being constructed to preclude any soft alternatives that scale back, but do not remove, the issues of invasiveness. Here the CNS displays understanding by attempting entry into the patient’s turn space to provide a collaborative turn completion sequence (Lerner, 1996, 2004) and to acknowledge this preference with the affirmative “yeah”.

At this point, the patient has produced a vast body of construction work and the preference is sufficiently clear that the CNS could successfully perform a collaborative turn sequence. Despite all this, however, the patient launches into a piece of reported speech (Holt, 1996), “`the lady`” is likely to be the doctor that the patient saw prior to this appointment. In turn, the patient is reporting medical information that can carry with it a category entitlement by proxy (Potter, 1996, p. 132). By reporting this speech, and making the other clinician’s category entitlement available, the patient is recruiting another person to corroborate their preference (Wooffitt, 1992). As a result, the preference can be treated as routed in the broader medical domain of knowledge rather than just the experiential domain (Landmark et al., 2015). In line with this move, the reported speech switches the focus from the dispreferred aspects of surgery to the upside of radiotherapy. Radiotherapy “`these days`”, has hearable implications that surgery might once have been superior, but radiotherapy has had time to catch up. This inference is made explicit in the next turn, where the patient posits that the treatments offer “`an equal chance`”, a piece of information that is correct. Curative treatments for non-metastatic prostate cancer have an equivalent success rate (Xiong et al., 2014). The patient then continues in latched speech to restate the likelihood equivalence but this time weaving the reported fact together with the binary of “`both (.) treatments`” and therefore foregrounding the decision-making implications.

In response, the CNS affirms this report to verify the factual quality of what the patient reported, and by extension the information exchanged by the other clinician. At this point, then, the patient has invoked the quality about prostate cancer that makes it such a preference-sensitive treatment (Shirk et al., 2017) and mobilised it as a resource for the construction of their preference. In what might appear as accounting after the fact, the patient restates, albeit reformulated, their preference to avoid “`the invasive surgery`”. This formulation ties together both strands of the developing preference, the dispreferred surgery and the dispreferred invasiveness of this class of treatment. Unpacking the construction at this point involves first the problematisation of invasiveness following the botched vasectomy and the spectre of risk associated with this experience. Furthermore, the reported and subsequently corroborated equivalence of treatment success rates flattens the efficacy advantages, which allows the patient to restate their preference as responsive to this archetypal preference-sensitive juncture.

Before proceeding to the next analysis, it is worth remarking on the length of this extract and analysis, and its significance for the argument I am making. While notably longer than others, this extract is an instructive example of the elaborate and highly distributed form that patients' preferences can take in decision-making conversations. The sheer length of the extract is significant because the sequence is essentially one for checking an indicative preference for radiotherapy, which in no way presupposes the complexity of the extract analysed. As for the elaborate nature of the preference, we can see this in the variety of sophisticated discursive acts that that the patient produced when in constructing their preference. For one, the interplay between remembering as a discursive act (Lynch & Bogen, 2005), presenting emotion categories as explanatory (Edwards, 1997), and claiming epistemic entitlement through appeals to prior medical experience (Heritage, 2012a, 2012b) is dense with discursive acts and entailed much interactive work. Although not all the preference work in this section was as long and dense as this extract, they do all demonstrate the highly elaborate, distributed nature of preferences and their construction in situ.

Analysis of the next extract will provide more insight as to how patients can draw on prior medical experiences and remembering as discursive acts for constructing preferences. Of note will be the work the patient performs to strengthen their epistemic entitlement based on prior experiences and familial connections. Again, the following extract is a substantial length, and this reflects the interactional space that some of these more complex projects of constructing a preference require.

Extract 4.8 (recording 6)

CNS: (0.2) sorry hh hah I know many people think about that and
they're like <oh no> the catheter but we i it it is it is
obviously important [to know what it]
PAT: [I know what the] pain is from when I had
my biopsy and I had a catheter [and I come round]
CNS: [oh did you (.) o]k
PAT: and as soon as I started to try and wee (1.1) i've never felt pain
like it in me life=
CNS: =oh really=
PAT: =but me dad bless him (0.4) he had bowel cancer and he had to
have (0.2) eventually he had to have a catheter and the nurs-
-es used to come out to the ho[use to him] and I know now wh-
CNS: [yeah ye:ah]
PAT: -at pain he went thr[ough] when when it had to be changed
CNS: [yes:]
PAT: every fo:?ur days becuz it solidifies [a at] the end so and
CNS: [yeah]
PAT: oh a:h jesus christ (unclear)=
CNS: =I mean what hopefully I [mean you]may have a different
PAT: [(unclear)]
CNS: experience this time hopefully with it because sometimes we
use different catheters different sizes sometimes erm you
know your body may not just like that that particular
catheter at that instance an on other occasions you may you
may you may be fine (.) so to speak on a different occasion
of having a cath[eter]

We join this extract as the CNS is discussing the procedural aspects of having a catheter after surgery. Although the CNS produces a piece of rhetorically generalised reported speech (Holt, 1996) to make a point about an important contrast (line 3), the patient overlaps and cuts off their turn. The patient's overlap begins an epistemic claim of entitlement (Raymond & Heritage, 2006; Heritage, 2012a, 2012b) to knowledge of an embodied phenomenon and lifeworld experience (Landmark et al., 2015). In launching the entitlement, the patient reports that they have experience with a catheter from their biopsy (lines 4 and 5). The revelation is met with a change of state token and tag question that displays the disclosure as novel information (Heritage, 1984, 1998). Despite the CNS speaking up, the patient talks through their response and produces an extreme case formulation (Pomerantz, 1986) "as soon as I started" (line 7) that also includes a temporal formulation to indicate immediacy and intensity to the experience (Button, 1990). Another extreme case formulation follows to present the embodied experience of wearing the catheter as outside of tangible comparison "never felt pain like it in me life" (lines 7-8). Here, again, the temporal formulation is important for the work of situating the severity of the experience as spanning a lifetime (Button, 1990). In latched speech the CNS produces another change of state token and tag question combination (Heritage, 1984, 1998), which might suggest that catheters are not typically reported as provoking such intense reactions. Perhaps due to the latched nature of the speech, the patient does not orient to the CNS's contribution and continues with their turn.

The patient pivots from their formulation, with a "but" to mention their father, and introduces this familial invocation with a display of sympathy "bless him" (line 10). After a short pause the patient reports that their father had bowel cancer. Moreover, that beyond the similarity of having had cancer, the father also had a catheter (line 11), and the patient builds the relevance of this telling across these similarities. From this relevance the patient moves into another epistemic entitlement claim, this time that they know the pain their father experienced (lines 12 and 14). By remarking that they "know now what pain he went thr[ough]", the patient mobilises the discursive resources of a relevant temporal formulation and a comparative epistemic claim. For one, the patient only claims to know the pain that their father experienced now, after wearing a catheter (Button, 1990). In addition, the knowledge claimed is that of their father's experience, and therefore the movement on an epistemic gradient is to bring the patient closer to the father's K+ position rather than outright challenge the CNS (Heritage, 2012a, 2012b).

By recounting further detail about the frequency with which the catheter was changed, and the reason for changing the catheter, the patient further builds their epistemic entitlement. This exchange echoes other extracts in this chapter as the epistemic entitlement is based on remembering and experience. In the cases of experience and remembering, the two are present as psychological states and acts respectively, and we see them produced and accomplished interactively, as discursive acts in these exchanges. Over the course of this extract, the patient has drawn on a claim to knowledge inaccessible to the other parties, due to the familial relation and embodied experience. In localising the claim to their father and their biopsy experience the patient constructs a preference that leaves the CNS with limited options. We see the constraints on the CNS borne out in the turns that follow where they produce a series of hopeful and probabilistic formulations that do little to incorporate or avoid the dispreference for a catheter.

This analysis has examined one of the ways that patients can draw on prior experiences, as a discursive act, to construct their preference. While the patient built up entitlement through their own embodied experience, they developed that entitlement further by weaving together their experience with that of their father, who experienced cancer and catheters. Therefore, the preference becomes something inaccessible to the CNS and deeply woven together with the patient and their experiences. In the next extract I will analyse an extended project of constructing a preference to avoid side effects associated with radiotherapy. The analytic focus will be on the way that the patient uses the discursive act of remembering and prior medical experience to construct a preference.

Extract 4.9 (recording 17)

1 CNS: d'you have any questions cos I talk a lot:
2 (1.3)
3 PAT: well basically mister (0.2) doctor what d'ya call it says
4 about when you have the (unclear) radiotherapy=
5 CNS: =yeah
6 PAT: or (y'know) there are those .hh it's possible sometimes
7 y'know bleeds and stuff like that
8 (0.5)

CNS: err: bleedi:ng (0.2) where
PAT: [well]
CNS: [blee]d
PAT: ee said (>well out<) your back passage [( )]
CNS: [from]: (.)
((stammering)) does he me:an >in regards to< the side effects:
PAT: side effects yeah=
CNS: =so there are some side effects of radiotherapy treatment
(0.4) th:e bleeding is not one that I'm: (.) particularly
[familiar with]
PAT: [it won't it w]on't affect me warfarin will it
CNS: hmm: no it shouldn't do no cos
PAT: no I'm sort of asking because
CNS: oh is this [what you mean I]thought you meant as in visible
PAT: [( )]
CNS: no n[o no]you should be able to
PAT: [no no] no like I mean like if I
take warfarin becuz it
CNS: oh your eye and are and things like [tha]t no: it shouldn't
PAT: [yes]
CNS: do [no]
PAT: [oh] cuz b- becuz it sort of like (0.2) thins the blood
out
CNS: yeah
PAT: I mean it's not gonna (0.4) cause (0.9) a bhu [larger]
CNS: [( ) n]ormally
do NO [no no]
PAT: [not a] lot of bleed[in]
CNS: [it] shouldn't do
PAT: a normal
CNS: WEll (.) >to be h[onest<]
PAT: [if I d]id end it
CNS: the radiotherapy treatment is localised to the prostate
gland anyway (.) so (0.5) y:'know (0.5) we're irradiating the
prostate

For this extract above, the CNS has come to a juncture after an extended informing and offers to field any questions the patient might have. After a notably long pause the patient takes up the offer, therefore completing the adjacency pair (Schegloff & Sacks, 1973) and produces a simplified upshot formulation (Heritage & Watson, 1979) of a piece of information given to them by another clinician. The patient uses loose reported speech (Holt, 1996) to mention a candidate side effect of radiotherapy treatment "`bleeds and stuff like that`" (line 7). Perhaps due to the disfluency and general characterisation of the effect, the CNS treats the report as insufficiently informative and requests clarification (line 9). In response the patient hurries through another loose piece of reported speech (Holt, 1996), but the CNS again seeks clarification by offering a candidate context for the other clinician's reported speech "`>in regards to< the side effects:`" (line 14).

The patient affirms this candidate context and then the CNS goes on to state that they are not "`particularly familiar with`" (lines 16-17) bleeding as a side effect. This claim to limited epistemic access (Heritage 2012a, 2012b) is useful for minimising accountability (Edwards & Potter, 1992) especially considering the importance of side effects in evaluating otherwise broadly equivocal curative treatments (Shirk et al., 2017). On the patient's side, although the formulations are loose and lay, they are reporting on information exchanged by another clinician. As such, the information carries with it the entitlement to knowledge that clinicians are commonly understood to have (Potter, 1996; Sharrock, 1974). Therefore, by repeatedly producing reported speech (Holt, 1996) throughout the sequence, the patient essentially plays this knowledge against the CNS, and their lack of familiarity (lines 17 and 18) might display an orientation to the entitlements associated with the reported speech.

Despite signs of intersubjectivity between lines 14-18 the patient asks another question, and this time introduces "`me warfarin`", a blood-thinning agent. The patient's question takes a yes/no interrogative format, and the CNS produces a type-conforming answer, affirming the patient's projected request for disconfirmation (Raymond, 2003). Over the following five lines there is a breakdown in shared understanding, which we can see the patient orient to in line 25 "`no like I mean like`". By line 27 the patient has received a further answer to their question, which is consistent with the CNS's previous answer "`no: it shouldn't`". The patient, however, responds with a change of state token, which suggests that they might be receiving unexpected or novel information (Heritage, 1984, 1998), and then immediately moves into accounting for producing the change of state token. Despite the accounting, the CNS produces a straightforward acknowledgement token "`yeah`" and does not orient to the patient's turn as providing anything novel or that challenges the CNS's, now repeated, answer.

As such, the patient has received a consistent answer to their question on four occasions in the sequence, and the CNS goes on to change the sequential trajectory. Here, the complexity of the preference is not in the subject, as that becomes clear over the sequence as a preference to avoid side effects that complicate the patient's existing medication. Rather, the preference is complex because it plays off the reported speech of another clinician. The preference, then, invokes a different kind of remembering and experience than that which featured in the first two extracts in this section. This distinction is key because the CNS has no access to the experience nor the remembering in question, but they do have biomedical knowledge of the topics that they cover. As such, the CNS offers modulated and contingent responses and there are multiple attempts to re-establish shared understanding. Further complexity comes with the lay and loose reports that the patient offers, which often led the CNS to request further clarity and information to respond appropriately.

Despite the differing lengths of these three extracts, the distinct issues of treatment they cover, and ways they invoke experience, this last point unifies them. Patients' productions of prior experiences suggest that patients treat them as possessing explanatory coherence and therefore as functional in constructing and accounting for their preferences. Notably, the invocation of prior experiences runs as a sort of parallel to patients' preferences, in that the nominal simplicity belies the complex interactional character of the action. While it is easy to say that a patient suggested they wished to avoid surgery because of a prior experience, this does not capture the entire picture. Further to being constructions, patients' preferences are discursive acts that feature epistemic claims as one aspect of their construction. The ways that patients accounted for epistemic claims included using acts of remembering and appeals to private mental experiences. Distinct discursive acts such as remembering and appealing to private mental experiences pose questions as to how clinicians respond to the associated preferences. It is, then, through the interactional work of construction, and the interweaving of potentially simple sounding but personally and uniquely complex experiences and other resources, that gives us the constructed phenomena of patients' preferences.

4.5 Discussion

Having analysed preference construction projects that span a broad spectrum of complexity and length, preference construction was not a standardised process, and patients' preferences were not a homogenous phenomenon. Patients' preferences cannot easily be reduced to snapshots in the way that the institutionalised notion of SDM has historically suggested through its modelling. Perhaps the best conceptual model of SDM to-date is the TALK model (Elwyn et al., 2017), which has discrete components or phases but remains clear on the importance of interactive aspects of the decision-making process and patients' preferences. Of course, there are cases where the patient puts forward something straightforward and immediately intelligible, but this is not overwhelmingly the pattern. Often the simplest preference formulations come later in the decision-making process and are decisions in all but name.

In turn, the appointments become procedural informing exercises to ensure that the patient is aware of all the relevant information necessary to lock in an informed preference. Now, it remains important that preference construction could be identified in the dataset, for that was the primary aim of this research. Naturally, a stable and reproducible pattern of generic organizational features over fifty extracts would have been perfect, but that does not reflect the interactions captured and reported on for the project. Indeed, while I did not have much to say about the quantity of distinct preferences, I did capture some of the variability in both more complex and ostensibly fixed and firm preferences. Opening the topic up, however, is a valuable contribution, especially considering the desire for a model of SDM that reflects and facilitates the process (Elwyn et al., 2017). In this case, we have some initial findings for a model rooted in and reflective of patients' preferences as they get constructed and discussed.

One possible takeaway from this chapter, however, is support for the claim that that SDM is distributed and takes place across various settings and interlocutors (Rapley, 2008). For instance, the diagnostic appointment, the post-diagnostic appointments with CNSs, and different settings outside of the healthcare encounters. Indeed, the prevalence of talk about patients' preferences in the dataset and analyses in this section, suggests that these appointments are only one snapshot of the decision-making process. As a result of these analyses, we perhaps find that people are not always orienting to preferences and SDM. That said, parties are always orienting to the fact that there is a decision to be made. This, then, might be a problem of framing how we consider, and approach SDM. One implication can be that we tend to think of SDM in one neat and tidy way. For instance, a clinician simply stating the following “here are your options on the table, what do you think you would like”. However, SDM does not typically take that form, and it is not actually like that. Shared decision-making is deferred, takes place over time, and is infused with lots of discursive and critical communicative conduct. The work of SDM continues and develops across the decision-making process, not just being limited to decision-making conversations, but also the whole illness journey and experience.

Further to not always orienting to preferences and SDM, it is possible also that patients do not orient to SDM formulaically. In fact, patients orient to the status of the decisions in different ways. For instance, as a decision still to be made, by themselves or with someone else, as something they have firmly decided on for various reasons, as something they are working through in relation to previous experience etc. The message might be that clinicians need to appreciate that SDM is not a box to tick but an iterative process that unfolds through different meetings in different ways; and perhaps that patients use it for different purposes. Indeed, as demonstrated in the last analytic section of the chapter, patients may pursue lots of projects when constructing a preference. When pursuing those projects, and constructing their preferences, patients are also engaged in many discursive and conversational acts that interweave and generate an elaborate and distributed preference. As it has become clear that there are many paths that patients can take to the construction of their preferences, it follows that clinicians might have to work hard to track preferences and make them consequential. In the next chapter, analysis of preference construction will look at the work of CNSs in rendering patients’ preferences visible and consequential for decision-making discussion. A further look at the work involved with patients’ preferences will encompass the subsequent handling of preferences throughout the consultation.

Chapter 5: The receipt and subsequent handling of patients' attempts at constructing their preferences in situ

Chapter Overview

In the previous chapter I demonstrated that patients do indeed construct their preferences and provided examples of construction projects. My analysis revealed that preference construction was a heterogenous process, as patients drew upon different discursive devices and conversational acts in their constructions. As such, there was no sense of preferences as a systematic phenomenon. Having established that preference construction occurs, that construction was heterogenous, and preferences lacked systematicity there remained questions to be answered. Chiefly, what happens with preferences during and following construction? Although the final decisions were unavailable to me, it became clear throughout the dataset that preferences are not equivalent to decisions. Patients are not solely responsible for the influence of their preference on decision-making. In theory, patients' preferences can be resisted if unfeasible, decisively influential for the decision if straightforward, or potentially contested if a preference complicates the encounter. As such, there is an element of decisional responsibility, and in the extreme gatekeeping, to the CNS role. Patients' preferences do not exist in isolation and their construction, even their formulation, may often be insufficient to influence the decision made.

To begin with, it is important to revisit the concept of patient's preferences as they appear in the models and definitions of SDM. In the original model of SDM, the characterisation of patients' preferences was that "both patient and physician share treatment preferences" (Charles et al., 1997, p. 683). Furthermore, that a shared decision cannot occur without the exchange of preferences. Preferences have clearly been key to SDM since the beginning, but they have not been well defined. Indeed, the term preferences has been used interchangeably with values, attitudes, beliefs, opinions, and reasons (Elwyn & Miron-Shatz, 2010). A 2012 review offered a brief characterisation of preferences as "what patients want from their healthcare" (Street et al., 2012, p. 168). Despite these observations, however, a detailed definition of patients' preferences comparable to SDM has not been attempted. It would be instructive to compare this characterisation of patients' preferences with an example of a constructed preference taken from my previous chapter. This characterisation is not incorrect, but it is also not insightful as it largely trades on the vernacular sense of something being preferred simply being something that a person would choose.

A characterisation acting as a concise heuristic is not inherently problematic, but with problems of definition around patients' preferences (Elwyn & Miron-Shatz, 2010; Street et al., 2012) there should be more insight and instruction about patients' preferences. We saw in chapter 4 that while preferences can simply be what patients want, they can also be formulated through the lens of being least dispreferred, which is the first point worth making. Second, characterising preferences by reference to the forms that they can take and expressions they make would be more insightful. For instance, a preference may take the form of a list of items to avoid, a story of a previous medical experience, as well as straightforward statements of a preferred treatment. This list is necessarily not exhaustive given the heterogeneity seen in the sample. To give an empirical example, extract 4.6 demonstrated a patient presenting needles as a dispreferred item to be avoided. First by introducing a physical effect of fainting, then by claiming similarity with their mother's experiences, and lastly giving an example of prior experiences with needles. Preferences may be very brief or expressed as part of longer interactive sequences where patients apparently seek to account for their preferences.

We might, then, consider preference construction itself as insufficient for accomplishing a preference-shaped shared decision. Successfully constructing a preference does not guarantee that it will be influential for the decision-making process. The reasons why preference construction itself appears insufficiently influential, however, is unclear. Although looking to the appointment as an interaction may prove revealing. For instance, while clinicians have been reported to elicit patient's preferences by formulating hypothetical preferences and treatment proposals, these formulations were designed to encourage acceptance of clinicians' preferred options (Landmark et al., 2017). Furthermore, paraphrasing patients' treatment stances has similarly been used to elicit and check preferences, but these were sometimes paraphrased to appear less legitimate to undermine patients' preferences (Landmark et al., 2016). Therefore, while ostensible SDM behaviour has occurred, the interactional accomplishment may be highly significant to the preference that gets expressed and the decision that gets made. The processes of eliciting and checking preferences, then, are highly context dependent. The CNSs in these encounters might be engaged in more work than the steps of SDM suggest. Patients might have constructed a preference in such strong terms, and with such a strong commitment, that they halt the progress of the decision-making business. Neither scenario discount the construction or elicitation of a preference, but they suggest reasons why looking closer than construction or elicitation is necessary.

What we can see, then, is a contrast between what is theorised, modelled, and assumed about patients' preferences and the ways they are treated in decision-making encounters. This contrast is akin to that between the notion of preferences as a stable phenomenon, or in some cases a cognitive construction, and the interactive construction of preference demonstrated in the previous analytic chapter. As such, there are grounds to investigate the role of patients' preferences as they appear in treatment appointments. This chapter will build on the analysis of the previous one to examine how patients' preferences are received and handled following their construction. The intention behind this analysis is to move beyond the generic treatment of patients' preferences as essential, but loosely defined, and continue to illuminate their practical role. Analysis will be split into two parts, each dealing with the receipt and handling of patients' preferences. The first will look at cases where a patient's preference is treated unproblematically and incorporated into the business of the appointment. The second will explore instances of how preferences that prove more challenging to the business of the appointment are handled.

5.1 Preferences on the record: Unproblematic receipts

As stated in the introduction, the analysis presented will focus on the receipt and handling of patients' preferences. In turn, extracts will include construction projects in progress, the aftermath of preference construction, and cases where outright preference statements are produced. This variety of extracts corresponds with the heterogeneity of preference construction projects reported in chapter four. Therefore, it is both representative of the snapshot of the decision-making process captured in the dataset, and the lack of systematicity I observed in preference construction. This analytic section primarily concerns instances where patients' preferences are consonant with the clinical recommendation for surgery as first choice treatment for prostate cancer. One exception appears, in extract 5.4 where a patient presents with a reported initial preference and little knowledge of the treatment options beyond name, and this is treated by the CNS as unproblematic. Before the analysis begins, I wish to remark that this chapter will demonstrate a more conversation analysis inflected analysis, and as such the focus is less obviously psychological. Instead, the focus is on the organization and management of sequences of talk, but not to the exclusion of psychological considerations.

Extract 5.1 (recording 3)

COM: [mm mm] and he’s (.) talked about the consequences of
each o[ne] what the results [(would)]
CNS: [ea]ch one [side ef]fects [yeah]
COM: [yeah] yeah
CNS: and what do you think so far
(0.9)
PAT: well hh I was just saying to my *name redacted* here .h that
it’s a bit like ladies having vasectomies
CNS: hmm
PAT: whip the whole thing off
CNS: ok
PAT: erm=
CNS: =yeah=
PAT: =erm >y’know< (.) it’s erm a little bit (1.6) demasculating
in some ways=
CNS: =yeah=
PAT: =erm better to have it
CNS: hmm mm
PAT: as I say vasectomies again come into it [surg]ical
CNS: [yeah] yeah
yeah
PAT: it’s a basic part of (0.2) masculinity (but on the other
hand) you’re safer

24 CNS: yeah (.) yeah
25 PAT: rather than taking a chance
26 CNS: so you're sort of leaning towa::rds surgery then=
27 PAT: =yes=
28 CNS: =is that what you're saying (.) mkay
29 (1.5)
30 PAT: >yeah<
31 CNS: err do you have any questions about that or d'ya think-
32 has that been covered for ya
33 (1.4)
34 PAT: I think he's covered most of it erm I'M SURE (.)

At the beginning of the extract, the companion characterises the diagnostic appointment. The companion reports that they were informed of the consequences of each treatment option, which suggests the clinician engaged in option talk (Elwyn et al., 2017). Despite the companion having a turn in progress the CNS overlaps and interrupts to mention side effects (line 3). After the companion confirms that they were informed about side effects, the CNS treats the account for claiming to have no questions as sufficient. Indeed, they then ask a question designed to elicit the patient's thoughts on these options if not their outright preference. After a gap in line 6, the patient responds to the CNS with an intelligible temporal formulation (Button, 1990) "`was just saying`" that situates the upcoming information as contemporary. The patient follows with a simile making both surgery and the gendered notion of "`ladies having`" the procedure topical. Surgery, here a vasectomy, is characterised by the lay formulation "`whip the whole thing off`", implying a gloss of surgical procedures as one and done. I note that while the patient may have meant hysterectomy, they consistently said vasectomy throughout.

The possibility of trouble formulating follows as the patient repeats the non-lexical vocalisation "`erm`", before introducing a gender identity concern. That is, the notion that having the surgery to "`whip the whole thing off`" might be seen as "`a little bit (1.6) demasculating`", which opens the patient's preferences up to lifeworld concerns

(Mishler, 1984) as well as medical ones. Interestingly, gender membership categorisation work was not necessarily as prominent in the data as one might expect. That is not to say that ostensibly gendered talk was not observed, but that the production of identity work, especially relevant to preference construction, was infrequent. In this extract, then, we have a notable case of gender membership categorisation work where the discursive work is key to the preference work. I remarked earlier that the “`demasculating`” line was notable for foregrounding a lifeworld concern, but it is also a piece of discursive identity work. The patient offers the “`demasculating`” function of the surgical procedure as a statement with explanatory coherence. Arguably, the hearable upshot of the characterisation of “`demasculating`” is that this outcome would be significant in terms of masculine identity. When we consider the principle of word selection, the patient could have chosen any number of alternatives, but went with one that can clearly be heard as gendered.

Although unclear what exactly they refer to, the patient concedes that it might be “`better to have it`” and is observably weighing out the pros and cons of surgery. As such, the work of preference construction is not only visible and interactive but is a process that could be done internally, with the outcome simply reported afterwards. Since the CNS acknowledges the turn rather than seek clarification, and the patient returns to the vasectomy simile, they might be referring to a candidate male characteristic such as erectile function. This referent would be consistent with the masculinity concern and the side effects of surgery. More acknowledgement from the CNS follows in overlap with the patient’s introduction of surgery as explicitly being the option under discussion. The equivocation between issues continues, as the patient enacts a comparison between the pros and cons of surgery. As such, we see the patient weigh the balance between a more discursive lifeworld-oriented concern with masculinity (Mishler, 1984) and a clear concern with their medical safety and treatment efficacy. Despite formulating the con strongly, as “`a basic part of (0.2) masculinity`” the patient contrasts this with the safety of surgery.

The balance might appear to swing over towards the pros of surgery as the patient uses both the lay preferential word rather and the language of risk in the formulation “`taking a chance`”. As such, the CNS moves into a more clearly elicitation-implicative turn and, in a softened, or less than decisive fashion, formulates the upshot (Heritage & Watson, 1979) “`so you're sort of leaning towards surgery then`”. Perhaps orienting to the absence of a clear preference formulation, the CNS’s question is qualified and does not imply a firm commitment. After a notable gap the patient quickly confirms the CNS’s upshot in line 30. Accepting the answer, the CNS proceeds to ask if the patient has any outstanding questions. The patient declines this offer, and, in text not included here, the sequence goes on to describe the clinician they saw previously in positive terms. Therefore the CNS helps render the patient’s preference as on the record and by extension potentially influential for the decision-making process.

The preference is treated as unproblematic and the only response from the CNS is to offer to field further questions on this preference. There is no caveat or contest, and the preference is straightforwardly incorporated into the business of the appointment. Again, it might be relevant that the preference for surgery is consistent with the clinical recommendation for surgery as the first-choice treatment. This extract, and the interactional work it contains, is an exemplar of the phenomenon I focus on in this section. For one, we can see the patient publicly work through pros and cons of the decision, which glosses the preference as ostensibly being thought through. If we couple this public display of deliberation with the reported discussion between patient and companion (lines 7-8), then we see a preference that came to be constructed. Beyond this clear demonstration of construction, the unproblematic receipt of this preference and straightforward way it is incorporated into the encounter is instructive. This sequence of receipt and handling quickly gets the preference on the record and proceeds to checking. In turn, this sequence suggests that patients’ preferences need to be received by a CNS rather than merely stated. Indeed, without the CNS acknowledging the preference as on record and facilitating its integration and progression there is not an obvious path to influencing the treatment decision.

Extract 5.2 (recording 12)

```
1  CNS:       [mop] up [thos]e (.) [thos]e small surrounding ar[eas ]
2  COM:                [yeah]
3  PAT:                  [ok]      [yeah]                       [yeah]
4  CNS:     that contain .h the disease still
5  COM:     [I don]’t know but I think we’re edging towards that aren’t
6  PAT:     [mm hm]
7  COM:     we be[cuz of yo]ur age as well (0.3) y- y’know [it’s]
8  PAT:          [e e: yeah]                               [yeah] wi
```

```
 9          we’ve sort of yeah I th[ink ]just just ta y’know ta (0.2)
10  COM:                           [yeah]
11  PAT:    a quick chat=
12  CNS:    =[ye:a]h]
13  COM:     [yeah]
14  PAT:        [y’k]now [an- ]just
15  CNS:                 [yeah]     d’yu want me to just elaborate a
16          little bit more on about the surg[ery]
17  COM:                                     [yes]
18  PAT:                                        ple[ase yes]
19  COM:                                           [yes ple]ase
20  CNS:    SO erm °>hold on° we’ll try not to explain too much<°
21          ([spie]l)=
22  PAT:     [yeah]
23  COM:    =ye[ah]
24  CNS:      £[ok]£ but erm the operation is done upstairs
```

In the above extract there is a far briefer construction project, which the patient’s companion undertakes in lines 5 and 7. For context, the CNS has been informing the patient and their companion about the procedure of having radiotherapy after surgery. In line 6 the patient produces an acknowledgement token to display understanding of the prior talk, while the companion begins a new project in overlap. Perhaps orienting to the relatively early point in the decision-making process, proximal to the diagnostic appointment, the companion begins their turn with the less certain “`[I don]’t know`” (line 5). More hedging follows as the companion formulates the lead-in to their preference as “`but I think we’re edging towards that`” (line 5). Immediately there is a contrast between the two cognitive invocations of first not knowing and second “`just thinking`”, as such the preference is incipient and probable rather than a preference proper. By being both undecided and “`just thinking`”, it follows that the statement of preference might follow a similarly softened form. Indeed, by formulating the preference as “`edging towards that`” the companion suggests a preference more than declares one. The verb, edging, implies a slow and subtle move in one direction rather than a firmer and perhaps more decision-implicative alternative.

The companion recruits the patient to the project with the tag question “`aren’t we`” (line 7) to which the patient affirms in overlap (line 8). The preference, contingent as it is, becomes fleshed out in line 7 as the companion accounts for this “`edging towards`” with “`be[cuz of` `yo]ur age as well`". As there is no further exposition about the specific role of age here, the companion might be invoking age as self-explanatory resource. Indeed, after invoking the patient's age, the companion leaves a short pause "`be[cuz of yo]ur age as well (0.3) y'know`" which appeals, rhetorically, to the intelligibility of the invocation of age as an explanatory resource while also projecting towards the extension of a turn beyond its current juncture. After the preference is formulated, the patient produces a line of talk that is marked by disfluency throughout. It might be a sign of trouble formulating, and the patient does produce a similar appeal to intelligibility and projection of turn extension with a "`ta y'know ta`" (line 9). It is only after a brief pause that the patient states a possible subject in "`a quick chat`" (line 11). Although not abundantly clear because of the disfluency, both CNS and companion acknowledge the patient's formulation affirmatively in latched speech. In turn, demonstrating that they understood the patient's formulation rather than, for example, requesting clarification in response.

In this extract the patient's preference is received and handled positively and there could be multiple options for this receipt. For one, the preference is not strongly formulated and therefore implies no strong commitment to a firm position. As such, the preference does not dismiss any treatment options out of hand. Second, the preference is for surgery and therefore consistent with the institutional clinical recommendation for surgery when patients are sufficiently fit to undergo surgery. Third, the preference accords with a key function of these appointments, which is to sufficiently inform patients that they then make shared decisions influenced by informed preferences (Elwyn et al., 2017). It is key to remark that while the first possibility is an interactive one visible in the data, the other two are extra-discursive and therefore considered more analytically speculative. This extract is distinct from the previous one in that while the preference is tentatively for surgery, the preference is clearly an initial rather than informed one (Elwyn et al., 2017) and the CNS treats it as such by offering to inform the patient further. With this framing of and orientation to the preference as initial the CNS puts the preference into the business of the appointment without a commitment to surgery being presupposed.

This exchange is useful for its part in showing the variation in extent of preference construction, with such a brief project being produced by the companion rather than the patient. Moreover, in the importance of receipt and handling of preferences. That is to say, the initial preference being received positively then requires integration and further action in the appointment. Once the preference has been received it can then be straightforwardly integrated into further information exchange that advances the appointment towards decision-making. Unlike the previous extract there is no public display of pros and cons, although there is observable construction work, and as such the unproblematic receipt has distinct sequential implications. The patient and companion here both affirming the desire to know more about the procedure, as opposed to reporting a prior sufficient informing. In the next extract, there is another distinct construction project and again a different, albeit unproblematic, receipt as we consider further the variability and consequences of the handling of these constructed preferences.

Extract 5.3 (recording 13)

1 PAT: at this present time (1.5) asked him if: (1.2) well
2 jus- >just< how quickly these cancers grow (0.5) because
3 my- my initial (1.3) reaction was (0.8) not to do anything
4 at all °and° just .h see (0.4) what's happening (.) al-
5 -though (0.5) i don't understand (0.5) what the risks are
6 (.) of doing that (.) with a (0.4) apart from (0.3) .hhh
7 being (.) proactive (0.7) i don't know (0.6) it's .hh the
8 whole thing it's come as er (1.7) well no- not so much as a
9 shock becausee my eldest brother died from prostrate cancer
10 .hhh and that was the initial (1.3) reason why was
11 investigated=
12 CNS: =ok=
Eight lines omitted
13 PAT: and that's how it all started
14 CNS: ok (1.0) d'YA want me ta (0.3) expand on (.) all the
15 treatment options so (.) active surveillance (0.6) ra-
16 -diotherapy I can talk about them all surgery as well

While the extracts in this section are unified by their demonstrations of unproblematic receipt and handling of preferences, they are distinct in their interactional constitution. In this extract the patient takes a multi-turn extended sequence to furnish a story that reveals an initial preference not to pursue treatment. This extract is another instance where the CNS has asked the patient about their understanding of the previous appointment. We join the encounter right after the patient lists the options they were offered. To begin with, the patient introduces a temporal formulation "`at this present time`", which is intelligible as marking their reported actions as in the moment of that previous appointment (Button, 1990). In lines 3 and 4 the patient states the preference that corresponds to that temporal formulation, active surveillance, and accounts for this preference with a question about the speed with which prostate cancer grows. Notably, the patient's preference is a distinctly lay formulation "`not to do anything at all`" compared to the term active surveillance.

Moreover, the "`at all`" in the preference intensifies the formulation beyond the other, curative, treatment options. Having reported their initial preference, the patient concedes that they "`don't understand (0.5) what the risks are (.) of doing that`" and inoculates against any possible notion that they might be invested in resisting treatment (Edwards & Potter, 1992). This kind of inoculation work is notable because although there are other cases of patients inoculating their turns, these do not pertain to resisting treatment. Rather, the patients who perform inoculation tend to produce these around alternative options or potential overclaiming. Moreover, the fact that this preference is an initial one is interesting because it is complementary to the inoculation work but is not something broadly seen throughout the dataset. In turn, the patient makes clear that this is an initial rather than informed preference (Elwyn et al., 2017).

In lines 7-9 the patient accounts for this initial preference by way of characterising their diagnosis as possibly surprising albeit "`not so much a shock`". The inference of the patient's characterisation being hearable as something short of shocking but sufficiently comparable to warrant denying an outright shock. The patient reports that their eldest brother died of prostate cancer and, in lines omitted, describes their appointment with a clinician that started their prostate cancer diagnosis trajectory. In response, the CNS acknowledges the patient's contribution and a one second pause is left for self-selection (Sacks et al., 1974). Self-selecting, the CNS asks the patient if they would like more information on the treatment options available to them. The CNS produces a turn-initial "`d'YA want me ta`" which marks the question as taking a yes/no interrogative format (Raymond, 2003), with the remainder of the turn comprising the available options. The "`d'YA`" from the CNS is interesting because the one second pause following the turn-initial response makes available the possibility of self-selection, but the patient does not take this opportunity. Further interest here is that the CNS leaves that pause and does not produce their offer of further information earlier. Here the CNS might be orienting to the lay formulation of active surveillance as doing nothing at all, and concession that they do not understand the associated risk (line 5).

This initial preference (Elwyn et al., 2017) makes available the inference that the patient has not been sufficiently informed to the point required for SDM (Charles et al., 1999). As such, the CNS treats the preference as an appropriate departure point for further informing, indicated by the choice of "`expand`" rather than a generic alternative such as talk about. If we consider a model of SDM, such as the three talk model (Elwyn et al., 2017) then this would belong to the initial team talk stage where clinicians describe available choices and work to establish appointment goals. The patient's preference appears to be treated unproblematically by the CNS's orientation to its status as initial and related implication that it is neither fixed nor firm. Notably, the CNS does not challenge the preference, nor do they proceed immediately into the possible further informing.

Rather, the CNS's orientation treats the preference as a reflection of the patient's position in an earlier stage of the decision-making process. An offer is made to the patient in lines 14-16 that demonstrates an understanding of the preference as initial and therefore treats it as being potentially malleable in response to further information. I would suggest that the patient's preference being intelligible as initial, and potentially malleable, marks it as amenable to straightforward sequential progress towards the next stage of decision-making. The patient in this extract also provides a clear example of construction in action and demonstrates what is distinct from a standardised notion of preference elicitation. This construction is notable because although it is an initial preference, it draws on the lack of information in its construction as initial. We have seen two initial preferences and one more informed preference so far, and all of these have been straightforwardly received as unproblematic. Beyond that receipt, they have all been handled seamlessly in quickly transitioning to further business in the appointment.

In this extract, then, I have attempted to demonstrate how intricate the receipt of the patient's preference is in the exchange, as opposed to a hypothetical elicitation and confirmation exchange. Furthermore, the patient's tentative preference utterance elicits the offer of information several lines later, which is an action we might expect to precede a preference statement.

Extract 5.4 (recording 18)

```
1   PAT:     erm (0.2) I was given choices about what (.) options I
2            [can:] (0.2) do .hh and my option is to have thee surgery
3   CNS:     [yeah]
4   PAT:     (.) and to remove it [(.) er]m .hh and they were just going
5   CNS:                          [°yeah°]
6   PAT:     through (0.2) er:m (.) some of the (0.2) pre-op (0.3) err
7            (options) post-[op]
8   CNS:                    [ye]ah
9   PAT:     aspects that I need to be aware of
10  CNS:     yeah °ok° So are y↑ou familiar with what the (0.3) pocedures
11           called [erm d-       ] would you g[et it if (          )
12  PAT:            [((lips smack))]            [err yEAh I I get it
13  CNS:     (called)]
14  PAT:      yeah I ] I read the booklet last night [I’]m sorry I can ne-
15  CNS:                                             [ok]
16  PAT:     -ver rememb[er the (         ) heading of it [(            )
17  CNS:                [↑t]ha:t’s alright                [hmm it’s a bit
18           of a mouthf[ul anyway robotic assisted r:adica]l laparoscopic
19  PAT:                [yeah           radical pros   yeah]
20  CNS:     prostatec[tomy]
21  PAT:              [yeah]=
22  COM:     =yeah
23  CNS:     (h)mm yeah we-
24  PAT:     so: I read through this booklet
```

In the above extract we can see a somewhat different unfolding of the unproblematic receipt of a preference, in that there is repair work involved in reaching the unproblematic receipt status. While the CNS affirms the patient’s preference, they go on to check this preference with a perhaps unexpected question. This extract begins with the patient providing an upshot formulation (Heritage & Watson, 1979) of their previous appointment. In this upshot, the patient reports that the appointment was ostensibly consistent with SDM as they were offered the choice of available options. By line 2 the patient states their preferred treatment of “`thee surgery`” and broader preference “`to remove it`”, standing as it does as an account for the surgery. Indeed, the preference “`to remove it`” can only indicate surgery as that is the one treatment that removes the prostatic tissue from the body.

Therefore, the patient constructs their preference very briefly and moves on to resume their upshot formulation of the previous appointment. The upshot continues to characterise an appointment that sounds consistent with SDM to the extent that the clinician informed them about aspects surrounding the surgery. In turn, the patient has now reported being offered options, informed as to which options they are eligible for "`options I [can:] (0.2) do`", and having received information about the surgical procedure. As such, the patient can be seen as legitimising their preference by framing it as arising out of the proper channels and being constructed in response to information exchange. This same pattern of epistemic claims on the patient's side as discursive acts of preference construction was also observed in chapter 4 and my analysis of preference construction projects.

In response, the CNS acknowledges and affirms the patient's preference, but also asks if they know the name of the surgical procedure. This question might function to check the patient's preference since they stated it outright in their earlier upshot. Moreover, as the patient claimed to have been informed about the surgery and presented this as part of the legitimisation of that preference, the CNS might be checking the extent of that informing. The patient produces the second pair part (Schegloff & Sacks, 1973) by answering in the affirmative "`yeah I ] I read the booklet last night`" and goes on to address the hearable implication in the question that they provide the name. While it appears that the patient is going to name the procedure, on account of having read the booklet last night, the temporal formulation (Button, 1990) intelligible here for the proximity to the appointment, the patient instead claims to have forgotten. Indeed, the patient characterises the forgetfulness as persistent, they can never remember, which allows them to answer in the affirmative without naming the procedure.

As mentioned at the beginning of this analysis, the CNS's interrogative in lines 10-11 is unexpected. While a patient might be expected to recall the available options, that is not the case for the highly technical names of the procedures. Indeed, the CNS's somewhat disfluent interrogative suggests that they might not expect the patient to know the answer. Despite this, the patient treats the interrogative as a request for them to confirm they have performed the informing that they reported. The patient, however, answers the question only to the extent of affirmation, as per a yes/no interrogative (Raymond, 2003). As such, the patient does not provide the propositional context that would indicate beyond doubt that they had indeed informed themselves. In so doing, the patient mobilises the discursive act of remembering

(Edwards & Potter, 1992) to claim that they can "`never remember`" (lines 14-16) and therefore avoid accusations of not having done the informing.

The CNS responds by accepting the patient's memory claim, corroborating the possibility of not remembering by deeming the name "`a bit of a mouthful anyway`" (lines 17-18) before then naming the procedure. This exchange here, then, is a departure from the unproblematic receipt of previous extracts as it is a repair sequence (Schegloff et al., 1977). In particular, the patient's claim that they "`can never remember`" (lines 14-16) is a self-repair attempt (Schegloff et al., 1977) to account for their earlier affirmative, but propositionally lacking, answer. We can see in the CNS's response, as they offer acceptance "`that's alright`" which would stand as the second part of an adjacency pair, they take no issue with this repair attempt. In addition, the CNS goes on to account for the patient's ostensible difficulty remembering by characterising the name as "`a bit of a mouthful anyway`" (line 17-18). The CNS accepts the repair sequence relatively unobtrusively and the business of the appointment proceeds with the resumption of the patient's project. All of this is handled sensitively and throughout the preference for surgery is treated unproblematically and is impactful for further sequential and institutional business towards the decision to be made.

Although it is not possible to comment on the treatment decisions that these patients ultimately made, their preferences were straightforwardly integrated into their appointments. Three of the four preferences were for surgery, so it is possible that consistency with the clinical recommendation was a factor, although this is not something I can ascertain from the data. Besides this consistency, the preferences typically facilitated the decision-making business of the appointment, or the work of the CNS. For instance, they put a preference on the record so that they can take the appointment further in the direction of informing about the thus far preferred treatment. Although a preferred treatment might be the one the patient receives, the decision may be made later and there is time, then, to ensure the patient hears all relevant information. Alternatively, they implied an incipient preference and then accepted the offer of more information about this option. Therefore, it might also be important that these preferences had clear and stepwise sequential implications in addition to the consistency with a clinical recommendation.

Having clear and stepwise implications might be significant for the way that my previous chapter presented both decision-making and preferences as being oriented to in distinct ways at distinct times. Decision-making is not always oriented to as the immediate next action, although there is typically a consistent orientation to a decision as having to be made. Patients' preferences that have clear and stepwise implications, then, appear to be both more amenable to, and oriented towards, deciding. In turn, clear and stepwise preferences may be better able to move treatment appointments towards a decision being the next or a more immediate act. That is, the time until deciding or ratifying a provisional decision becomes the next act might be understood as being reduced when a preference has clear and stepwise implications. By contrast, the next analytic section will investigate cases of patients' preferences that appear to challenge the decision-making business or progress of the treatment appointment. The preferences being received as challenging to the treatment appointment entails that the CNSs also handle those preferences differently, and this will also be explored.

5.2 Receiving and handling patients' preferences that prove challenging to the business of the appointment

Having now reported on instances where preferences were straightforwardly integrated into the encounter, this section turns to preferences that proved less easy to integrate. Here, less easy to integrate ranges from having to inform patients that their preferred treatment might be unavailable through to patients voicing a preference for avoiding an essential part of treatment. This section contains more extracts than the previous one, and that is simply a reflection of the appointments in the dataset. Although not every appointment featured extensive preference construction work, it was observed that preferences proved more difficult to integrate more often than they proved straightforward. Indeed, as mentioned previously 10 of the 21 appointments featured decisions that were either awaiting ratification or had been put into motion. This left the five firm preferences and six non-firm preferences to be received and handled. I would contend that five of these 11 preferences were received as challenging while two had non-committal treatment preference work that did not form part of the analysis. The first extract will demonstrate a preference that is less easy to integrate by virtue of preferring a treatment option that the patient has not been confirmed as suitable to undergo.

Extract 5.5 (recording 2)

CNS: o:k it’s just to say you’ve had a diagnosis a::nd what we’ve
y’know what we’ve the plan is we’ve given you a decision=
PAT: =yep=
CNS: =to make and that y’know
PAT: h we’ve just been discussing (0.4) y’know t[he: th]- options
CNS: [ye:a:h]
PAT: as well=
CNS: =yeah
PAT: y’know a::nd .h the point that you made there was quite (.)
apt
CNS: mm
PAT: that if you have surgery then you get two bites of the cherry
on it
CNS: mm::
(1.8)
PAT: y’know=
CNS: =°mm°=
PAT: so that’s (0.4) the other lady didn’t say that
CNS: ye:ah °I know°
PAT: so you know that’s worth thinking abou[t] [and it’s]
CNS: [i]t[is wort]h
thinking about
PAT: and it’s now y’know sort of made me think (0.3) perhaps
CNS: yeah
PAT: y’know

26 CNS: as i said it’s a (.) because we’ve not formally discussed it on
27 the MDT although she’s given it to you
28 PAT: yeah
29 CNS: the option may still end with radiotherapy for you d’ya get
30 me
31 PAT: ye:ah

One reason a CNS might not receive a preference as something to straightforwardly influence decision-making is that it is not yet possible to confirm that option. This extract begins with the CNS providing an upshot (Heritage & Watson, 1979) of the diagnostic letter for the patient’s general practitioner. The CNS’s upshot ends with the invocation of the need to decide. Perhaps orienting to the conditional relevance (Schegloff, 1968) of decision-making, the patient begins to launch a project pertaining to treatment options. Here the footing (Goffman, 1981) is notable because the patient reports that “`we’ve just been discussing`” and the patient’s companion is therefore presented as being involved in decision-making relevant conversations. Although this interaction remains dyadic, the companion becomes an active contributor to a potentially preference-shaping discussion through their role in a stretch of option talk (Elwyn et al., 2017). As this discussion is reported to have “`just`” taken place, a temporal formulation (Button, 1990) provides a context of recency and relevance with the discussion being so close to this encounter. Moreover, as the relevance of this discussion has been established, it follows that implications for preference can be ascribed to something interactive and collaborative rather than internal cognitions and computations.

When we examine the patient’s contributions in lines 9-13, we see that they ground their construction work in a piece of reported speech (Holt, 1996). This reported speech being something the CNS said, albeit not in the recording, and therefore the incipient preference comes into view on the back of the CNS’s contribution. By invoking the CNS’s contribution in this way, particularly through reported speech, which is often used to substantiate (Wooffitt, 1992, p. 159) and provide evidence (Holt, 1996) the patient brings the CNS into the construction process. In turn, the preference construction continues to exist in an interactive space, here being responsive to relevant information provided by the CNS. We can see this positioning of the CNS further in line 18 where the patient compares the CNS’s contribution with that of the clinician, likely either a CNS or doctor, they previously saw. Rather than simply acknowledge the patient's comparison with the "`ye:ah`", the CNS affirms that they are aware of the fact the other clinician did not state this idiom. It is also noteworthy that the speech reported is an idiomatic or figurative phrase, which is rhetorically useful for glossing a generality (Drew & Holt, 1988) and a finality or sense of having the last word (Drew & Holt, 1998).

The patient continues by characterising the idiom as "`worth thinking about`", which the CNS affirms in overlap. In their next turn, however, the patient goes further and reports that the idiom has made them think a certain way. The patient does not announce what they thought, but instead appeals to intelligibility with a turn-final "`y'know`", which the CNS orients to as being understandable. In response, the CNS orients to the patient's contribution as implying a preference for surgery and begins to launch a project of explanation. As the option of surgery has not been "`formally discussed`" by the patient's multidisciplinary team, the decision about whether the patient is suitable for surgery has not been made (lines 26-29). Here the local sequential organization is notable because the CNS offers a candidate explanation for the possibility of surgery being unavailable before announcing that possibility. One reason for this might be that providing the explanation first might gloss the decision as procedural and soften the announcement. It could also, however, be the case that announcing the possibility of being unable to have surgery might be understood as a dispreferred response, and the CNS creates an interactional buffer between the preference implication and potential dispreferred response.

While the patient's preference is not contested, and the CNS does not attempt to steer the patient to another option, the preference cannot straightforwardly influence the decision-making at this point. In this case, it is a procedural issue that complicates the possibility of the patient's preference being incorporated into the appointment unproblematically. As such, the CNS does not work against the preference, but instead invokes the institutional machinery of decision-making. Although this does not change the fact that the patient's preference is handled in a way that halts its potential for influence, the preference is not received as problematic or an outright challenge to the business at hand. Therefore, this case is significant for the preference according with the clinical recommendation for surgery but having to be halted due to institutional constraints. It is also notable that in the previous chapter I demonstrated that preferences could look distinctly messy in practice. Furthermore, that patients' preferences can be constructed haltingly, hinted at, and turn on the contributions of CNSs such as in this extract.

Extract 5.6 (recording 1)

PAT: so I'd rather not put myself through the invasive surgery
CNS: ok (.) so I see both sides so I know aha for me=
PAT: =mm=
CNS: =the surgery works really well yes
PAT: yes
CNS: erm and erm yes you do lose things like your erections but t-
hey do work towards sparing nerves .h to enable spontaneous
erections if they're able to
PAT: mm
CNS: radiotherapy can still have that effect on your erections an-
-yway it can still have an effect on your waterworks
PAT: mm
CNS: so you can still come out of radiotherapy as y'know with pr-
-oblems with your waterworks and you could still come out wi-
-th problems with your erections as well
PAT: ok=
CNS: =ok so:: erm but as I say each person is an individual
PAT: mm
CNS: and where some persons do really really well some people
y'know person don't always do the same
PAT: mm

In this extract, we join the encounter after an extended preference construction sequence at which point the patient produces a one-line preference statement. The choice of phrase "`rather not`" stands as a clear indication of preference while the specific component of the preference is tagged to the treatment it implies "`invasive surgery`". In response, the CNS acknowledges the patient's preference but then launches their own project. As the patient's extended preference construction sequence, not included here but analysed in the extract 4.7, was a response to a checking question the CNS's "`so`" might indicate that the patient's contribution has been pending (Bolden, 2009). The CNS invokes their category entitlement (Potter, 1996) by virtue of seeing "`both sides`" and makes an epistemic claim (Heritage, 2012a, 2012b) to know “`surgery works really well`” (line 4). The invocation of “`both sides`” and proximity to the patient’s preference makes available the inference that the CNS might be preparing to challenge the patient’s preference. With the introductory “`for me`” and “`both sides`” the epistemic gradient positions have the CNS at K+ to the patient’s K- (Heritage 2012a, 2012b).

In the extended turn that follows, the CNS concedes that surgery presents the side effect of erectile dysfunction but promptly minimises the issue by reporting that this might be avoidable (lines 6-8). Therefore, while the initial concession might suggest that the CNS was doing impartiality as per Sacks’ characterisation of the work speakers engage in to appear to be ordinary via “doing “being ordinary”” (Sacks, 1984, p. 414), the minimisation and subsequent description of the side effect probabilities of radiotherapy might undermine this. In line 6 the patient might be producing a script formulation, which is a description of an activity as typical and therefore not requiring an account (Edwards, 1994), with their appeal to “if you’re going out”. Script formulations are necessarily rhetorical acts and can be unsuccessful if the recipient counters the formulation.

It is unclear how the CNS might have responded as their attempt to claim speakership failed and the patient proceeded to formulate another topical interrogative about incontinence permanence. The CNS, however, responds to this new interrogative in a hedged and probabilistic fashion that might be heard as a poor fit with the patient’s implication of the seriousness of incontinence as a side effect. The plausibility of this suggestion perhaps lies in the breakdown of intersubjectivity that the patient makes clear in line 5 “[no no I understa]nd that”. In the possible script formulation, made partially uncertain using the contingent if rather than the more definitive when, we can observe that the patient sets up “going out” as an action that can be scripted (Edwards, 1994) and therefore oppositional to the CNS’s probabilistic treatment of side effects

In lines 10 and 11 the CNS presents two candidate side effects of radiotherapy close together. By phrasing the erectile dysfunction side effect as “`problems with your erections as well`” the CNS makes clear the possibility of two side effects for radiotherapy. The two effects contrast with the single one attributed to surgery in numerical terms but also the previously mentioned minimisation possibility of enabling “`spontaneous erections`” (lines

7-8). Moreover, the CNS continues to restate the candidate side effects but this time invokes the footing of the patient with the effects prefaced by “`you can`” and “`you could`”. As such, the CNS moves from the less personal “`radiotherapy can`” to the more personal “`you can`”, which ties the effect to the patient.

Despite this focus on the side effects of radiotherapy, the CNS goes on to remark that “`each person is an individual`” (line 19) and returns to the task of doing impartiality. Taking this further, the CNS remarks that patients have unique responses to these treatments and their side effects. Based on the work produced throughout this sequence of extended turns the CNS appears to be contesting the patient’s preference. While notable for having no response to the preference for avoiding invasion, the CNS’s turns do undermine the option of radiotherapy relative to surgery. That said, the CNS’s entire project is couched in an appeal to doing impartiality with the undermining project bookended by notions of “`both sides`” and that “`each person is an individual`”. A lot of interactional work, then, goes into the handling of the patient’s preference, to both argue against it and avoid appearing insensitive or confrontational in so doing. The consequence of a receipt such as this, is that it advances progressivity along the CNS’s line rather than that of the patient.

Particularly remarkable with this extract is the observation that it is driven overwhelmingly by the CNS from line 2 through to the end. As such, the patient spends the exchange producing minimal turns that do not go beyond displays of acknowledgement or recipiency. While the patient mirrors the CNS’s “`yes`” in line 5, the remainder of their turns are either the non-lexical “`mm`” or minimal “`ok`”, which lack positive or negative valence. The patient, then, also receives the CNS’s project of doing impartiality in non-committal minimal turns, which may reflect their relative tension with the clear preference formulation in line 1. Whether the patient is simply respecting speakership rights via minimal acknowledgements or letting their preference speak for itself is analytically unclear, but the CNS makes full use of the interactional space afforded to them. We can see, as a result, that a clearly formulated firm preference was not treated as being particularly influential or exempt from the possibility of being reversed or altered.

Extract 5.7 (recording 16)

```
1  PAT:                        [yeah]
```

```
2            yeah I mean y- incontinence I find that intolerable
3   CNS:     ((lip smack)) well they’re all possibilities (.) ok I can’t
4            definitively say [(              )]
5   PAT:                      [no no I understa]nd that I don’t expect you
6            ta say I’m just telling ya that ma- (0.1) I mean that wouldn-
7            -‘t be very nice if you’re going out and stuff [like] that
8   CNS:                                                    [WAIT]
9   PAT:     is it temporary or would it be permanent
10  CNS:     it’s difficult to say sometimes patients (0.2) do: (.)
11           sometimes as a result end up with erm (0.4) y’know (.)
12           <lifelong> effects from radiotherapy treatment .hhh there’s
13           all possibilities y’know not everyone has these y’know they
14           [(    )]
15  PAT:     [no but] if you’re the one that does then that’s what
16           matters
17  CNS:     unfortunately t[ha]t but it is a side effect of treatment
18  PAT:                    [mm]
19  CNS:     for prostate cancer=
```

One potential problem with handling and managing patients’ preferences is that the preference might ultimately be unfeasible. A patient might want something that the clinician cannot do anything about. Preferences might be unfeasible because they increase risk, desire an unavailable treatment, or attempt to avoid a commonplace side or treatment effect. In this extract, the patient is discussing urinary incontinence as a post-radiotherapy treatment effect. The preference, then, also relates to radiotherapy since that is the option under discussion, and the CNS suggests the patient will be having radiotherapy. The production of an extreme case formulation marks a clear display of preference, or dispreference, and the extremity of the formulation glosses incontinence as a “legitimate complainable” (Whitehead, 2015, p. 580). In turn, the CNS responds with a dispreferred turn marked by the smacking of their lips and turn-initial “well” (line 3; Pomerantz, 1984).

Furthermore, the CNS remarks that all side effects including incontinence are “`all possibilities`” (line 3), therefore all side effects are similarly probabilistic. The CNS proceeds to state that they “`can’t definitively say`” (lines 3 and 4) whether the patient will experience any of these side effects. In turn, the CNS’s reformulation of incontinence as an incumbent of the category side effects positions incontinence as bundled together with treatment. That is, side effects are category-bound activities (Jayussi, 1984; Sacks, 1992, vol.

1, p. 40-41) for those who undergo prostate cancer treatment. I observed in the previous analysis that the CNS could be seen as doing impartiality after Sacks' notion of "doing "being ordinary"" (Sacks, 1984, p. 414). Similar work can be found in this exchange, with the CNS formulating the likelihood of urinary incontinence as one among "`all possibilities`" (line 3). The CNS, then, is positioned as simply reporting on one possible treatment effect and doing so impartially or professionally. This CNS's "`all possibilities`" remark has similarities to the CNS's "`each person is an individual`" in the previous extract. While the patient acknowledges the CNS's contribution and inability to offer a definitive answer, they also orient to the response as ill-fitted.

The patient appears to orient to the CNS's response as shifting from personal to impersonal. As such, the patient's response suggests a breakdown in intersubjectivity, which is consequential for the business of the sequence. We can see this in the patient's contributions from lines 5-6, which show the patient attempting to correct the CNS's displayed understanding. The patient initially treats the CNS's turn as inappropriate and possibly indicative of misunderstanding, as they respond in misalignment "`no no I understand`". After which, they begin a project of re-stating that this initial statement was a telling rather than the interrogative that the CNS's treatment suggested (line 6). The patient might be seen to orient to the CNS's rhetorical work of categorising incontinence as one of various side effects. The patient does so by appealing to intelligibility with "`I mean`" before accounting for the stated dispreference for incontinence rather than the category side effects. In turn, the patient re-states their preference. An affective "`wouldn't be very nice`" component and a temporal "`if you're going out`" (lines 6-7) one gets produced that designate incontinence as a specific preference issue rather than a treatment contingency. The patient's receipt of the doing impartiality in line 15 is also notable, here, as it suggests that the parties have not yet resolved the intersubjective breakdown. Indeed, the patient might be considered to have presented a sequential opportunity for further talk in the question about permanence (line 9) but the CNS's return to doing impartiality receives a restatement of intersubjective trouble.

For the patient, it is not a case of indirectly requesting information by reporting a complainable, or a biomedical question, it is a lifeworld statement about quality of life. Indeed, it is a question of the "voice of the patient" (Mishler, 1984) and it is at tension with the biomedical knowledge of the CNS (Landmark et al., 2015). The issue of incontinence is formulated explicitly in the patient's first turn and hearably relevant for preference construction. In response, however, the CNS produces another instance of doing impartiality in response to the patient rendering a lifeworld concern (Mishler, 1984). This exchange, then, is an awkward case for SDM. The aim of SDM is to bring patients' and clinicians' ideas together, albeit without the presupposition that SDM would become intuitively easier. Indeed, what occurs in this exchange is a mismatch between the patient's lifeworld-oriented point of view and the biomedical role of the CNS. Perhaps the CNS is constrained by the institutional parameters of their role, but the response to the patient appeared disruptive and poorly fitted.

Two takeaways are especially notable, and the first of these is the tension between the lifeworld and the biomedical not as theoretical or conceptual positions (Mishler, 1984) but as the contributions made and domains invoked by the respective parties. It appears to me from the patient's contributions to this sequence that they are not divorcing the subjective experience of an effect from its biomedical likelihood. We would not necessarily expect this either, since a preference is "what patients want from their healthcare" (Street et al., 2012, p. 168). As such, the preference need not prioritise the treatment of cancer over the subsequent health related quality of life; a domain that urinary incontinence would affect. Indeed, the patient gives voice to a subjective sounding complaint such as "`not very nice`" and offers a candidate example that is tethered less to the biomedical and more to subjective day-to-day issues (lines 5-7). While it is important not to reach beyond the data for the extra-discursive in language and social interaction research, the choice of candidate example and word selection indicate a more subjective side of preference rather than a purely biomedical concern with efficacy. If we were to conceptualise preferences solely as a preferred treatment option, then we might find issue with the question of the subjective. However, treatment options are not the sum of patients' preferences as my previous analytic chapter spoke to by revealing the elaborate and highly distributed nature of patients' preferences and their construction.

It is important also to note that biomedical does not straightforwardly imply an extra-discursive claim but is rather a vernacular descriptor for the domain of specialist knowledge that a CNS is entitled to by virtue of their categorical incumbency (Jayussi, 1984; Potter, 1996; Sharrock, 1974). Furthermore, while the patient is not exclusively voicing efficacy or curative concerns they are still accounting for their preference and involved in preference work. As such, the distinction between a subjective side of the treatment and primarily biomedical evaluations of efficacy is one introduced and made relevant by the patient. For the CNS there is this same tension visible, as they do not pursue the patient's subjective perspective. Rather, the CNS pursues an ostensibly impartial or professional account of the biomedical perspective with a small sympathetic concession in the "`unfortunately`". Excepting the "`unfortunately`", however, the CNS does little to engage with the patient about their preference, and this is the second takeaway. The biomedical pursuit is doing impartiality by speaking more generally and probabilistically, but also closing off fruitful discussions of what might animate the patient's dispreference. As such, there is no exploration of the preference or what might ameliorate the dispreference in the event of radiotherapy treatment. There are questions, then, to be asked about the possible constraints on the CNS, whether institutional role constraints or constraints around the unpredictability of treatment or side effects among individual patients.

Extract 5.8 (recording 6)

```
CNS:     weeks this is literally [jus-]
PAT:                             [stil]l enough
COM:     in your booteh=
CNS:     =in your [bottom]
PAT:              [still ] enough=
COM:     =you won't see it
PAT:     still enough
CNS:     b(h)less y(h)ou=
CNS:     WELL Y'KNOW=
PAT:     =i know=
CNS:     =>WITH THEM< WE'RE JUST TALKing about the options anyway you
         don't have to think about anything yet or decide a-
         an[ythi]ng at this point these are just me .hhh being very
PAT:       [yeah]
```

15 CNS: open and informative telling you everythink about all the
16 treatment options]
17 COM: [no we need to kn]ow everything=
18 CNS: =absolutely .hhh ok (0.3) so that’s hormone therapy treatment
19 .hhh erm (.) and then there is (.) erm (.) brachyth-

As suggested by the heading of this section, the focus is on how patients’ preferences are received and subsequently handled by CNSs. These extracts therefore often begin during, or after, a patient’s construction project. For this case, the patient has constructed a strong preference to avoid the needles involved in hormone therapy treatment and we join the encounter in the aftermath. Please note that while this text is not included here, it was analysed in the previous chapter as part of extract 4.4. At this point in the encounter the CNS is attempting to minimise the significance of the hormone injections. Although the turn is aborted, it is probable that the CNS was appealing to how infrequent these injections are, once every three months, by launching an intensified characterisation “`literally [jus-]`”. The patient, however, ignores turn-taking conventions (Sacks et al., 1974) by interrupting the CNS to shut down their turn as insufficient before completion. In this response, “`still enough`”, the patient might be orienting to the CNS’s turn as a minimisation project, which could undermine the patient’s preference. As such, the patient rejects the CNS’s project out of hand, not allowing its completion.

Notably, the patient’s companion is also involved in this minimisation project. In line 3, the companion produces a more lay characterisation of the injection as “`in your booteh`”. The companion’s formulation might be designed to soften the patient’s stance by juxtaposing the seriousness of the preference with the more familiar and less serious sounding “`booteh`”. In latched speech the CNS repeats the companion’s contribution but reformulates “`booteh`” into the less casual “`bottom`”, as an attempt at corroboration (Wooffitt, 1992). Again, however, the patient rejects the minimisation out of hand and repeats their initial response “`[still] enough`”. Moreover, the patient again treats the CNS’s turn as insufficient and interrupts them prior to completion. Despite the patient rejecting both the companion and CNS’s attempts, the companion continues to attempt the minimisation project. In line 6, the companion shifts from the appeal to infrequency to an appeal to the lack of a visual trigger. Here the companion is essentially invoking a sense of being out of sight, out of mind and constructing a characterisation of the patient's preference accordingly. A version of the preference to avoid needles that is sufficiently weak enough to accept needles if they are not seen.

For a third time, however, the patient dismisses the attempt and repeats their initial "`still enough`" a second time. Having constructed a strong preference and gone as far as claiming a phobia of needles, the patient might be continuing to orient to the minimisation efforts. Accepting the appeals to infrequency or the ostensible invisibility of the needle would undermine the constructive work that went into their version of the preference and its established strength. Despite seemingly abandoning the minimisation project, the CNS shifts their focus to the sequence at large. The current sequence is characterised as "`JUST-TALKing about the options`", and this rhetorically disarms the preceding talk by glossing it as just talk and therefore denies its action-orientation. Moreover, by "`JUST TALKing about options`" the sequence is framed as being concerned with option talk rather than preference talk (Elwyn et al., 2017), which again stands to minimise the patient's contribution. This project continues as the CNS tells the patient that they do not "`have to think at this point`", which the patient acknowledges in overlap (line 14). In lines 13 and 15 the CNS's project goes further by ascribing deontic authority (Stevanovic, 2012) to themselves in a characterisation of this point as them "`telling you everythink`". Producing a matter-of-fact declarative in "`telling you`", rather than a more inclusive alternative, such as discussing with you, does not presuppose an interactional spot for the patient to respond. As such, having found no success in minimising the patient's specific preference, the CNS moves on to minimise the issue of preferences entirely at this point.

At this point we have seen three or four examples of the receipt of patients' preferences as challenging or problematic. There has been some variability in how the receipts have proceeded, and the interactive slots and possibilities that they offered. In extract 5.5 for instance, the preference was received as challenging because it projected a request for confirmation that could not be granted. While the preference was received as challenging, then, by virtue of the commitment it implied, the sequence was able to proceed without breakdown or conflict resolution. By contrast, we saw a case in extract 5.7 that presented an intersubjective breakdown that ultimately went unresolved. The CNS, again unable to provide the commitment to confirmation that the patient's preference entailed, effectively closed the exchange with a minimally sympathetic appeal to the matter-of-fact nature and occurrence of side effects. Although both preferences had similar implications and both projected difficult commitments, they produced distinct interactive work that subsequently had markedly different implications for how the receipt could proceed in the decision-making business of the appointment.

Extract 5.9 (recording 11)

```
CNS:                                [do] you want to talk to you about
         that (0.2) briefly about that (.) what it is
PAT:     well waell (0.6) (I’ll see how I’ll be/we do in the hand of)
         name reda[cted] I’m sure he’s gonna make ( )s incisions[ all]
CNS:              [yeah]                                        [yeah]
PAT:     th time I think doh doh don’t >know< if there’s any point in
         [that  ]cos all I want is this to be gone=       =so so no
CNS:     [°yeah°]                                  =yeah=
PAT:     that’s fine thank you=
CNS:     =OHkay ohkay (.) so: (0.3) °dhuh° ok that’s fine the[n so]
PAT:                                                         [yeah]
CNS:     the- so part of erm (0.3) having s::- the (nerve spared one)
         not having nerve[s sp]ared (.) erm is part of sometimes a
PAT:                     [yeah]
CNS:     side effects o[k which is WH]Y which is why you made them
PAT:                   [s]ide effects]
CNS:     erm get erectile dysfunction[n ok] .hhh so erm (0.5)
PAT:                                 [yeah]
```

This extract comes during the CNS informing the patient about the side effects of surgery. More specifically, the CNS has asked if the patient wishes to know more about nerve-sparing versus non-nerve-sparing surgery. As the patient produces a turn-initial well, repeats it, and then leaves a notable pause this suggests that their turn will constitute a dispreferred response (Pomerantz, 1984). The CNS’s question presented as a yes/no interrogative (Raymond, 2003), and the turn-initial “`well`” might suggest that they are not producing a projected yes/no answer. The patient not only declines the offer, but they also eschew the typical responses projected by the yes/no interrogative (Raymond, 2003). By way of accounting for the dispreferred response the patient produces an idiomatic formulation “`in the hands of`” that ascribes a sense of sufficiency and therefore finality (Drew & Holt, 1998) in leaving the matter to the surgeon. Moreover, the patient produces an upshot (Heritage & Watson, 1979) of the surgery as making incisions (line 4) and moves from this upshot to question the necessity of further information. Here the simplistic upshot formulation is a rhetorical move that glosses the procedure as straightforward and therefore not requiring the assistance offered by the CNS.

Despite closing off the CNS's offer with idiom and upshot, the patient accounts for the declination further by stating their preference in line 7. Here the patient's preference is formulated as "`cos all I want is this to be gone`" with the straightforwardness of the preference hearable as not necessitating further information. Indeed, the version of surgery the patient constructs as their preference is one that counters a more technical and thorough alternative by way of its lay formulation of an outcome, namely getting it gone. After latched acknowledgement from the CNS the patient proceeds to explicitly link the preference to the declination by stating "`so so no that's fine thank you`" (lines 7-9). By this point, the patient has idiomatically put themselves "`in the hands of`" the surgeon and therefore beyond the stage of the informing, undermined the need for further information with a simplistic upshot, and positioned their preference as one that does not necessitate the CNS's offer. In response, the CNS acknowledges the patient's position but displays signs of disfluency throughout, possibly because of the dispreferred response and its extent.

After the disfluency the CNS goes on to ratify the patent's declination stating, "`that's fine`". That said, the CNS then ignores the implication of the patient's declination in line 12 by launching the project of informing that the patient declined. Although the CNS acknowledged the patient's position, they might disregard it on the grounds of institutional obligations. Yes, the patient has stated a clear preference, but the patient is declining information that could be considered relevant for an informed preference (Elwyn et al., 2017) and sufficient information exchange (Charles et al., 1999). As such, this sequence might be a case of the contextual situation of the talk in an institution being prioritised ahead of its sequential one. The CNS, then, acknowledged the patient's preference, both to skip the informing and as an account for skipping the informing, but ultimately oriented to the context of the treatment appointment. As a result, the patient's preference is disregarded in order that the CNS can perform one of their institutional obligations and other aspects of SDM.

5.3 Discussion

This chapter investigated the receipt and handling of patients' preferences to build on the analysis of preference construction in chapter four. Analysis revealed that patients' preferences were typically received in two ways. The first of these ways was as unproblematic and straightforward to integrate into the appointment. This receipt was observed when patients' preferences clearly indicated a decision had all but been agreed, were for surgery, or prompted further information exchange by the CNS. The other way was patients' preferences being received as a challenge to the decision-making business of the encounter. In these cases, patients' preferences often had more complicated implications for, or firmer commitments to, stances that might ultimately prove unable to influence treatment decisions. For instance, preferring to avoid urinary incontinence and voicing this preference in strong terms despite likely experiencing incontinence because of treatment. That said, the heterogeneity of preference construction revealed in chapter 4 was again observed in this analysis. For example, extract 5.5 demonstrated a patient working up a preference for surgery, which we might expect to be received and handled as unproblematic. The CNS, however, had to inform the patient that they might not be eligible for surgery. Therefore, the otherwise straightforward preference required the CNS to invoke the institutional machinery of decision-making in response.

The most striking findings are of course those that demonstrate the receipt and handling of patients' preferences as challenging or problematic. That said, it was no less remarkable that patients' preferences were received positively when they were amenable to straightforward institutional and sequential progress. On the level of conversational organization, it fits with the established preference for progressivity and dichotomy of preferred and dispreferred responses (Pomerantz, 1984). That is, we would reasonably expect that a statement with straightforward sequential implications would be favourably received and sanction further progress. Of course, the opposite response being observed when the preferences entailed more complex implications suggests that this basic domain of preference organization, in the technical conversation analytic sense, remained operative and observable in this specialised institutional context. A preference for a curative treatment such as radiotherapy, then, could prompt a dispreferred response despite it being an acceptable treatment option. With regards to the institutional level, the findings are noteworthy because they speak to a set of real constraints on patients' preferences. There were little to no constraints on patients constructing their preferences in the sense of entering or producing a project of construction. However, the distinct patterns of receiving and handling patients' preferences enacted a constraint on which preferences were understood as feasible and therefore consequential.

Patients' preferences were consequential, in that they were influential, primarily when they accorded with the clinical recommendation for surgery. In turn, the interactive work of the CNS was straightforward because they simply had to affirm an incipient decision, informed preference or proceed to another relevant act such as information exchange. What is significant here is that the technical domain of preference organization superseded patients' actual preferences in the exchanges. Rather than focusing on what can be done with the patients' preference or seeking for a way that it might prove influential the CNS would instead undermine challenging treatment preferences or do impartiality in the face of preferences that would occasion dispreferred responses. Of course, CNSs face real institutional constraints, and some preferences are indeed straightforwardly unfeasible such as guaranteeing the absence of a particular treatment or side effect (extract 5.7). That said, with few exceptions (extract 5.4 for positive receipt) and (extract 5.9 for challenging receipt) the technical domain of preference organization was operative and preferences or preference-implicative work that would not easily imply a dispreferred answer were received unproblematically compared to inverse examples. Perhaps the institutional constraints around what can be done with patients' preferences are also important for the technical organization of preferred or dispreferred responses and the in situ receipt and handling of the patient's preference.

Both the unproblematic and challenging receipts of patients' preferences revolve around similar poles. In each case, the technical domain of preference organization remains operative, and an unproblematic receipt is prompted in a similar way to a challenging receipt. Now, the difference in prompt sits between the local conversational organization and the propositional content of the patient's preference. If a preference is for something that a CNS can provisionally affirm, such as an institutionally preferred treatment option, then receipt and handling will typically be unproblematic. Similarly, if a preference has clear stepwise sequential implications, for example sanctioning further information exchange, then it will be received unproblematically and treated as amenable to the business of the appointment. The inverse of this pattern holds true for the receipt of patients' preferences as challenging, which is significant for suggesting a generic or reproducible mechanism. The intersection of preference organization as a technical domain of local conversational organization and patients' preferences having propositional content oriented to accomplishing actions therefore appears relevant to how patients' preferences are received and handled. The scope for negotiation with preferences received as challenging is obviously limited and the parameters for avoiding this receipt are similarly narrow but this is also the case for unproblematic receipts. In turn, it would be useful to understand that patients' preferences constructed in situ can be received in a comparable way to any formulation that might occasion either a preferred or dispreferred response.

It became clear from the analysis in chapter four that preference construction alone might not be sufficient to influence the decision-making process towards the patient's preferred treatment option. From this chapter's analysis, questions began to arise about how influential patients' preferences could be for their overall treatment decision. The literature reviewed in the introduction pointed to a suggestion that preferences might not exert influence in decision-making business for a range of reasons. One was that practitioners might prioritise medical grounds even if they eschew preferences (Sommers et al., 2008; Scherr et al., 2017). Another was that preference elicitation and checking looked very different to our theoretical definitions when conversation analysis was used to analyse the actual talk-in-interaction (Landmark et al., 2016, 2017). In some instances, preferences could only be influential in a very specific way, since they were bound to the elicitation tool used (Couët et al., 2015). While initially only prompts for this investigation, my analysis revealed findings that were supportive of these claims. Not exclusively, nor perfectly, but the evidence suggested that in reality patients' preferences were substantially constrained in their opportunities for influence.

In the extracts where patients' preferences were received as challenging, the work of the CNS often involved footing (Goffman, 1981), institutionally preferred treatment, and identity work akin to doing impartiality. Patients' preferences can be seen to throw CNSs into difficult positions with little room to manoeuvre. We can see in extract 5.9, for instance, how the patient's declination of further talk about side effects was in fact followed by the side effect talk previously offered. When a patient constructs their preference in a way that cuts short the institutional role of the CNS, they may not be able to action that preference. For one, such a preference clashes with the requirement to inform patients about the risks of treatment, although this is speculation rather than an empirical observation. When a patient formulates a clear preference to avoid needles as part of the hormone therapy treatment, the CNS is again in a tough position. To my knowledge, it is not possible to disregard the Dectapeptyl injection for hormone therapy treatment, and the patient's preference is therefore simply not feasible.

As such, we can observe that the CNS worked to gloss the exchange as "`JUST TALKing about the options`" (extract 5.8, line 11) rather than an exchange grounded in a firm preference. Here, then, the CNS moved to minimise the patient's preference once it became clear that the tension between the strength of the patient's position and the unfeasibility of its execution was halting progressivity. Even when the patient expressed a preference for the surgery, which was the clinical recommendation, in extract 5.5 the CNS was not able to guarantee the preference. Rather, the CNS revealed that the treatment decision might be made for the patient by the multidisciplinary team. Such a decision would reorient the patient's decision-making process around a more limited set of options that excludes their preference. In this exchange the footing (Goffman, 1981) was notable because the CNS refers to the multidisciplinary team as "`we`". As such, the CNS was positioned as part of the institutional machinery of decision-making but not decisive nor personally responsible for the patient's treatment decision.

All these cases are interesting, then, because they illustrate constraints on both parties that are relevant for patients' preferences. Patients are most obviously constrained by the CNSs' handling of their preferences, as CNSs have the institutional authority. Clinical nurse specialists put the preference on the record, or do not, and move the decision-making journey closer to ratifying a treatment decision. Clinical nurse specialists, however, are also constrained by the institutional role that they perform and the tensions that this makes relevant for appointments. For one, the uncertainty of a side effect constrains the CNSs' extent that they can offer patients definitive answers to their questions, such as in the case of the urinary incontinence in extract 5.7. Another constraint on CNSs is that they are not the decisive figure in the decision-making process. Indeed, the patient and CNS collaborate on establishing a preferred treatment option but the institutional machinery of decision-making ultimately rules on this option. For instance, the multidisciplinary team, the options available at local NHS foundation trusts, and variables around the patient's general health and fitness.

We see this constraint in extract 5.5, and the CNS acknowledges their role as one of many cogs in this decision-making apparatus.

One possible important consideration for this project of doing impartiality is the fact that treatment decision-making often involves uncertainty in the forms of, for instance, treatment outcomes and side effects. If I was to characterise this uncertainty, I might term it raw uncertainty as it is very real and somewhat unpredictable rather than an imagined notion of a precise risk that CNSs might prefer to provide. Indeed, we can observe throughout these extracts that CNSs refrain from giving precise risk statistics or fixed pronouncements. As such, we might suppose that there was not a preferred format of risk to communicate to the patient. For example, the ability to tell patients that there is a 75% chance of incontinence but 100% chance of fatigue that remains constant might facilitate clearer risk communication but is not seen in the exchanges.

Rather than this precise risk communication, we instead observe that patients are told of a risk and that the CNS simply does not know or cannot guarantee whether a patient will encounter that side effect. Patients, then, must make decisions and choose between options that entail uncertain but very real risks of distinct side effects without a firm idea of whether they will experience these effects and with what severity. Unsurprisingly, this raw uncertainty around risk communication is observed when we consider preferences that are received as challenging. There is a tension between those patients' preferences that seek to ascertain a more precise likelihood and or avoid a risk and the response of the CNSs that abstain from fulfilling the actions these preferences request or presuppose. Of course, the reason for CNS abstention might simply be the absence of firm or precise statistics, or it could be a wish to avoid prospective liability for potentially uncertain information.

For the sake of my analysis, however, what remains interesting is the project of doing impartiality and how it effectively problematised patients' preferences. A preference, then, is subject to further factors and considerations than simply "what patients want from their healthcare" (Street et al., 2012, p. 168) and these factors can impede both the handling and construction of a preference. For one, what a patient wants may be uncertain or unfeasible and as such the preference either does not get to be influential or becomes modified. Immediately, then, a preference no longer stands in as the initial function of what a patient wants but becomes something different that could be interpreted in two distinct ways. The first is that the preference shifts from an initial preference that might have sounded nice to a patient but proved unfeasible to an informed preference where the patient makes an educated choice and wants what is best from what is available. Second, however, is that the patient in fact abandons their preference and follows the clinician towards the least dispreferred available option based on credible information.

Now, there is nothing wrong with the second trajectory, but it is worth considering if it more accurately accounts for the process of coming to an informed preference or for negotiating a least dispreferred option. Again, negotiating a least dispreferred option is not necessarily a problem and can indeed be considered a form of preference, as one simply moves in a different direction. That direction being from preferred to least dispreferred rather than the inverse. That said, it might not be entirely accurate to characterise the process as moving from an initial to an informed preference. It is true that a patient moves from an initial preference, and that they are likely to have been further informed, but this does not entail that the subsequent choice is a preference in the same sense as the initial preference. Moreover, the constraints on patients' preferences that we see with those received as challenging are consequential for preferences in a way that might not otherwise be clearly articulated in any definition of preference. We can speculate, then, that what occurs in these cases where a patients' preference is received as challenging is an underemphasised aspect of preference construction in addition to a clear example of handling patients' preferences.

There might be a suggestion, then, that preference is a somewhat ill-fitted name for what occurs in real terms. While most extracts featured examples of preferences that were consistent with the characterisation of "what patients want from their healthcare" (Street et al., 2012, p. 168), that is perhaps an oversimplification. Certainly, the notion that patients' preferences shape their treatment decision was not straightforwardly supported by the recordings in the dataset. By contrast, the literature that revealed patients' preferences were sometimes being handled in ways that betrayed their ostensible consistency with SDM was supported (e.g., Landmark et al., 2016, 2017). There is no question of conduct here, that is not the aim of this work, but it does pose a question about how well the theoretical notion of preferences and expectations about their role in decision-making appointments fit. There are various possibilities that might be usefully considered in response to the poor fit between preferences as a theoretically important aspect of SDM and the interactive work of preferences that I report on.

In turn, I will briefly consider two suggestions for helping to address this issue. The first, is a problem with how interactive work that might be considered disruptive of the decision-making and preference rendering processes is conceived of in SDM models. That is, the work of receiving a preference and possibly negotiating its subsequent handling and scope for influence may be conceptualised as an unhelpful interruption or even unrelated to the elicitation and checking work. I argue that the interactive work of constructing, formulating, and accounting for preferences, no matter how unlikely or peculiar the form, is an integral part of the process of constructing a preference and by extension cannot be divorced from the ultimate preference. While I do not believe that promising models of SDM such as the three talk (Elwyn et al., 2017) or Implement-SDM (Joseph-Williams et al., 2019) models perform especially poorly in this regard, I do think work is required to improve our understanding of patients' preferences. In turn, my second suggestion is to offer a candidate definition of preferences, in particular preferences as constructed (Elwyn & Miron-Shatz, 2010). I would suggest that we define preferences as constructions in the following terms or similar: Patients' preferences are constructed phenomena that they render in their healthcare encounters responsive to their healthcare values, available treatment options, and information from their healthcare practitioner. Moreover, these constructions are comprised of such wide-ranging discursive devices as appeals to prior medical experiences, characterisations of previous medical appointments, and invocations of emotional and cognitive states as explanatory components.

In turn, the next analytic chapter will explore a less obvious site of preference work by investigating the presence and function of laughter in treatment appointments. A focus on the presence and function of laughter in treatment appointments also points to greater heterogeneity in preference conversations. As such, we would want to see more instances of the phenomena and patterns reported in this chapter, in a larger dataset, to corroborate and possibly confirm these findings.

Chapter 6: The production of laughter in treatment appointments and its function for sequential progress

Chapter overview

This chapter is the final analytic contribution to the thesis and focuses on perhaps an unexpected example of preference construction work. Throughout this chapter I will focus on the production of laughter in post-diagnostic prostate cancer treatment decision making appointments. A focus on the production and function of laughter in treatment appointments was not one I anticipated. Indeed, of all the analytic chapters this is the one that developed most in line with the concept of "unmotivated looking" (Psathas, 1995, p. 45). By unmotivated looking I mean that the idea of exploring laughter came from my increasing familiarity with the data. A process of analytical noticing occurred as I continued to observe instances of patient, clinician, and shared laughter in the recordings. These instances were collated, and I examined the collection for any possible patterns or analytically interesting conversational work. Both the prominence of shared laughter and prevalence of laughter from the CNSs caught my attention and I therefore decided to explore these cases. Upon further examination it became clear that there was a case for laughter's place in an understanding of preference construction.

While the preference construction functions that laughter performs might be more subtle than the construction projects reported in chapter 4, it is still insightful and wholly relevant to the focus of my research. As such, my analysis will focus on the actions that laughter can be seen to accomplish in these appointments. The broader analytic claim of this chapter is that laughter functions to sanction sequential progress. As a result, the analyses will track this phenomenon across a spectrum of the production and organization of laughter that spans degrees of complexity. To begin, analysis will consider cases where laughter straightforwardly sanctioned sequential progress and required little or no interactional work. The second analytic section investigates more complicated instances that would often involve extended sequences and distinct conversational acts. In the final analytic section, I examine the flexibility of seriousness as an interactive resource relevant for laughter and related sequential progress. Concurrent with this analytic claim is the claim that laughter stands in for and/or represents the subtlest form of patient's preference construction in these appointments.

6.1 Introduction to the study of laughter as social action in healthcare

For laughter to serve a function in these appointments there needs to be a socially organized and interactional conception of laughter as a communicative resource. As Harvey Sacks and his students took conversation analysis from the lectures to the academic publishing world this interactional conception of laughter began to develop further. Although Sacks was already characterising the local organization of jokes in his lectures in the 1960s, as quite simply "You tell a joke, there's a laugh" (Sacks, 1992, vol. 1, p. 15), owing to their status as ceremonials, the first conversation analysis publication on laughter came later. This publication, Schenkein's (1972) study of laughter particles, observed that laughter which hearably referred to prior talk was often laughter at the talk immediately preceding its production. Sacks would subsequently develop Schenkein's finding further, reporting that "(l)aughs are very locally responsive - if done on the completion of some utterance they affiliate to last utterance and if done within some utterance they affiliate to its current state of development" (Sacks, 1974, p. 348). There was, then, substantial development in a short time as work went from laughter as ceremonials to a responsive and locally organized phenomenon that was analytically tractable. Once empirical analysis began in earnest, a development from this ceremonial conception of laughter to one of laughter as a responsive and locally organized phenomenon became clearer (Schenkein, 1972; Sacks, 1974).

We, therefore, have some basic foundation for the socially organized nature of laughter and its local organizational contexts of production. The next step is to relate this to the ways that interlocutors manage and engage with the local organization of laughter. Building on this insight, Gail Jefferson began to develop a characterisation of the interactional organization of invitations to laugh. One of the techniques for inviting laughter is for the current speaker to produce a "post-utterance completion laughter particle", where they follow their utterance with laughter either immediately or after a pause (Jefferson, 1979, p. 80). These particles can be met with reciprocal laughter to show acceptance of the invitation, or the absence of laughter such as silence. When an utterance is understood as a laughable, there is an "invitation/acceptance sequence" (Jefferson, 1979, p. 80). This sequence is crucial because an alternative trajectory of recipient laughter is a recipient volunteering laughter. Volunteered laughter typically comes at what has been termed a recognition point; a precise or expectable position in the interaction for a response such as laughter (Jefferson, 1974). With speaker-produced laughter, the producer orients to the projected appropriateness of laughter as the relevant next act. Speakers may also invite laughter through interpolated laughter within an unfolding utterance, which a recipient might treat as a recognition point (Jefferson, 1974) and thereafter take the invitation to laugh.

Of course, invitations to laugh are not obligations to laugh and can be declined. Silence, however, is not sufficient for declination, and the initial speaker may pursue laughter as a response to their laughter or laughable (Jefferson, 1979). Indeed, recipients must produce a verbal alternative to laughter, such as extending the topical talk, to decline an invitation to laugh. As such, recipients can shut off the relevance of laughter as the next act, whether in overlap, a possible completion point, or immediately post-completion (Jefferson, 1979). A recipient must, however, decline the invitation to laugh if they wish to shut down laughter's relevance and subsequently terminate the pursuit (Jefferson, 1979, p. 93). An example of successfully declining laughter is seen in response to laughter produced by speakers who also perform troubles-telling (Jefferson, 1984). Jefferson found that a speaker who told a trouble would also laugh, but the recipient would instead offer a serious response to the trouble. Troubles-tellers who produce laughter are said to exhibit troubles-resistance and to be handling their situation well, while the recipient demonstrates troubles-receptiveness by treating the trouble as serious (Jefferson, 1984, p. 351). While the troubles-teller might laugh, they are not necessarily inviting the recipient to laugh.

Troubles-tellings are a particular sequential context, and in that regard are relevant for the present research, which is both a particular context and one where we might expect to find troubles-tellings. Particularly relevant for this research is what Jefferson found on the occasions that troubles-teller and recipient both laughed. Instances where both parties laughed were associated with a buffer topic, broadly a "time-out for pleasantries" from the sequential project at hand (Jefferson, 1984, p. 351.). Buffer topics are interesting because they can remain topical or be unrelated, although they typically take the form of an anecdote or a joke. Beyond this, buffer topics hold consistent with the other features of laughter in troubles-tellings in that they are not normative but rather interactionally accomplished. That is, their invitation is typically the troubles-teller's business, and the troubles recipient may not immediately laugh; rather requiring more interactional work to reach that acceptance point. In sum, buffer topics are a way for speakers to detach from the sequential context of a troubles-telling so that they can engage in laughter even if the topical talk of the troubles-telling continues (Jefferson, 1984).

Alongside Gail Jefferson, one of the researchers who has contributed the most to the development of the study of laughter as an interactional resource is Elizabeth Holt. Especially relevant to this chapter is the finding that shared laughter is relevant for topic termination as non-lexical pre-closings that suggest exhaustion of the topic at hand (Holt, 2010). Perhaps most crucial to this chapter, however, is Holt's work on seriousness/non-seriousness and how interlocutors can produce or abstain from producing laughter to treat turns as serious, non-serious, or a combination of both (Holt, 2013). As such, interlocutors can weave together laughter and topical talk plus seriousness and non-seriousness to ease sequential work or facilitate sequential progress by softening otherwise hearable delicate actions (Holt, 2013). It is worth noting that Holt's work, like Jefferson's, primarily concerned everyday non-institutional talk, sometimes also dealing with telephone data. As such, the earlier research on laughter tended towards more generic and reproducible findings in non-specific contexts. In the following sections of this chapter, I will overview the inroads that language and social interaction research has made into laughter in healthcare interactions.

Having characterised some of the fundamental work that shapes our understanding of the socially organized nature of laughter, it is worth providing some context-specific detail. Despite the early ties between institutional encounters and both ethnomethodology and conversation analysis, as discussed in the second chapter (Turner, 1972; Coulter, 1973; Wootton, 1977; Sacks, 1992) it took some time for the study of laughter in institutional interactions to come to the fore. The study of laughter in healthcare encounters has largely stemmed from the seminal *Routine Complications* (West, 1984), and a distribution pattern of laughter that became clearer with subsequent research (Haakana, 2001, 2002; Beach and Prickett, 2017). Laughter was not necessarily as uncommon as we might expect, but the manifestations were distinct. For one, unilateral laughter was overwhelmingly more common than shared or reciprocal laughter. Practitioners were observed to laugh less than patients, and to take up invitations to laugh from patients less frequently than patients would take up practitioners' invitations (1984, p. 125-127). Beyond these numerical findings, much of West's work in *Routine Complications* focuses on "salutations, and the mutual exchange of names" (1984, p. 120) and this stands in as the truly conversation analytic thrust of West's chapter. The numerical findings remain influential, however, as they reveal a distribution pattern that has been found again and again.

For one, a study of various institutional interview contexts in Sweden, from job interviews to post-trial interviews, found that unilateral laughter was far more common than reciprocal laughter (Adelswärd, 1989). Similarly, a study of Finnish healthcare encounters almost twenty years after West's work observed this same distribution pattern (Haakana, 2002). Haakana goes on, however, to argue that the numerical analysis alone is insufficient, and that conversation analysts need to engage in the fine-grained microanalysis that typifies their discipline. Furthermore, Haakana remarks that the institutional incumbency might be characterised by a professional or neutral quality. Therefore, laughter may be heard as potentially unprofessional, whereas smiling might be deemed an appropriate affective alternative (Haakana, 2002, p. 228). Smiling in these instances typically referred to the production of utterances in a smiley voice. Indeed, much like Jefferson's troubles-telling findings (1984), patients' laughter was not routinely considered to invite laughter but to index "delicate interactional slots" (Haakana, 2002, p. 226). Patients were seen to routinely laugh when they performed a potentially delicate action such as challenging a practitioner's understanding (Haakana, 2001). In turn, Haakana (2001) suggested that smiling might serve as an appropriately affective response to laughter that doesn't invite reciprocation, such as around potential delicate actions or moments.

What became immediately apparent from the current dataset was that the distribution pattern of laughter evidenced above was not observed. Indeed, here were CNSs who laughed more frequently than their patients. By the time that I felt confident laughter would make an analytic topic I had observed in a collection that CNSs laughed on sixty-eight occasions compared to patients' fifty-four. Perhaps understandably, patients did initiate laughter and formulate laughable utterances more than clinicians, although not by as clear a margin as in West's (1984) or Haakana's (2002) studies. That said, the distribution of laughter is clearly distinct to the pattern identified in the literature to date but for one notable exception. A study of gynaecological appointments, although not focused on the numerical data, observed recurrent reciprocal laughter in service of verbal play between patient and practitioner (Ragan, 1990). One explanation for this similarity might be the nature of the content of these encounters. For Ragan's (1990) study the patients were engaged in an intimate physical examination and for this study the appointments spend a significant amount of time discussing urinary and sexual function in addition to the invasiveness of the pre-diagnostic prostate cancer screening tests. As such, the role of laughter in appointments that require discussions of sexual implications and intimate examination may perhaps be mobilised to a sociable goal.

Of course, the finding that patients produce laughter as a marker of a delicate action, or in service of problem resolution (Haakana, 2001) is relevant for this current project. As are other observations that help illustrate the form and function of laughter in healthcare encounters. For example, the potential delicateness of gynaecological exams was seen to be headed off by the parties engaging in a side sequence (Jefferson, 1972) wherein they produced verbal play (Ragan, 1990). By producing verbal play together, patient and practitioner were able to not just achieve task-oriented goals but also social goals that helped minimise threats to face (Goffman, 1967; Brown & Levinson, 1978) and bring the parties together in delicate moments (Ragan, 1990). Unlike much of the other research (West, 1984; Adelswärd, 1989; Haakana, 2002) the parties engaged in reciprocal laughter throughout these encounters to produce the verbal play (Ragan, 1990). Focusing more closely on my specific area of study, we find that a recent study of oncology consultations once again found the familiar laughter distribution pattern (Beach & Prickett, 2017). Most relevant, however, was that they reported patients produced laughter around the troubles or challenges that were raised throughout the interaction. Again, practitioners were not typically invited to laugh, did not often reciprocate laughter, and functionally laughter was used to manage delicate moments in the consultation (Beach & Prickett, 2017).

Having reviewed some of the now well-established research on laughter in healthcare encounters, albeit briefly, the chapter shall proceed with the analysis. Analyses are divided into three sections that correspond to various degrees of interactional work and sequential complexity. The first section reports on instances where laughter effectively performs the function of a receipt token, and straightforwardly sanctions progress through an affective display of understanding. Increasing in complexity, the analysis then explores extended sequences and the production of buffer topics for allowing an interactional intermission from potentially delicate moments. The analysis concludes with an investigation of the production of laughter and the interplay between designing and treating turns as serious, to soften otherwise delicate business and moments. As such, I draw on the work of Gail Jefferson and her work on inviting laughter (1979) and laughter in troubles-tellings (1984). Prominent also in these analyses is the work of Elizabeth Holt, particularly her research on laughter and seriousness (2013) and laughter and topic termination (2010). These findings are especially useful for explicating the function of laughter in the extracts reported on below.

6.2 Laughter and straightforwardly sanctioning sequential progressivity

This analysis will focus on instances where laughter is produced in positions that we might otherwise expect to see straightforward acknowledgement. These instances were notable because laughter would sanction sequential progress via standing in for acknowledgement tokens or softening potential delicate actions. While perhaps lower stakes, laughter could stand in for preference construction and patient involvement. The link to SDM here is in sanctioning progress, and the relation to preference construction is in the patient's tacit approval. Functionally, from a healthcare ethics perspective, we want patients to tick a box saying I have no objection to the business at hand. This can be considered positive preference, but practically it is in tension with the actual mess of working out preference through the interaction.

There is a tension between an explicit list of patients' preferences that must be brought to bear on the interaction and the more tacit work of construction and formulation we see operating from various levels of straightforwardness that span laughter to outright protest. Taking this tension forward, it follows that the most tacit, and therefore least disruptive way to sanction sequential progress, at least where a receipt token is in some way treated as insufficient, may be laughter. In terms of decision-making, the production of laughter both allows progress of institutional business and therefore progress towards a decision and demonstrates that the patient does not take the current business as a threat to "what patients want from their healthcare" (Street et al., 2012, p. 168) and therefore their preference.

Extract 6.1 (Recording 1)

PAT: it's not nothing's like that (0.2) because the test-
         -osterene you're just stopping the testosterone
CNS: yes
         (1.0)
PAT: yeah (0.9) so I might I might not have to shave so often then
CNS: ahahahaha well I can't guarantee you that

7 PAT: a hua ha ha aha ha
8 COM: what drug is it that stops the testosterone

At this point, the patient has reached the end of a story formulation that built up their entitlement to knowledge on female hormones through prior employment history. Throughout this story formulation the patient proffered candidate side effects and asks about these in a tag question at the end of his extended telling. A short affirmation from the CNS might be expected considering the design of the tag question as one that projects an affirmative answer (Raymond, 2003). Once the CNS provides the projected answer, the sequence reaches a point of recognisable completion and a transition relevance point, which is evident from the notable pause before the next turn. The patient acknowledges the CNS's answer and after another notable pause formulates a follow-up question. As previously mentioned, one of the concerns with decision-making is that progress might stall, or a delicate moment might cause a problem.

The exchange above is an example of a potential delicate moment, as the patient asks about a side effect; one that was the subject of an experiential story formulation. The question having been answered, the patient then softens the sequence with the production of laughter and a turn that they mark as non-serious via that laughter (Holt, 2013). As the CNS responds with laughter particles (line 6) they appear to treat the patient's turn as non-serious (Holt, 2013). Interestingly, the patient reciprocates the laughter despite the CNS's laughter not falling in a post-utterance completion point (Jefferson, 1979). In turn, the patient appears to treat the CNS's response as either at least partially non-serious (Holt, 2013) or a recognition point for laughter (Jefferson, 1974). Whichever response the patient performed, the laughter in this extract not only sanctioned sequential progress but also performed preference construction work by means of indicating that concerns have been satisfied. The patient was able to ask a potentially delicate question, receive an expected and therefore preferred response (Raymond, 2003), and could indicate, subsequently, that there was no problem to "what patients want from their healthcare" (Street et al., 2012, p. 168) at that point.

Extract 6.2 (recording 7)

1 CNS: Sometimes patients can feel quite lethargic and quite fati-
2 -gued with it (0.6) .hhh erm hot flushes night sweats sudden

```
          flashes and an an an (0.2)[ sweats coming on]
PAT:                                [I get all that no]w]
COM:                                                 [get] that
CNS:      hmm bless ya
PAT:      °a ha ha°
CNS:      bless you .hhh erm and <moo::d> can be effe<cted> ok so
          sometimes your mood can fluctuate a bit so you can (.) be a
          little bit ..h emotional
```

This extract sticks with the notion of lower stakes but also begins to demonstrate variability in how laughter can sanction sequential progress. For example, the patient alone produces laughter in a hushed voice, which does not get treated as an invitation to laugh by the CNS. In the sequence, the patient produces an utterance that threatens progressivity because of its status as a potential complainable. As the CNS outlines side effects for hormone therapy the patient begins speaking in overlap. Although the CNS has not finished, the patient might orient to the three-part list (Jefferson, 1990) as projecting possible completion and therefore a transition relevance place. The patient orients to the list of effects to voice what is hearable as a complainable by reporting that they already experience the side effects. The companion's turn is cut off, but in using two of the words from the patient's turn, might be understood as a corroborative effort (Wooffitt, 1992). Although the CNS responds minimally with their turn, they use it to produce a sympathetic demonstration alongside their receipt token. Notably, the patient does not expand on the potential complainable nor engage directly with the sympathetic demonstration.

Instead, the patient produces a short string of laughter particles in hushed voice, which may be to manage the subjective side of their potential complainable. By subjective side, I refer to what Edwards termed "the way that a complaint may index the speaker/complainer" (Edwards, 2005, p. 5). That is, a speaker might interpolate, or subsequently produce, laughter to indicate that they are not belabouring their complaint (Edwards, 2005). In turn, although the format of the initial utterance may be heard as projecting a complainable, the affective stance is marked as distinct from a whinger with an intractable complaint. Laughter, then, manages the potential delicacy of a poignant moment (Beach & Prickett, 2017), as the patient reports experiencing side effects prior to treatment. As such, the patient can get an ostensible complainable related to treatment preferences the on record without the turn being understood as a complaint, thanks to the indication that they are not whinging (Edwards, 2005). This delicate management affords an opportunity for the CNS to orient to the report as less than entirely serious (Holt, 2013) and possibly topic terminal (Holt, 2010). In turn, it is the production of laughter that lays the ground for sequential progress and enables the CNS to continue with institutional business. The sequence is not disrupted beyond this short insertion, or side, sequence (Jefferson, 1972), as the CNS continues to outline the side effects afterwards in text not shown.

Extract 6.3 (recording 16)

```
1   CNS:     =it VARies it VAries erm: (0.2) some (.) patients (.) y'know
2            feel (0.2) completely exhausted hh and some feel a little bit
3            more tired than usual but it does vary it doesn't mean that
4            you're going to get things straight away (.) it may (0.1) be
5            subsequent injections (0.1) so (.) on (.) going inject[io]ns
6   PAT:                                                           [mm]
7   CNS:     >are< where you might start to feel the side effects which
8            I'll talk about in a moment=
9   PAT:     =yeah can you still drink your glass of wine and that with
10           this stuff [(up ya)]
11  CNS:                [yes you] can still drink when you've had medi-
12           -cation
13  PAT:     ah huh huh
14  CNS:     ok .hh so fatigued (0.2) ERM feeling (0.2) hot flushes hot
15           sweats sudden hot flashes that can occur >be< one of the side
16           effects .hhh (.)
```

In the exchange above we have perhaps an even simpler example of laughter functioning to sanction sequential progress. The patient responds to the CNS's turn in latched speech to ask about drinking alcohol while taking medication. The patient words their propositional content euphemistically and uses a yes/no interrogative format to project a positive answer (Raymond, 2003). Although the CNS translated the euphemistic content into the straightforward "`can still drink`", the yes/no interrogative format receives its preferred response in line 11. Therefore, the sequence is complete in organizational terms as the interrogative was answered appropriately in the preferred format. In turn, the patient volunteers three laughter particles in line 13, with no clear invitation to laughter or marked laughable in the preceding sequential context. Here, then, the laughter particles effectively stand in for an acknowledgement token, such as the similarly non-verbal “`mm`”, as a standalone display of recipiency. With this display of recipiency, the patient chose laughter of all viable alternatives and laughter might therefore have a particular function in this position.

Shared laughter has been linked to topic termination (Holt, 2010), perhaps due to indexing a juncture (Button, 1991) in the topic that indicates the exhaustion of the sequence at hand and subsequent closing relevance. The patient, having had their question answered, may have subsequently invited laughter through their post-utterance completion laughter particles (Jefferson, 1979) as a potential closing-implicative act (Holt, 2010). As shared laughter needs to be interactively accomplished rather than normatively presumed, the CNS continues with the topicality they introduced between lines 7-8. In turn, while the CNS does not orient to the patient’s laughter as a prompt for shared laughter and topic termination (Holt, 2010), they do orient to it as an indication of acknowledgement, no problem, and a sanction for sequential progress. Indeed, while shared laughter might have exhausted topicality and therefore moved away from conversational business (Holt, 2010), the patient-side laughter simply allowed topical progress to continue unimpeded. We see, then, that while one possible function of laughter was not brought to bear on the interaction, laughter was able to perform preference construction work and demonstrate that the appointment could continue relatively seamlessly.

We can see then that those delicate moments in the interaction might be managed through laughter production. Whether it be through a buffer topic that allows for interactants to produce levity in the interactional space, or through inviting laughter around a delicate topic or turn. Whichever form these productions took, they ultimately sanctioned sequential progress. Whether they softened an action that might otherwise be disruptive or received something possibly disruptive or delicate with laughter. Moreover, laughter might treat some utterances as sufficiently serious for the propositional content and its topical implications but also non-serious enough to facilitate progress despite the delicate topicality or action. At its simplest however, laughter can just indicate that although a receipt token might be treated as insufficient or inappropriate, the sequential business at hand can proceed.

Extract 6.4 (recording 15)

```
1   CNS:      =and it may well (0.2) be affected as well (0.3) with you
```

```
2            having the production of testosterone stopped (.) so with
3            this drugs- (.) stopping the production of testosterone
4            >testosterone< gives you your sex drive .hh libido will be
5            reduced (.) when you have this drug=
6    PAT:    =couldn't be more reduced could it
7    CNS:    eh he he he he he .h(hh)hh (0.4) so: erm yeah (.) so going on
8            to the side effects of the injection then so because we stop
9            that production of testosterone .hh you can experience some
10           side effects ok=
```

In this extract, the CNS is outlining the effects of hormone therapy treatment where they concern sexual function. Considering the accepted cultural knowledge that sexual dysfunction and reproductive organs are largely private matters, it stands to follow that this discussion might be understood as delicate. In turn, the CNS builds a softened and probabilistic account of the effect characterised by repetition and stops and starts that indicate disfluency. Reduced libido and sex drive can be heard as potentially undesirable occurrences by their belonging to the category of treatment effects. Crucially, however, the patient has previously reported low libido and poor sexual function. In latched speech the patient produces a rhetorical question that suggests they orient to low libido already and that this might not be an especially significant effect. The rhetorical question is formatted to project agreement as the preferred response, grammatically speaking, through its yes/no interrogative format (Raymond, 2003).

In line 6, the "`could it`" hints at two possibilities; one being the shared knowledge of low libido as previously reported and the other a potential indicator of a laughable moment. In response, we see the CNS treat the rhetorical question as a recognition point to volunteer laughter (Jefferson, 1974) thereby treating the patient's turn as indicating a laughable moment. By laughing as the singular response to the patient's turn the CNS might be helping the interaction transition to topic termination. Holt (2010) observed that laughter can be understood as a pre-closing contribution as a non-lexical response. Couple the CNS's non-lexical response with the patient's figurative expression, looking back as it does to a prior admission, and this pair of turns appears to indicate topic termination (Holt, 2010). An understanding of this action would appear to be borne out by the CNS marking the upcoming talk as progressing from the issue of libido to the broader topic of side effects.

Extract 6.5 (recording 17)

```
1  CNS:    facial hair can sometimes become less coz obviously men have
2          (0.2) test(h)osterone .h uh huh huh £she says as he strokes
3          his beard£ uh huh hu:
4  PAT:    huh heh
5  CNS:    ER it can sometimes become a little bit less you don’t have
6          to shave as frequently
```

One of the functions of laughter for managing delicate moments we have discussed was getting an action on record in a sufficiently soft manner as not to disrupt progress. Naturally, we would have a keen interest in patients’ use of this resource, but laughter is a generic non-lexical resource for all interlocutors. In turn, this extract provides an example of the CNS mobilising this resource to perform the same function that patients have, such as in extract 6.1 with the post-completion laughter particle. Informing patients about side effects is a fundamentally delicate action because they are typically undesirable and particularly delicate in preference-sensitive decision-making contexts as they could be claimed as the reason for one choice over another. In interaction terms, side effects are possible prompts for rejection, for protracted sequences, or for ostensible rash decisions.

The CNS produces an interpolated laughter particle (line 5), which is immediately followed by a longer string of laughter particles and an account for the laughter given in smiley voice. Here the CNS designs their turn to couch the action between two strings of laughter particles further to the smiley voice. As such, laughter is a pivot between a straightforward informing, an informing-relevant noticing, and once more a straightforward informing. By remarking on the patient’s embodied conduct, the CNS can pre-emptively offer a candidate complainable that the patient might produce in response to the initial informing. It does not, however, take away the interactional slot or space for the patient to formulate a complainable or for instance a disprefered response. Indeed, giving voice to the patient’s embodied conduct ensures that not only facial hair, but the patient’s beard specifically is made conditionally relevant (Schegloff, 1968).

Furthermore, the smiley voice was followed by laughter, which might suggest that both the turn is designed for non-serious affective conduct and sequential progress (Holt, 2013), and that the CNS is leaving the interactional space for the patient to orient to the laughter rather than projecting the expectation such as with a joke (Sacks, 1992; Haakana, 2010). Beyond a preference for shared laughter and affiliation then, the patient has the speaker's rights to formulate their turn however they wish. Despite there being relatively few constraints on the patient's next turn, they respond minimally and choose to reciprocate the laughter projected by the CNS (Jefferson, 1979; Haakana, 2010). As such, the CNS has given voice to a candidate complainable, responsively to a patient's embodied conduct, successfully invited reciprocal laughter, and accomplished getting the patient to sanction sequential progressivity. Here then, the CNS has demonstrated that the function of laughter as softening actions to get them on record without halting progressivity is available also to clinicians. In the extract to follow, I will examine a case where not only does laughter not straightforwardly sanction sequential progress but prompts the CNS to account for their turn .

Extract 6.6 (recording 5)

```
CNS:    ((lips pursing)) u::h er i i if you- when you see name redac-
        -ted cos he would be the one who's going to do it .h erm he
        would outline all the risks uh in- every single risk >SO< at
        it's most basic (.) he chops there he chops there he cuts it
        all out .h but [we]            [do the surgery]
PAT:                   [PH]UH huhuhuhuh[uhuhuhu aha ha] ha ha ha ha
        ha
CNS:    yeah that's at its most basic but uh we use eh do it
        robotically so it's key hole surgery uhn- a little and a step
        beyond that so they use very fine instruments=
PAT:    =<yeah>=
CNS:    =a::nd erm it's done (0.5) uh::: h::h via:: we- they're all
        planted in the abdomen the the tubes for it to work through
        .h and name redacted sits next to you and does his tour via
        (1.1) his fingers=
```

The following extract is distinct from the others in this section, as the production of laughter is treated as unexpected by the CNS. It is a deviant case in a way, as while the production of patient-side laughter not being taken up is not uncommon, the treatment and its impact on the sequential trajectory are noteworthy. This extract demonstrates that laughter is not simply tethered to delicacy nor progressivity but is a resource that requires interactional work. Indeed, as with the patient's laughter changing the sequential implications of the talk, the CNS appears to treat the patient's turn as ascribing accountability. The treatment of the production as unexpected is also interesting, as the numerical data in the dataset suggests CNSs are not averse to sharing laughter or treating laughter as an appropriate act.

Although the notion of laughter straightforwardly sanctioning sequential progress seems unproblematic, as akin to a more affiliative receipt token, there is no guarantee of its success. Here, the CNS is outlining the surgical procedure in broad strokes. Being an outline, the CNS marks the upcoming formulation as a gloss or an upshot (Heritage and Watson, 1979), as being "`at its most basic`". The upshot is delivered through a three-part list (Jefferson, 1990) that trades on lay notions of chopping and cutting, which is far removed from professional alternatives such as incision. Despite projecting that they have more to say, the patient produces an emphatic breathy laugh particle and subsequently continues to laugh until the CNS abandons her projected turn. In the absence of any cues such as smiley voice, a post-utterance completion laughter particle (Jefferson, 1979), or a clearly formulated joke (Sacks, 1992, vol. 1, p. 15) it might appear that the CNS designed the upshot as a serious, if informal, utterance. With such an extended sequence of laughter particles the patient appeared to treat the upshot as non-serious, and as such changed the sequential implications of the turn (Holt, 2013). We see this in the CNS's decision to restate their pre-upshot marker "`at its most basic`" before then re-attempting the turn previously cut off in line 5.

Therefore, without formulating a challenge, complainable, or request the patient's turn prompts the CNS to account for their turn design after the fact. Based on other extracts examined, it appears plausible that a straightforward receipt token or similar display of understanding would avoid the CNS's repetition. Indeed, that a simple yeah would indicate that there are no current problems with the sequential or institutional business. We can see this in line 12, when the CNS's previously abandoned turn has been met by a straightforward yes and sequential progress continues unimpeded. Therefore, in the treatment of an ostensibly serious turn as non-serious (Holt, 2013), there was a disjuncture that problematised the progressivity project. The laughter, by problematising progressivity, steers the appointment back into re-treading old ground even if only briefly. In this case, laughter was not treated as nor did it act as an emotive alternative to an acknowledgement token, but perhaps instead as non-serious treatment of a colloquial but ostensibly serious turn (lines 4-5). As such, this is a reminder of the interactional accomplishment of laughter as sanction for sequential progress rather than taking it for granted. Moreover, it is an example of a deviant case in the function of laughter within prostate cancer treatment appointments

I mentioned at the beginning of this section that there is a tension between the healthcare ethics perspective of preferences and preferences as constructed by patients. For the former, preference is essentially outright stating that one has no objection to the business at hand, while the latter involves the mess of putting together and working out a preference over the encounter. With the function of straightforwardly sanctioning sequential progressivity, it is possible that laughter might be a useful resource here. When patients could produce an acknowledgement token or display of understanding, they instead produced laughter as an affiliative alternative. By producing laughter, the patient displays that there is no threat to "what patients want from their healthcare" (Street et al., 2012, p. 168), which is a working characterisation of preference. As such, there is a way for patients to provide or approximate the positive preference that healthcare institutions are looking for within the interaction. Furthermore, patients can engage in prosocial work in a way that might be beneficial for decision-making business as I will discuss in the next analytic section.

As I am concluding this section it is important to make a clarification and a distinction. The clarification is an obvious one, but needs stating, and that is that other more typical acknowledgement tokens, such as mm or ok, of course sanctioned sequential progress. The distinction, however, is that these acknowledgement tokens are produced for the express purpose of sanctioning sequential progress by virtue of displaying listenership and being minimally intrusive. Laughter, by contrast, is not and poses a higher risk of immediately halting sequential progress through inviting reciprocal laughter (Jefferson, 1979). Furthermore, if laughter is understood by a speaker as inappropriate, then there is another risk to halting sequential progress. Taken together, then, it is even more noteworthy that laughter was not only able to sanction sequential progress but did so around side effect talk (extracts 6.1 & 6.4). Indeed, the production of laughter largely avoided disturbances to progress and intersubjective breakdowns while also engaging in prosocial or affective work. A generic acknowledgment token would have likely gone unremarked upon and would not necessarily be understood as prosocial in a similar way to laughter. In the next section I will move on to examine longer sequences and the use of buffer topics (Jefferson, 1984) as a form of produced laughter.

6.3 Extended sequences and buffer topics

In this section, the focus moves from cases of laughter straightforwardly sanctioning progress to longer instances of, typically shared, laughter. Particularly pertinent to this section is the buffer topic (Jefferson, 1984) that was reported when troubles-tellers and troubles-recipients shared laughter. These buffer topics typically involved troubles-tellers telling a joke or anecdote as a “time out for pleasantries” (Jefferson, 1984, p. 351). For the following extracts the interest remains on both sanctioning progressivity and managing potential delicate or sensitive moments. Typically, these delicate moments concern personal topics such as sexuality and health-related quality of life and have the potential for halting progress. Moreover, it could also be possible that these delicate moments pose a risk to speakers’ face (Goffman, 1967). In turn, there were often extended sequences occasioned by the production of some potentially delicate utterance, which when aligned with laughter prompted a buffer topic. Often the buffer topic would be extended to allow that “time out for pleasantries” (Jefferson, 1984, p. 351) which afforded affective prosocial work and facilitated resumption of progress.

Extract 6.7 (recording 3)

```
1   CNS:    =and our role then is to: (0.2) just make sure you’re doing
2           well .h check on your waterworks make sure they’re improving
3           check in on you
4   COM:    °mm°
5   CNS:    erect↑ions↓ >much< not physically [but just to (b]e sure)
6   PAT:                                      [M HA HA HA HA]        .h
7   COM:                                          [ha ha]
8   PAT:    [ah ha: ha:]
9   COM:    [ha:: ha:: ]<Ha:: Ha:: Ha::>
10  PAT:    calm down [eh]
11  CNS:              [Ju]st to be sU:RE
12  COM:    you’ve got me [job then]
13  CNS:                   [A [ha]       A HA HA HA HA HA HA HA hua ha
```

```
14  PAT:                   [A HA HA ]HA
15  COM:     yes no yes no
16  CNS:     °aah ha ha°  A HA HA
17  PAT:     oo::h yes
18  CNS:     check if you're achieving what you wa[nt from y]'know
19  COM:                                          [A HUA HUA]
20  CNS:     with the exercise make sure you're using the pump correctly
21           .h y'know just make sure things are (0.2) y'know you're happy
22           [with ]how things are g[oing]
23  COM:     [yeah]                 [yeah] and do ya get checks annual ch-
24           -ecks after that to make s[ure]
```

Here the CNS is outlining the procedural steps involved in managing the effects of treatment on urinary and erectile function. Possibly aware of a sexualised interpretation, the CNS clarifies their remark about checking erections (line 5), which the patient and companion treat as laughable. In turn, both patient and companion volunteer laughter at what they understand as a recognition point (Jefferson, 1974). In line 19, we see the CNS reattempt their earlier turn, which they abandoned in the face of sustained shared laughter. Both patient and companion produce potentially playful and humorous utterances either side of this attempt, however, and the CNS abandons the project to reciprocate laughter. Eventually the CNS can restart their informing, but this comes much later, and after what we might consider a buffer topic (Jefferson, 1984). Buffer topics can be topical or non-topical and can comprise anecdotes or jokes for instance, but effectively function to allow "time out for pleasantries" (Jefferson, 1984, p. 351).

The companion's turn at line 20 might be understood as a joke, as per Sacks (1992, p. 15) jokes are a ceremonial such that, "you tell a joke, there's a laugh". I note that while the patient and companion treat their turns as offering laughables, the CNS shows no such orientation and perseveres with topical talk. As such, it appears that the parties understand the delicacy of the topic being discussed and work to buffer the serious talk until initial sequential progress can be resumed. This exchange is somewhat typical of the form and function of buffer topics in this dataset. That is, a potentially delicate issue for the patient is transformed into an interactional space for laughter that often produces prosocial work from the parties. One exception is that this is the only extract of the 4 in this section where the laughter is first produced by the patient and companion rather than the CNS. In the next extract we will consider an example where the CNS invites laughter in response to the patient’s turn, which instigates the buffer topic.

Extract 6.8 (recording 5)

```
1   CNS:   =absolutely it’s not as though you’re one of these erm
2          uhh y‘know one of these gym bodies that are (.) uh sticking it in
3          for >other< reasons you had it [f]          an and you
4   PAT:                                  [T]hat’s right
5   CNS:   nee::d testoste<rone> (0.6) as a man (.) for everything else
6          ((stammering but ultimately producing no utterance)) y’know
7          just to function really haven’t you=
8   PAT:   =have to start buying some dresses=
9   CNS:   u(h)hu(h)=
10  PAT:   =a ha ha ha ha ha ha ha ha
11  CNS:   [(      )]
12  COM:   [he might] be quite happy with that
13  PAT:   HA HA [HA HA HA HA] HA HA
14  COM:         [HA HA HA HA]
15  CNS:   SO (.) BUT we’ll but (.) I’ll still refer you to uhm see name
16         redacted our >erectile< function specialist have you ever
17         met him before (0.2) no=
18  PAT:   =no=
```

Here the CNS is affirming in strong terms the patient’s good patient narrative, which is a characterisation I suggest and interactive project which I subsequently discuss again in extract 6.12. To do so, the CNS invokes an alternative category to favourably compare the patient against. The patient is someone who took testosterone for erectile dysfunction, which is a valid medical reason. By contrast, the other group of “`gym bodies`” are marked by their misuse of testosterone, emphasised by the distinctly non-medical characterisation of “`sticking it in`”. As the CNS works up corroboration (Wooffitt, 1992) of the good patient narrative, we see the patient affirm the upshot in lime 4. The CNS continues to work up corroboration (Wooffitt, 1992) and ties testosterone in with healthy masculine function, as a legitimising device for otherwise potentially problematic behaviour. In so doing, the CNS produces an utterance somewhere between minimisation and an extreme case formulation (Pomerantz, 1986). The initial “`just`” and final “`really`” both imply minimisation work, as they downplay further any notions of medical misuse of testosterone. However, the “`to` `function`” may be hearable not just as an extreme case formulation, but also a possible face threatening act (Brown and Levinson, 1987). The potential for a face-threatening act is in the turn combining the category work of invoking successful incumbency of the “`man`” category with the hearable implication that the patient may not meet membership incumbency criteria (Jayussi, 1984; Sacks, 1992, vol. 1, p. 40-41).

In latched speech the patient orients to the hearable implication and offers a hypothetical consequence trading on this category membership criteria and an alternative category-bound activity (Sacks, 1992, vol. 1, p. 40-41). As they do not fit the male category, they would be incumbent in the female category, and the category-bound activity here would be buying and subsequently wearing dresses, which is hearable as markedly not male. The CNS responds by volunteering laughter, albeit through interpolated particles, which the patient reciprocates in a full string of laughter particles. The patient’s post-utterance completion laughter particles in line 10 mark their turn as an invitation to laughter (Jefferson, 1979), and as such non-serious (Holt, 2013). In turn, this treats the CNS’s extreme case formulation as nonliteral, and perhaps instead indexing a positive stance towards the patient and their good patient narrative. From this laughter the companion produces another hypothetical that revolves around the existing category work.

Both the patient and the companion laugh, which marks the companion’s turn as being understood as a joke. In turn, the extreme case formulation (Pomerantz, 1986) was transformed into the departure point for a buffer topic (Jefferson, 1984), which softened the delicate category implications of this extreme case formulation and laid the grounds for sequential progress. The CNS does then progress the interaction with their next turn marked by a turn-initial “`so`” (line 15) that proceeds to outline further procedural business. The exchange above concerned the patient’s prior medical history and the potential for a delicate moment in the treatment appointment. As such, this extract is somewhat distinct, as the other three concern side effects that the patient could face in the future. There is a link, however, as both extracts feature category work around the patient that is key to the buffer topic and laughter within, in this case male identity and age in the extract below.

Extract 6.9 (recording 9)

```
1   CNS:     .hhh you can get hot flushes you can feel a bit letha::rgic
```

```
2             certain w- at first (.) erm but (.) most of the chaps seem
3             to say it’s the sort of lethargy that when you sit down
4             (0.2) you know if you sit down after a meal or sit
5             down (.) in the evening you nod off (.) more easily [than ]
6    PAT:                                                           [mm mm]
7    CNS:     perhaps you norma[lly  do]
8    PAT:                      [than than] normal=
9    CNS:     =A H[UH HU HAH] HHEH .hhh[ HHE]    [if I]
10   PAT:         [a huh huh]          [alth]ough[ at ]£age redacted I
11            think ah that’s happening [now uh huh huh huh hu hu hu]
12   CNS:                               [yheah h    normally if I pu]t
13            wives in the room or partners I think they look at them
14            because you can see them go ((no sound – visual))
15   PAT:     yeah he’s doing it now [already A HUA  HU HA] HA HA HA
16   CNS:                            [ah ha ha ha ha ha ha]
17            well I’ve never had anyone say they’ve fallen asleep on the
18            driving or anything .hhh
```

As with all these extracts, the CNS is outlining the effects associated with hormone therapy treatment, and the focus here is on fatigue. The fatigue effect is packaged in probabilistic terms before a self-repair (Schegloff et al., 1977), which steps down from the firm “`certain`” to softer substitute “`at first`”. A softening project continues as the CNS offers a generalised piece of reported speech (Holt, 1996), with “`the chaps`” appealing to a lay non-medical audience characterising the effect in relatable terms. Indeed, the CNS pursues this project further with a simile, the projected relatability of which is demonstrated in the patient’s uptake and collaborative sequence completion (Lerner, 2004). Further to the demonstration of intersubjectivity, there is a display of shared laughter as the CNS latches their laughter and the patient reciprocates in overlap. Both patient and CNS attempt new turns closer together, and as the CNS cedes the floor, the patient produces a stretch of talk in smiley voice (line 10). This turn reports on the patient exhibiting the behaviour previously discussed in the sequence, as well as making relevant the patient’s advanced age as a possible category-bound activity (Jayussi, 1984; Sacks, 1992, vol. 1, p. 40-41). Moreover, this turn is marked by the post-utterance completion laughter particle (Jefferson, 1979), which does not receive the invited laughter. The move from smiley voice to laughter does not receive laughter either, despite this move leaving open interactional space for the recipient to orient to the projected laughter (Haakana, 2010). Instead of reciprocating laughter, in line 9, the

CNS re-attempts their initial project by recycling the "`if I`", which was cut off when they abdicated speaker's rights in line 6.

The CNS continues with their project and culminates with a visual act, that the recording could not capture, but is hearable as either implying or mimicking the act of dozing off. The patient orients to this act, affirms it as a viable candidate, and expands it to offer a candidate response to the act, which the CNS recognises as laughable (Jefferson, 1974) and the patient volunteers their own laughter to mark the turn as one to invite laughter (Jefferson, 1979). As the patient reports on what might be considered a trouble, by way of its similarity to the treatment effect, it might be seen that both the talk following and comprising this turn function as a buffer topic (Jefferson, 1984). We might make this argument as the patient demonstrates troubles resistance while the CNS shows troubles receptiveness (Jefferson, 1984, p. 351) in their initial response.

However, the CNS then goes on to produce a turn (lines 12-14) that the patient treats as non-serious (Holt, 2013) and goes on to expand this into a laughable and each party shares in reciprocal laughter, as seen in buffer topics where troubles-telling utterances feature (Jefferson, 1984). Once the shared laughter has finished the sequence continues with a resumption of the earlier propositional content, which is about the specifics of the fatigue and its severity. As such, shared laughter was not associated with topic termination in this case (Holt, 2010), but rather as the ratification of "time out for pleasantries" (Jefferson, 1984, p. 351). The potentially delicate moment of discussing this side effect (lines 5-8) was sufficiently softened by laughter to not impede sequential progress. Moreover, the patient demonstrates unproblematic treatment of a possible troubles-telling (lines 10-11) through a buffer topic, which again avoided the potential for halting sequential progress while engaging in prosocial work.

In the below extract, the focus on progress is slightly different, as it is the patient who introduces the potential source for a delicate moment. As such, the companion and CNS initiate and drive the buffer topic as recognisably being a space for laughter prior to further sequential progress.

Extract 6.10 (recording 10)

```
1   PAT:      [yeah on o]n the prostectomy one it s[ays] (0.2) you can s-
2   CNS:                                         [yes]
3   PAT:    you can start jogging (1.2) but that’d be a mir[acle]
4   COM:                                                   [inde]-
5           -pendently hhh (0.2) w(h)ow
6   CNS:    A HEE HEE HEE HEH
7   COM:    he says i couldn’t jog before
8   PAT:    i’ve ad me hips replaced [i’m not allowed to]
9   CNS:                             [A HAH HAH HAH HAH ] HAH HAH HA
10  COM:                             [a hah hah ha]
11  PAT:    so how does that work
12  CNS:    hah hah hah hah hah hah ha
13  COM:    heehe £like a dog£ a huuu huh .hhh hh
14          ((coughing))
15  CNS:    HHH ((lips smack)) £↑well£ you’d be surprised some many- (.)
16          many patients err (.) y’know (0.1) w:e always say six weeks
17          anyway WE’RE ALL (.) wor we WE ARE very (0.2) erm encouraging
18          in regards to physical activity can (.) y’know overall help
19          your (0.2) ((lips smack)) your health and wellbeing .hhh
```

This extract begins part-way into a sequence where the patient reports information they read in one of the information booklets they were provided previously. At the start it appears that the patient is formulating an interrogative, and the CNS demonstrates attentiveness with the acknowledgment token “`yeah`”. The patient leaves a notable pause but goes on to produce an extreme case formulation (Pomerantz, 1986) “`that’d be a mir[acle]`” in line 3 instead. Here, then, the patient contrasts their stated opinion with the claim of the surgical information booklet, which is potentially hearable as challenging or undermining the booklet. As the companion begins speaking prior to the patient’s completion and offers an affected “`w(h)ow`” (line 5) through an interpolated laughter particle, they can be seen as marking this contribution as non-serious and inviting laughter (Holt, 2013; Jefferson, 1979). The CNS orients to the prior turn as a laughable and takes up the invitation to laugh as a standalone response, not engaging with the propositional content of any preceding turns. With the topicality not having changed, and the floor open for self-selection (Sacks et al., 1974) the companion picks up the patient's sequence and expands it via reported speech (Holt, 1996), which the patient may be seen as collaboratively completing in their next turn (Lerner, 2004). Lerner demonstrated how an interlocutor can be complicit in the collaborative production of a turn while ensuring authority remains with the original speaker by pre-empting completion of a previous speaker's turn. Both companion and CNS start laughing prior to the patient's completion but treat the admission of hip replacement as a point to laugh.

Although it is not clear beyond reasonable doubt that the patient designed their turns to produce a joke across the sequence, the contrastive work done in the reveal has a dramatic quality amenable to laughter. In follow-up, the patient tags an interrogative to their reveal, which is similarly met with two-party laughter and treated firstly in relation to its perceived affective tone. The companion offers a candidate response, in smiley voice, couched between two strings of laughter particles that marks their design as non-serious (Holt, 2013). Furthermore, this turn invites laughter through the companion's post-utterance completion laughter particle (Jefferson, 1979). While the companion treated the patient's turn as non-serious, to the extent of volunteering laughter and then inviting further laughter, the CNS treated the turn as combination serious/non-serious (Holt, 2013). As such, the affective response is modified and scaled back from laughter, as with the companion, to smiley voice. This shift might mark the move from a more playful, less serious moment in the sequence to the more serious work of responding to the interrogative that was initially treated as a point to laugh. We might therefore see the sequence spanning lines 1-14 as a buffer topic, trading on first the hip replacement anecdote, so dramatically revealed, and the companion's smiley voice "`like a dog`" approximation of a joke.

With the CNS moving from standalone laughter particles in line 12 to smiley voice in line 15, this may speak to the shift in relative seriousness in the sequential environment. This is because smiling after laughter in medical contexts has been seen as a resource for clinicians to acknowledge an affective contribution while demonstrating understanding of a prior utterance as delicate (Haakana, 2010). In this case, the patient's tag question, formulated as oppositional to a trusted resource is understood as delicate while the affective and less serious work around its production also gets acknowledged. Furthermore, the CNS's smiley voice production is a response to the patient's interrogative, which then transitions into a series of topical extended turns for the CNS. We see here, then, not just a buffer topic (Jefferson, 1984) but also interplay between it and the design and treatment of turns as serious, non-serious, and a combination thereof (Holt, 2013). Through this interplay of relative treatment of seriousness, the topical implications of the patient's contribution were sufficiently softened prior to sequential progressivity. Any potential delicacy that might be heard in the patient's challenge via extreme case formulation (Pomerantz, 1986) is therefore made more amenable to straightforward progress.

As it may not appear obvious, the link between progress and preference construction should be made clear. One key aspect of these appointments, I argue, is that patients' preferences are constructed (Elwyn & Miron-Shatz, 2010). To be specific, patients' preferences are constructed across a series of moments where alternative sequential opportunities present themselves. We saw in the previous analytic section how the production of laughter can function as an approximation of positive preference instead of alternatives such as acknowledgement tokens. Patients would have the opportunity to respond with mm or ok for instance, but instead produced standalone laughter. By producing laughter instead of a generic display of acknowledgement, the affiliative nature of the production demonstrates that there is no threat to "what patients want from their healthcare" (Street et al., 2012, p. 168). The analysis in this section demonstrated how laughter and humour, since we saw the production of jokes met with responsive laughter, were important resources for carefully treading between these alternative sequential possibilities until the parties negotiate one. In particular, the production of laughter was observed to soften potential delicate moments in the interactions, particularly when parties engaged in buffer topics to facilitate otherwise delicate sequential work (Jefferson, 1984).

It is also possible to consider a further, albeit more speculative, point, which is that the institutional ordering of the appointment is in the direction of assent. When there is a potential breakdown in progressivity, such as a complainable, they get raised and either managed or negotiated. Once any potential or actual breakdown has been handled this contributes progress towards agreement to the preference currently in play or on the record. By institutional ordering towards assent I mean that we might consider there to be a parallel or mirror between the interactive work in service of sequential progress and the way that

CNSs move the appointments towards completion and closer to a decision. Of course, an orientation to progress is not uncommon in healthcare interactions and does not presuppose an interactive ordering towards assent. For instance, the three talk model (Elwyn et al., 2017) could be characterised as being oriented towards progress because it seeks to move patients from initial to informed preferences by way of progress from team talk to decision talk.

Again, this is a speculative suggestion, particularly because I cannot speak to the final treatment decisions that the patients made. However, the management or resolution of potential progressivity breakdowns, through extended sequences of laughter, is observable in these extracts and accompanying analysis. This matter is raised again in the discussion chapter where I consider what empirical work might be necessary to explore this possibility further. Returning to the present discussion, the buffer topics function to step aside from the commitments that decision-making preferences were presupposing to perform prosocial, sometimes face-saving, work. As such, the link to preference construction is in the procedural and sequential work that surrounds and shapes the process of construction. Negotiating and guiding the preference work as it builds towards a preferred treatment option and ultimately decision. In the final analytic section below, I shall consider the flexibility of seriousness as an interactional resource for both managing potential delicate moments and sanctioning sequential progress.

6.4 The interactional negotiation of seriousness as a tool for sequential progressivity

This section focuses on the interactive work involved in constructing or orienting to specific turns as serious, non-serious, or a combination of both. As such, this section draws heavily on the work of Elizabeth Holt (2013) and her research on the malleability of seriousness as an interactional construct around laughter. Furthermore, the function and consequences of either constructing or orienting to turns as, particularly, non-serious or a combination of serious and non-serious. Although examples of this interactional work have been seen in earlier extracts, this analysis will investigate these occurrences where they are most noticeable as the central interactional work of the extract. The relevance for SDM and patients' preferences is the function of laughter as managing potential breakdowns in progressivity and softening turns or actions that might otherwise suggest intersubjective, progressive, or preference-based trouble.

Extract 6.11 (recording 3)

```
CNS:     so there is a problem with the bladder if you have .h drinks=
PAT:     =right=
CNS:     =or something so that more or less’ll stay the same .hh
COM:     WE eh eh eh he’s not he’s he’s he sounds an £alcoholic£
CNS:     £no no no I know what he means£
COM:     no no i mean i[t happens if he wa]nts to go to the loo
CNS:                   [AHh       HA HA HA]
COM:     he’[s got to going ]to the loo=
CNS:        [£i think that’s]
CNS:     =£i think that’s [most] people t be honest [i don’t think th]ere’s
COM:                      [yeah]                    [yeah but I don’t]
CNS:     anything >y’know< brand new there really but what i- what we (0.3)
         with the surgery we do refer you to the continence service
         so we try and get you in befo:re surgery .h
```

An intersubjective breakdown is a possible delicate moment for most interactions, but these could prove particularly problematic in decision-making appointments. Maintaining shared understanding is a generic concern across social interactions, but it might become particularly relevant for potential delicate moments in preference sensitive scenarios (Shirk et al., 2017). This extract begins with the CNS producing an upshot formulation (Watson and Heritage, 1979) of a bladder issue that the patient and companion have asked about in text not shown here. Although the patient affirms the upshot, thereby sanctioning the CNS to proceed with their candidate response the companion voices an issue with the characterisation. There is marked disfluency in the companion’s turn with repeating productions and a self-repair (Schegloff et al., 1977) before they formulate their complainable. In smiley voice, the companion remarks that the CNS’s upshot hearably implies the undesirable category membership of “`£alcoholic£`”. This category membership might be heard to imply that the patient’s issue is a consequence of their category-bound activities (Sacks, 1992, vol. 1, p. 40-41) and perhaps be glossed unfavourably. As such, the upshot formulation is treated as a face-threatening act (Brown and Levinson, 1987) by the companion, who formulates a complainable albeit with the category term marked by smiley voice production.

In response the CNS both recognises the affective tone of the utterance and responds to the action it institutes by appealing to a shared understanding with the patient in smiley voice. Crucially, the CNS appeals to an alternative understanding, as they know "`what he means`", a point borne out by the patient's second line affirmation of the initial upshot. As such, the upshot can be retroactively glossed as a loose characterisation for the purpose of sequential progress and held distinct from the shared understanding. In turn, the CNS moves to avoid an intersubjective breakdown by an appeal to the patient's intended meaning rather than the implication of the upshot. The companion proceeds to affirm that there have been issues with the bladder, suggesting that their issue indeed lay more with the categorial implication than any possible intersubjective breakdown. Here we see the only laughter particles of the extract, as the CNS volunteers them in overlap (line 7), possibly as an escalation of the smiley voice. There is no uptake or orientation to the laughter, perhaps because there is no clear interactional space due to its placement as overlapping a developing turn-in-progress. Instead, the companion concedes that the CNS was not necessarily unfair in their upshot formulation via a tautological admission.

Despite the lack of reciprocation, the CNS continues to produce smiley voice while reformulating their abandoned turn and responding to the companion's propositional content. In so doing, the CNS appeals to normality and generalisability to inoculate against further problematisation of categorical implications. Although the companion attempts another turn, they do cede the floor to the CNS and ultimately sanction sequential progress. Rather than laughter standing in for an action like protest, or softening on the patient's side, the CNS uses laughter to soften potential open protest and attempt to re-establish intersubjectivity. Through repeated smiley voice and volunteered laughter, the CNS can mark their turns as less than entirely serious (Holt, 2013) even if the companion might not orient to this marking. As a result of these markings, and recurrent projections of laughter as something to orient to (Haakana, 2010), the CNS offers the possibility that they do not understand the current sequential environment as harbouring a problem. Although the companion did not affiliate to the CNS's affective tone, they did align with their resolution effort and did not formulate further complainables. Nor did they expand their initial complainable sufficiently to affect progressivity or jeopardise the sequential project of informing.

This preceding extract is interesting for the way that it demonstrates a distinct way of using the interactive flexibility of seriousness to manage a potential breakdown in progress and intersubjectivity. We might expect that a breakdown in progress or intersubjectivity would be resolved through reciprocal laughter or an overt demonstration of resolution. Here in this extract, however, the CNS was alone in producing laughter and yet the sequence was satisfactorily brought to progress and the disruption was relatively minimal. In this way, the exchange analysed in this extract is atypical for the section and demonstrates that the conversational resources of laughter and seriousness/non-seriousness reported on are equally available to all participants.

Extract 6.12 (recording 5)

```
CNS:          [a]nd that’s that’s ya key (0.2) .hhh in terms of er-
         your erectile function we used to do (everything) on the tes-
         -tosterone so it’s (.) i would guess it’s not the best is it
PAT:     no:=  [no n]o i mean since i ad this (.) pee ess ayy test=
CNS:     =at th[e mo]
         =yeah=
PAT:     =i’ve stopped it anyw[ay]      [beca]use ((puckering))
CNS:                          [ok] right [yeah]
PAT:     they said they uh h erm (.) testosterone is the prostrate-
         -‘s friend=
CNS:     =ye[ah]
PAT:        [hu] hua ha ha ha ha ha ha
COM:     he’s just never had it=
CNS:     =y(h)ea(h) hah ↑↑Why don’t you (.) yeah but it’s easy to say
         that y’know we have me- you >happen to< have men that have
         (.) have (.) had testosterone and we never see them you know=
PAT:     =yeah=            [yeah]
CNS:     =it’s just one of [thos]e thing[s]
```

Unlike the previous extract, this one demonstrates reciprocal laughter between patient and CNS; indeed, it is the only such case in this section. Furthermore, the work of softening a potential delicacy falls on the patient’s side, while the seriousness of the exchange is cooperatively negotiated. The CNS outlines post-treatment procedures associated with erectile function and suggests that testosterone use might prove problematic through a tag question predicated on the prior disclosure of testosterone use. The tag question is a yes/no interrogative, which makes a yes/no answer the relevant answer format, and projects an expectation of an affirmative answer as the default response (Raymond, 2003). As expected, the patient affirms, but they also transform the answer into an extended telling despite the CNS orienting to the projected answer as marking the patient's turn as hearably complete. Once the CNS cedes the floor, the patient formulates a timeframe of recency that projects a newsworthy telling (line 4; Button, 1990) as part of establishing speaker's rights for the extended production. The CNS understands the ongoing sequence as an extended telling through the string of receipt tokens and does not attempt a new sequential project (Sacks et al., 1974; Sacks, 1992, vol. 2, p. 21). It becomes apparent throughout the patient's turns that they are constructing a good patient narrative marked by their adherence to medical advice and responsiveness to pertinent information. By invoking this archetype of a good patient, an interactive project that I suggest, the patient can work to head off any incipient trouble that the historical testosterone use might occasion.

In constructing the good patient archetype, the patient produces a piece of reported speech (Holt, 1996) from previous healthcare encounters, which is conditionally relevant (Schegloff, 1968) and fitted to the possible problem at hand, as well as broader adherence to medical advice. Further to the work of this narrative, the patient laughs after completion of their initial utterance as an invitation to laughter (Jefferson, 1979). There is no uptake by the CNS despite the invitation, and instead the companion proffers an expansion on the hearably laughable prior turn. Notably the CNS produces interpolated laughter in response to the companion's turn, which is interesting for two reasons. One is that laughter is embedded in a receipt token, excepting one particle, which suggests the possibility of treating the previous turn as conveying a laughable that indexed non-seriousness as well as conveying a combined sequential implication for advancing the project of heading off possible trouble around the historical testosterone use (Holt, 2013).

The patient has therefore accomplished construction of an ideal good patient, while the collaborative work of laughable turns with the companion soften the potential problematic or delicate issue, as we see from the CNS's uptake. The cooperative work of negotiating seriousness and non-seriousness accomplishes the sufficient softening of the potential delicacy around testosterone use, receives and acknowledges the good patient construction, and sanctions sequential progressivity towards further institutional business. As stated at the start of the analysis, this is the only example in this section where laughter is shared by the parties. While laughter in the extract to follow is one-sided, the non-serious nature of that exchange is similarly cooperatively negotiated. The next extract also concerns the issue of blocking the production of testosterone, albeit as a possible prospective consequence for the patient.

Extract 6.13 (recording 15)

CNS: >voice can< softens slightly cos men naturally have a
a deeper voic[e cuz]testosterone so that can
PAT: [mm hmm]
CNS: soften slightly=
PAT: =↑i’ll have to speak like this↑=
CNS: =ah heh heh heh heh hee heeh £many patients talk like that
sometimes£ AH hah hah hah ha ha: .hhh erm hhh sometimes you
get some hair thinning on the top won’t >necessarily<
fall out but can (0.1) thin slightly .hh erm (0.2) and erm
(0.4) again sometimes you can get a loss of libido becuz
testosterone being stopped=

One possible function of laughter around these delicate moments is to get actions on record in a way that is sufficiently soft as to not halt progressivity. The possibility of halting progressivity is pertinent because this phase of the consultation is heavily CNS-led and comprised primarily of information exchange. Here the CNS not only outlines one of the side effects of hormone therapy but embeds the reasoning in the sequence perhaps in the interest of progressivity. First, the patient acknowledges the effect with a receipt token but when they self-select at a potentially hearably complete transition relevance place (Sacks et al., 1974) they use their turn to produce an exaggerated turn. The patient’s production is marked as exaggerated by the affected high pitch it is produced in, and exaggeration can be used to indicate construction of a laughable (Drew, 1987).

We can observe from the CNS's volunteered laughter that they understood the turn as, minimally, a combination of serious and non-serious, if not entirely non-serious (Holt, 2013). The CNS's observable understanding of the turn as less than entirely serious becomes clearer when their response is produced in smiley voice (Haakana, 2002, 2010). Importantly, the CNS does engage with the propositional content and action of the patient's turn to offer an appeal to normality and therefore minimises the patient's concern. The production is couched between two strings of laughter particles to soften the response and expand the non-seriousness that they understood to be present in the patient's initial turn. Despite the patient not laughing, they were able to accomplish voicing a possible hearable complainable, receive somewhat playful reassurance, and sanction progressivity by offering a laughable instead of a generic receipt token.

Extract 6.14 (recording 17)

```
CNS:     but >some o< the s:ymptoms and side effects that I'm ex:plaining
         are very individualised so you mAY get some you may get none
         you may get all of them .h you may not even get it during
         your first injection (0.4) ok (0.2) .hh
PAT:     i'll have to change shops will a
CNS:     pardon
PAT:     .hh won't av to stai- change[ shops will i] £like start
CNS:                                 [a heh heh heh]
PAT:     shopping at women's (.)[ clothin- clothes and (     ) ]
CNS:                            [ERR hopefully not no no eh heh]
PAT:     unless i start buying that
COM:             [(oh brother)]
CNS:     £unless y(h)ou've got a burning desire to do that a heh heh
         heh heh huh heh (.) .hh so erm yeah so that's s:- some of the
         side effects that tHAt can potentially occur ok=
PAT:     =right
```

Here in recording 17 the CNS is once again characterising the side effects associated with hormone therapy treatment as contingent and probabilistic. In so doing, the CNS can both inform the patient about the effects to fulfil their institutional obligations while also ensuring that they not be held accountable for variability in onset and occurrence. The patient responds by formulating an interrogative, but the CNS treats this as insufficiently informative and therefore insufficiently actionable. In turn, the CNS requests clarification, and opens an insertion sequence. Accordingly, the patient reformulates the interrogative, making a change in word selection from "`will`" to "`won't`", and the CNS orients to the new format as a laughable. The patient goes on to produce the subsequent speech in smiley voice, indexing either playfulness or minimally a degree of non-seriousness (Holt, 2013).

Despite the CNS volunteering laughter at a recognition point (Jefferson, 1974), the patient does not treat their project as complete and proceeds to complete their turn. Within this turn the patient offers a categorical incumbency and category-bound activity (Sacks, 1992, vol. 1, p. 40-41) that turns on the gendered implications of hormone therapy side effects. Again, the CNS overlaps the patient's turn by engaging with the propositional content and then producing laughter to invite reciprocation. The patient continues to treat their project as incomplete and begins to expand on the original utterance, which the companion remarks on with a flippant idiom. Here the CNS recycles the patient's initial word selection of "`unless`" and offers a candidate sequence alternative marked by interpolated and standalone laughter particles. Here the laughter prefigures an incumbency marker, "`so`" (Bolden, 2009), which suggests it is produced to close topicality and push on with new business, following as it does from laughter as a non-lexical pre-closing contribution (Holt, 2010).

Throughout this exchange the patient produces an interrogative, with candidate example, concerning a potential consequence of a treatment effect they might encounter. As such, the act of asking the interrogative, and its subject, might be considered potentially delicate; especially considering the CNS's contingent and probabilistic informing. The production of smiley voice, then, in line 7 and its hint at non-seriousness is key for indicating that there is possible uptake of the patient's turn as not entirely serious (Holt, 2013). As the CNS laughs twice after line 7 it appears that they took the indication of non-seriousness. The laughter and non-seriousness are the tools that soften the patient's interrogative and its subject so that it can be discussed in a less serious, but non-trivial, and unobtrusive way thereby avoiding the possibility of halting sequential progress. While the patient does not perform preference construction work, their laughter does not approximate positive progress quite like we saw in section 6.2, their willingness to allow the interaction to continue, and the CNS to suggest topical closing with their "`so`" (line 14) could be understood as a demonstration that there is no challenge to what they want when coupled with the smiley voice and apparent non-seriousness.

Extract 6.15 (recording 16)

```
1  CNS:   =erm facial hair production so (.) erm (0.1) beard facial ha-
2         -ir can become a little bit les[s because of that]
3  PAT:                                  [i just bought a n]ew razor as
4         well so i need to know that heh heh heh heh heh:=
5  CNS:   =well it MAY i- it- these are all depend[ent these are al]l
6  PAT:                                           [yeah i know that]
7  CNS:   possibilities=
8  PAT:   =yeah
```

In the extract above we have a deviant case where the production of laughter does not soften a potentially delicate moment but prompts a dispreferred response from the CNS. Indeed, this is the only extract in this section where the CNS produces no laughter particles, despite successful examples of ostensibly similar exchanges across this analytic section. The CNS is outlining the effects associated with hormone therapy treatment and explaining how stopping the testosterone production might inhibit facial hair growth. The patient begins speaking in overlap and produces what is hearable as a complainable, pertaining to a recent relevant purchase. However, the patient tags their ostensible complainable as an invitation to laugh via a post-utterance completion laughter particle (Jefferson, 1979), and as such also minimally a combination of serious and non-serious work (Holt, 2013). Despite these markings, the CNS provides no orientation to any hearable laughable and instead treats the turn purely as formulating a complainable.

From a preference organization perspective, we see the CNS preface their response with a dispreference marker "`well`" (line 5; Pomerantz, 1984). Moreover, the attempts at vocal productions are cut off abruptly with glottal stops before the initial production under attempt is abandoned and the CNS returns to the probabilistic and contingent characterisations of the side effects; engaging with the topicality and propositional content of the patient's action but not the affective tone. The patient follows up to affirm that they knew the content of the CNS's turn, and therefore imply that the turn was not designed for the function that the CNS understood it to perform. From this case we might see that laughter can also fail to manage a delicate moment or soften a delicate action if the local environment is not well managed. For instance, we might suppose that producing a hearable complainable in overlap displays an insensitivity to the sequential environment. Indeed, it might indicate an urgency in production because of the violation to the turn-taking allocational system that it requires (Sacks et al., 1974).

In this final analytic section, we can again see the production of laughter as a resource for managing potential delicate moments. Of particular interest was extract 6.11, which showed the CNS producing laughter to resolve an intersubjective and progressive breakdown. Although neither patient nor companion reciprocated laughter, they ultimately allowed sequential progress to continue after the resolution attempt. An attempt that turned on CNS-side laughter and smiley voice, the latter of which was sometimes shared with the companion as some sign of affective work (Haakana, 2002). This extract is interesting because it is not an outlier in this section, rather these delicate interactional moments tended to produce CNS-side laughter with only one case of reciprocal laughter and one deviant case of patient-side only laughter. In these cases, then, the malleability of seriousness as something interactional that can soften the sequential location is successful for potential delicate or poignant moments. With the successful accomplishment of managing these possible delicate or poignant moments, the parties can avoid breakdowns in sequential progressivity or swiftly address them. As such, decision-making business can largely continue unimpeded, and patients get to raise points that might otherwise halt progress. Doing so allows for the sufficiently softened points to be received, and typically acknowledged, while also suggesting that these points are not a threat to “what patients want from their healthcare” (Street et al., 2012, p. 168), and by extension not problematic for patients’ preferences. Notable, also, was the deviant case in the last extract of this section that demonstrated how laughter remains a resource rather than a given force or axiom of managing delicate or poignant moments.

6.5 Discussion

The focus of this chapter has been on the role and function of laughter in post-diagnostic prostate cancer treatment appointments. In particular, the various ways that patients, their companions, and clinicians can use laughter both to manage or soften potential delicate moments and sanction sequential progress; sometimes simultaneously. For one, patient-side laughter was seen to function as a standalone response to a turn, and subsequently indicate that there was no threat to “what patients want from their healthcare” (Street et al., 2012, p.

168) and therefore also no potential barriers to preference nor sequential progress. In these instances, it might also be found that parties share in reciprocal laughter, which similarly indicates that the sequence is marked for progress beyond its current juncture. Ostensibly, laughter in these cases functions similarly to a receipt token; it is a simple display of acknowledgement and understanding that is distinct in being more overtly affiliative. With a generic piece of information, a receipt token would overwhelmingly suffice across occasions, but with the potential delicacy of, for example, a treatment effect informing, there may be more possibilities for preference-based issues to arise and sequential progress to become halted.

As laughter can approximate a positive preference and indicate that there are no present problems, it can also aid more complex interactional work where the sequence is less straightforward. In the second analytic section the focus fell on ways that laughter could soften or manage a potentially delicate moment. One resource that parties often drew on was a buffer topic, which is an extended sequence that can feature jokes or anecdotes and offers speakers “time out for pleasantries” (Jefferson, 1984, p. 351). As such, the buffer topic allowed further interactional space before the sequence progresses that speakers could use to perform prosocial and affiliative work. Typically, these exchanges represented the link between laughables and laughter more clearly. That is, anecdotes that turned on the formulation of a laughable and invitation to laugh, as well as jokes were more frequent. Shared and reciprocal laughter were common across these extracts, and they often turned on the affiliative or prosocial function of laughter. As such, they could bring together patient and CNS and soften the delicate moment via the exchange of affective responses. This affective exchange functioned also to sanction sequential progress, as we saw in section 6.3, since the potential delicate issue was typically avoided due to the production, and often reciprocation, of laughter. As such, laughter was again relevant for decision-making in the way that it was able to allow potential sources of delicate moments or actions to unfold in a softened sequential environment of prosocial and affiliative work.

In section 6.4, I observed that the notion of seriousness and non-seriousness as a flexible interactional resource was present in exchanges where softening or managing delicate moments was a concern. As with humour or laughables (Jefferson, 1979), there is no normative relationship between non-seriousness and laughter (Holt, 2013). That said, the ability to gloss one’s own turn as non-serious with smiley voice or laughter or treat another’s turn as non-serious through the same vocal productions was significant for the business of these exchanges. In extract 6.11 the CNS was able to ultimately soften a potentially problematic implication of their upshot by continued affective productions that indicated non-seriousness. Similarly, patients were able to perform this softening function through these same indications of non-seriousness in extracts 6.8 and 6.13. As with standalone laughter and sequential progress, however, indications of non-seriousness were not always sufficient as seen in extract 6.15 and its deviant case. Altogether, however, laughter proved to be relevant to and functional for patients' preferences and decision-making in a subtle but useful way of keeping the appointment progressing and helping avoid delicate or problematic moments. The findings of this chapter will be discussed further alongside the previous empirical chapters in the next and final chapter.

Chapter 7: Discussion and conclusion

Chapter overview

Over the six preceding chapters I have attempted to first make the case for a fine-grained discursive psychological analysis of patients' preferences in situ and second provide the first example of this research. Chapters 1 and 2 established the background for the research by demonstrating the importance of patients' preferences to SDM and the notable absence of language and social interaction research on the framing and construction of preferences. The methodological and analytic frameworks of discursive psychology and its antecedent conversation analysis and ethnomethodology were detailed and linked to the case for preference research in chapter 3. Finally, I conducted a series of detailed and rigorous analyses across chapters 4-6 with three distinct foci on patients' preferences. First, the identification and characterisation of patients' preferences as constructions; second, the distinct ways that CNSs handled patients' preferences; and third, the function of laughter for patients' preferences and SDM. This final chapter, then, will consider the work collected in the previous chapters of the thesis with the aims of this thesis, the analysis, and findings being summarised. Implications for research and practice will be discussed alongside suggestions for applications in each domain. Findings will be evaluated by comparison with the extant literature, appraisal of perceived limitations of the research, and possibilities beyond the scope of this thesis.

7.1 Summary of the thesis

7.1.1 Summary of rationale

At the beginning of this thesis, I introduced a host of models and definitions of SDM. These models and definitions overlapped with each other and shared a unified philosophy of collaboratively agreeing a preference-shaped decision. Indeed, patients' preferences was the essential element most observed across models of SDM (Makoul and Clayman, 2006). Furthermore, moving from an initial preference to an informed one, through a step of preference talk, was deemed a key goal of SDM (Elwyn et al., 2017). As such, patients' preferences were clearly significant for SDM, and SDM had become an ethical imperative (Coulter et al., 2017). All this said, patients' preferences were inconsistently defined (Street et al., 2012), treated as stable and transitive beliefs or opinions rather than unique constructions (Elwyn and Miron-Shatz, 2010), and not consistently brought to bear on patients' treatment decisions (Sommers et al., 2008; Couët et al., 2015; Scherr et al., 2017). Therefore, while it was clear that patients' preferences were crucial to SDM, it was unclear what exactly authors meant by preferences, what preferences looked like, and if preferences could indeed be consequential for SDM.

Further to the lack of clarity on what patients' preferences look like there was also a scarcity of empirical research into what preferences look like in the wild. Extant research had not focused on providing examples or characterisations of patients' preferences in situ. Such an absence is significant because if we accept that patients' preferences are constructions (Elwyn & Miron-Shatz, 2010), then it is not sufficient to treat preferences as non-specific endorsements for treatment. Moreover, not understanding preferences as in situ constructions limits both our understanding of the forms that preferences take, plus the work that entails, and the scope for working practically with preferences in appointments. One study by Landmark and colleagues (2016) did investigate the ways that practitioners attempted to elicit patients' preferences through hypothetical formulations of patients' treatment stances. This study was instructive and insightful for bringing the empirical observational approach of conversation analysis to patients' preferences, but its focus was on practitioner-side elicitation.

The specific value of using conversation analysis was that the actions accomplished in situ would otherwise be reported in a way that obscured the actual form that the conduct took. That is, a non-language and social interaction and less granular approach might have unproblematically reported that clinicians attempted to elicit patients' preferences. It was by using conversation analysis that the finding of the disparity between the ostensible SDM compliant action and the interactive work of seeking institutionally aligned preferences (Landmark et al., 2017) was revealed. Despite this significant revelation, there remains no conversation analysis or discursive psychology research, to my knowledge, focused on the interactive work of patients constructing a preference (Elwyn & Miron-Shatz, 2010), and the production and management of discursive devices and acts that construction can entail in treatment appointments in situ. Of course, this scarcity is itself notable but is increasingly noteworthy when we consider the disappointing results of SDM implementation research.

Indeed, we might suggest that the absence of any substantive work into what patients' preferences look like informs the poor implementation attempts. To provide one example, a study measured the concepts of anxiety about cancer, initial preferred treatment, and interest in sexual activity in a conventional manner; but the researchers were unsuccessful when they tried to use them to predict the outcome of the interactions (Scherr et al., 2017). Another potential piece of support for the significance of the absence of empirical observational research on preferences in situ comes from broad discrepancies between practitioner perceptions and behavioural reports. For example, practitioners have reported a belief that they were effectively already engaged in SDM (Joseph-Williams et al., 2017), despite research showing poor attempts at engaging patients about their preferences (Coüet et al., 2015) and involving preferences in treatment (Sommers et al., 2008). In these cases, it is entirely possible that practitioners were proceeding on the assumption that the elicitation of a preferred treatment prior to ratifying a decision accurately suffices as SDM. In turn, the absence of empirical observational research that provides clear examples of patients' preferences as something they construct, and examples of the constructive process, was a clear gap awaiting an insightful contribution.

7.1.2 Summary of aims

The primary aim of my research was to investigate the presence and role of patients' preferences in post-diagnostic prostate cancer treatment appointments and explore the implications for SDM. As such, my research question was: How do patients' preferences shape treatment discussions in decision-making appointments? I aimed to explore how, if at all, the ways that patients and clinicians talked about patients' preferences might be consequential for treatment decision-making conversations. To achieve this aim, I broke down the research into smaller aims. As such, my specific aims were as follows:

1) To identify where, and how, talk about patients' preferences occurred in the appointments

2) To investigate how patients interactively constructed their preferences

3) How talk about preferences got organized as part of the appointments

4) How preferences were consequential for the decision-making business of the appointments

These aims might sound generic enough to generalise across interactions, so it is necessary to contextualise and highlight the specificity of my research. I note also that these aims make no mention of laughter, as while this became a research question it was one that developed within the existing framework of aims. I was interested in where, and how, talk about patients' preferences occurred in prostate cancer treatment appointments. As such, the medical context was of an illness with equivocal treatment efficacy and no gold standard treatment (Zeliadt, 2006; Xiong et al., 2014) and the institutional context was one of making a highly preference-sensitive decision (Shirk et al., 2017). The research was designed to collect audio recordings of prostate cancer treatment appointments and subsequently analyse these recordings with discursive psychology, which has not, to my knowledge, previously appeared in the published literature. As such, I aimed to make contributions to the healthcare interaction and SDM literature by revealing the interactive work and discursive devices and actions that constituted and were entailed by discussing and the construction and handling of patients' preferences. An additional consideration is that the clinicians in these appointments were CNSs, who are an understudied population in decision-making and language and social interaction research.

Identifying where talk about patients' preferences occurred was a consistent aim throughout the chapters but was explored most clearly in chapter 4, which concerned the act of constructing patients' preferences. There was also a concurrent focus on the investigation of how patients interactively construct recognisable preferences in chapter 4. In chapter 5 the focus fell more squarely on how talk about preferences got organized as part of the appointments by considering the way that CNSs received patients' preferences. The consequences of patients' preferences were also at the forefront of chapter 5 since it focused also on the way that patients' preferences were handled after receipt. Chapter 6 focused less obviously on patients' preferences because the analysis concerned the production and function of laughter in these treatment appointments. Laughter was not a topic I had previously identified for a research question, and as such emerged from a process of responding to recurring phenomena in the data called unmotivated looking (Psathas, 1995, p. 45). Patients' preferences were key to chapter 6 however, as analysis explored the possibility of laughter performing a tacit kind of preference construction work in addition to a resource for sanctioning sequential progress.

Unmotivated looking (Psathas, 1995, p. 45) is the practice of approaching data without prespecified aims and noticing the phenomena that recurs. For instance, while I investigated a series of post-diagnostic prostate cancer appointments, I identified a surprising quantity of laughter across the dataset. Laughter was an unexpected topic that I came to without a prior interest or objective. Recurrent phenomena subsequently lead researchers to a collection of instances, which give direction to the development of the research question. As I cannot claim to have approached the data with no hint of an existing interest in patients' preferences, it is worth contending that true unmotivated looking is not typically attainable in research on a specific institutional context such as healthcare interactions. Instead, I would assert that while my broader interest in this data preceded its collection, the specific research questions truly developed and were shaped by the data. Chapter 6 and the investigation of the production and function of laughter in appointments was a topic entirely responsive to recurrent instances in the dataset. Once an uncommon pattern of laughter distribution was observed, and a collection of interesting recurrent cases were gathered, the chapter became an investigation of how laughter was relevant for patients' preferences and SDM.

To achieve these aims I adopted the "package of topic, method, and theory" (Edwards, 2012, p. 427) of discursive psychology (Edwards & Potter, 1992). A discursive psychological approach was chosen for two reasons. For one, conversation analytic research had begun to show that ostensible SDM and preference behaviours could look different in practice. Namely, that eliciting or checking a patients' preference could involve undermining or arguing against the patient via rhetorical moves (Landmark et al., 2016, 2017), and non-language and social interaction approaches had missed this revelation. While the conversation analytic work was instructive, it did leave a clear space for a discursive psychological contribution to explore preferences as a psychological constructed phenomenon. The second reason was that the focus on both the constructive power and action-orientation of talk-in-interaction in discursive psychology (Wiggins, 2016, p. 9) made it a clear choice for the psychological phenomenon of patients' preferences. There is a track record of discursive psychology having been used to good effect on similar topics such as attitudes and opinions (Puchta & Potter, 2002). Constructs such as these have been shown as interactively produced and subject to local conversational organization rather than straightforwardly existing out there as standardised absolutes.

7.1.3 Summary of analytic findings by chapter

I argue that among the observations made about the data and appointments there are three particularly worthy of emphasis. The first key takeaway is that patients' preferences were indeed often constructed, whether these were extended projects or short cases of accounting for a simple preference. Second among takeaways was that patients' preferences were received and handled in two distinct ways by CNSs seemingly responsive to the complexity of the implications of the preference. Third was that decisions and decision-making were oriented to variously depending on the placement in the interaction and encounter. As such, I could observe a temporal story whereby preference construction would occur within and across a sequence of appointments and parties' orientations to decision-making took distinct forms. One form was acknowledging a decision needed to be made or orienting to a decision previously made in principle. The other orientation was to turn-by-turn articulating a preference and negotiating an outcome.

Considering a central driver of my rationale was disparities between conceptual notions and actual observable preferences, the first analytical chapter investigated the construction of preferences. This chapter explored the ways that patients were observably constructing preferences and the organization of and forms that patients' construction projects took. It became clear, then, that patients' preferences could not be reduced to simple notions like stable opinions or positive evaluations of one treatment option over others. This analysis found three distinct patterns of preference construction. The first was closest to that anticipated by SDM models. Patients expressed a firm preference such as "`you want it gone [as simple as th]at`" (extract 4.4, line 11), about surgery as the preferred treatment, and the interactive work of construction primarily revolved around accounting for and legitimising the preference. For example, a patient would provide an upshot (Heritage & Watson, 1979) of a previous appointment that characterised it as having appropriately informed them to the extent that they were presenting an informed preference (Elwyn et al., 2017). The second pattern of preference construction saw patients engaged in complex interactive work involving distinct discursive devices and conversational acts. Emotion categories and emotional states (Edwards, 1997) or mental states and cognitive processes in particular were key to these preferences.

As such, patients might hint at a preferred option by, for instance, suggesting that they were thinking of a treatment option without naming it (extract 4.5) or prefer to avoid a treatment due to fearing a core aspect of a treatment procedure (extract 4.6). The third distinct pattern was when patients would appeal to prior medical experiences as a means of working up epistemic entitlement to a preference as part of its construction. In this pattern, one patient referred to a surgical complication that they reportedly could never forget as a key driver in their preference for radiotherapy rather than surgery (extract 4.7). Another patient wove together a memory of their previous experiences with catheters and their father's comparable experiences to firmly indicate that catheters would be dispreferred (extract 4.8). As such, there was clear variability in the ways that patients constructed preferences, and in the discursive devices and acts used, but these preferences were ultimately unified by the observation that they were indeed all interactively constructed.

Although there was not an abundance of cases, and I am therefore mindful not to overclaim, I do wish to spotlight some of the discursive stake and accountability work observed in patients' constructions. Patients were seen to engage in inoculation projects that either mitigated the possible claim of being invested in refusing a particular treatment option (extract 4.7 and surgery) or in accounting for a firm bur clear preference as something that merely brings relief (extract 4.2). In fact, the stake work largely appeared relevant to pre-emptively avoiding a possibility that patients might be resisting a given treatment or in some way treatment-relevant information. There were also examples of accountability as something interactively ascribed (Potter, 2000, 2005), as the CNS claimed not to be particularly familiar with bleeding as a side effect in extract 4.9 and sought to minimise prospective possible accountability. We might consider, perhaps speculatively, that the stake and accountability work suggest various orientations in situ. One orientation to the responsibility for decision-making and another to CNSs as institutionally obliged to inform patients sufficiently. Furthermore, an orientation to an expectation that patients are to collaborate with clinicians to make a decision both parties can endorse and is ideally shaped by an informed preference (Charles et al., 1999; Elwyn et al., 2017). Both parties, then, might occasionally display sensitivity to the possibilities of accountability and responsibility but this is speculative and would require more cases and further empirical investigation to corroborate.

I observed in my second analytic chapter that patients' preferences were broadly received by CNSs in two distinct ways. For one, preferences were received as unproblematic and treated as straightforwardly amenable to decision-making business and sequential progress. There was one arguably deviant case, as a misunderstanding was resolved by successful patient-side self-repair (extract 5.4; Schegloff et al., 1977), but otherwise patients' preferences were received as straightforward or unproblematic. Being received as straightforward meant preferences were integrated into the appointments without issue or were put on the record unproblematically. The suggestion made for the receipt of preferences as straightforward was that these preferences had clear and stepwise sequential and practical implications, which might align with the institutional ordering of the interactions towards assent and ultimately a decision. It is crucial to clarify, however, that sophisticated interactive work went into the receipt and handling of even the most ostensibly straightforward or unproblematic preferences. Rendering a patient's preference as on the record, in extract 5.3 for example, included ascertaining whether it was initial or informed, orienting to the relative firmness of the preference, and performing subsequent business that reflected an orientation to decision-making as an act for later. As with the construction of a clear but seemingly straightforward preference in chapter 4, receiving and handling a preference unproblematically entailed substantial interactive work.

One thing to note is that preferences were received as challenging more often than they were treated as straightforward. Although it is hard to point to something specific in the data as explanatory, it may be interesting to consider whether the stage of decision-making trajectory was significant. That is, as decision-making is understood within NHS England as a distributed process, the sequential and medical contexts may not have been appropriate for ratifying a decision or preference; something typically done fairly immediately prior to treatment. One notable piece of language and social interaction research into decision-making work is worth remarking upon here, as it concerns this understanding of distributed decision-making. Rapley (2008) argues that the decision-making process is one that shifts and develops across a series of appointments and encounters and is therefore distributed. Moreover, the decision is also distributed over the people involved in the decision-making process, it is not a singular, cognitive decision in the mind of the patient. Rapley's (2008) argument draws on a series of research he has been involved in and makes a convincing case, albeit perhaps limited in scope. As such, my finding that decision-making might be oriented to differently per the position in the patient's diagnostic journey supports this argument.

The second pattern observed was receiving and handling patients' preferences as challenging and therefore not easy, or even possible, to integrate with the decision-making business of the appointment. Patients' preferences were received as challenging when, for instance, they indicated a treatment option that was only a possibility rather than confirmed as available (extract 5.5). In this case of a preference for a conditional treatment option, the CNS invoked the institutional decision-making machinery of the multidisciplinary team to account for the possibility that the preferred treatment option might ultimately not be feasible. As such, the CNS had to work not to be heard to undermine or contest the patient's preference while also making clear that this preference cannot be guaranteed to influence the overall treatment. One particularly interesting discursive act was something I referred to as doing impartiality after Sacks' notion of "Doing "being ordinary"" (Sacks, 1984, p. 414).

In cases where I considered CNSs to be doing impartiality, they engaged in glossing specific side effects as one among various possibilities (extract 5.7) or idiomatic responses such as a non-specific appeal that "`each person is an individual`" (extract 5.6, line 17). In turn, receiving and handling patients' preferences as challenging might be understood as a potentially delicate act, and as such it is notable that CNSs both worked to avoid implications of undermining preferences and merely providing all the information. The findings from this chapter also hinted at the possibility that the notion of preference-shaped decisions might be an oversimplification. That is, in addition to institutional constraints that cast preferences as impossible, CNSs engaged in discursive work around doing impartiality that restricted engagement with challenging preferences beyond their status as challenging. A point worth noting here is that historically a decision was considered shared irrespective of whether a treatment option was mutually preferred (Charles et al., 1997). As such, patients' preferences have the interesting position of potentially being the single influential preference in a treatment decision or having no formal influence depending on which option is ultimately endorsed. A shared decision or decision-making sequence could involve a project that appears to push back against a patient's preference or even rules it to be unfeasible despite the outward appearance of what might be considered paternalistic or exclusionary behaviour.

Having investigated the construction of preferences and begun to reveal some of the ways that preferences were handled, my final analytic chapter explored the role of laughter in SDM. It is important to restate that I was not simply taking my existing research questions into the data, and I came to the topic of laughter due to its surprising prevalence, especially on the side of the CNSs. Indeed, not only did I observe that both parties shared in reciprocal laughter, but that CNSs both took up invitations to laugh and invited patients to laugh. Essentially, the laughter produced in those cases approximated a positive preference by demonstrating the absence of issues and moving the interaction forward with an affective marker. The function of laughter was seen to be sanctioning progressivity either straightforwardly or through softening a potentially delicate moment over several turns.

In straightforward cases, laughter functioned similarly to a receipt token by indicating that the business at hand was both understood and posed no threat to what the patient wants. With more complicated cases, the production of laughter was consistent with previous conversation analytic research into healthcare communication. That is, laughter was often produced to manage potentially delicate or poignant moments (Beach & Pricket, 2017). Often this production would include a buffer topic that would allow the sequential transformation from potentially delicate or sensitive to a “time out for pleasantries” (Jefferson, 1984, p. 351). Therefore, laughter could either sanction sequential progress when there were no threats to what the patient wanted, or it could allow interlocutors to take developing talk into a different interactional space. Once in this space, interlocutors could work through potential trouble and manage or avoid possible threats to decision-making business or patients’ preferences.

7.2 Limitations of the research

Before proceeding to the contributions that my findings make to research and practice, it is important to address possible limitations of my research. When applying for ethical approval, I stipulated an upper limit of 35 audio recordings for the research dataset. A total of 22 recordings were made of 22 individual post-diagnostic prostate cancer treatment appointments in the same ambulatory outpatient setting. The dataset, then, was less than originally aimed for in terms of number of recordings and these recordings varied significantly in terms of length with a range of 10 to 90 minutes. Data collection proved difficult to achieve in a busy clinic, especially considering the professional responsibilities of participating CNSs that take priority over their voluntary data collection role. Indeed, although ethical approval was in place and a digital recorder provided by early October 2018 the first recording was not taken until January 2019. Furthermore, data collection was unable to continue beyond March 2020 due to the Covid-19 pandemic and there was therefore not scope to add to the dataset. That said, the data I did collect was a type that is extremely difficult to get and rarely collected, so each recording has novelty and value in this regard. Beyond novelty and difficulty, there was enough data to substantiate some of my analytic claims but not all of them.

It is unclear, however, whether my initial upper limit would have been sufficient to substantiate all my analytic claims for the following three reasons. The first is that while these recordings were of post-diagnostic treatment appointments there was no guarantee that the conversation would feature preference talk. Appointments varied in tone and content from long sequences of information exchange to brief discussions about managing cancer or reiterating a decision awaiting ratification. Indeed, as mentioned throughout the thesis, decision-making in NHS England is understood as being distributed across both time and appointments. Therefore, it is extremely difficult to anticipate whether an appointment would contain any substantial preference or even treatment decision talk. Second, and related, was the variability in recording and appointment length with some recordings lasting between 10-20 minutes and others between 60-90 minutes. Recording more appointments, then, could have produced a batch of recordings comprised of brief restatements of decisions-in-principal or extensive sequences of information exchange. As previously mentioned, neither of these scenarios guarantee preference talk. Being a distinct approach to the study of the social world, discursive psychology does not have fixed numerical criteria for dataset sufficiency. Rather, the process of attaining sufficiency might be considered more fluid and involve pragmatic sufficiency for substantiating analytic claims.

While novelty and difficulty are relevant criteria for assessing a dataset, the fact remains that sufficiency for substantiating analytic claims remains the most important metric for judging the relative success of data collection. There are two considerations worth entertaining when we examine the dataset I collected. The first is that my chapter on laughter can be seen as having performed best on the metric of numerical sufficiency, as laughter was the most prevalent analytic foci throughout the data set. By contrast, preference construction and the handling of patients' preferences were less frequent, but these phenomena are less commonplace in the vernacular than laughter and this raises a crucial point. The observation that patients' preferences were indeed constructed was significant because it is something argued to occur in healthcare encounters (Elwyn & Miron-Shatz, 2010) that we have very little, if any, fine-grained observational evidence for. By contrast, the prominence of laughter is significant because it runs counter to the research on laughter in healthcare encounters (West, 1984; Haakana, 2002; Beach & Prickett, 2017). The second is that other language and social interaction theses have reported datasets between 5.5 (Shaw, 2012; Flinkfeldt, 2016) to 12.5 hours (Hofstetter, 2016). As such, my dataset of 9.65 hours falls within a historically acceptable range of dataset size for thesis submission.

For preference construction, then, our first metric for significance and sufficiency is arguably weighted less towards numerical sufficiency because there are a finite number of opportunities to construct a preference. Moreover, the question of patients' preferences as constructions concerns what these constructed preferences look like and how they come to be constructed. Laughter, however, is interesting in the first instance because research tells us we should not expect to find such prominence of laughter especially from CNSs. The preference construction analysis, then, needs to establish instances and a characterisation of a constructed preference or the construction process before I can entertain concerns about numerical sufficiency. With laughter, however, there needs to be sufficient numerical cases to be noticeable and then interesting relative to the historical patterns of prominence and distribution. Once this interest has been established, and the material is a candidate for further analytic interest, it can then be investigated in a similar way to the preference construction data. Indeed, the way that I became interested in laughter as part of this research was through its surprising prominence in the dataset; and only subsequently did I uncover its functionality for preference work.

I will not pretend that numerical sufficiency is unimportant, but I would contend that my dataset was sufficient to substantiate some if not all my analytic claims. Indeed, the consideration most worth discussing is the strength of the dataset in answering the research questions and addressing the aims of the research. My position is that this dataset was sufficient to settle some key questions but not others and that such a position does not undermine the analytic work or claims made. For instance, this dataset shows that preferences are indeed something that patients interactively construct in situ (Elwyn & Miron-Shatz, 2010). Furthermore, my analysis demonstrated that discursive psychological processes such as stake inoculation (Potter, 1996) and category entitlement (Edwards and Potter, 1992) affect the construction of patients' preferences. The sequences wherein patients worked to construct their preferences were heterogeneous however, and I was unable to establish a taxonomy of preference construction. A larger data set may be required to establish a taxonomy of preference construction, such as Schegloff's (1996) suggestion of 50 or more cases for establishing an action as generic and reproducible. Similarly, while I was able to establish that the way clinicians receive and subsequently handle patients' preferences was consequential for decision-making business, there may well be more to say with a larger collection. Again, it is necessary to restate that these numerical limitations in no way invalidate the analytic work or claims made, but rather emphasise that caution is taken when advancing these claims.

Perhaps more relevant to discursive psychologists and conversation analysts is the decision to make audio recordings rather than video. There are scholars who might strongly favour the provision of video data, especially conversation analysts, to analyse the embodied behaviour of interlocutors. Now, this is of course a valid point and especially in contexts where one might presume to find substantial embodied behaviour or be particularly interested in multimodal analysis. For my research, however, there were factors that mitigated any desire to provide video recordings. For one, a sensitivity to the patients who were volunteering their participation in the research. Cancer treatment discussions are sensitive moments, which patients often share with companions such as spouses or relatives and can prove to be emotional encounters. Moreover, since research with the NHS is required to demonstrate public patient involvement, I was keen that this involvement shape and influence the research where possible. Making this influence possible entailed attempts to put patients' concerns, suggestions, and privacy first which involved minimising the extent that patients were exposed or put out there.

An additional practical consideration was the difficulty of relying on healthcare staff to set up recording equipment in a busy outpatient clinic setting. Audio recordings were easier to implement into the appointments and less disruptive since they simply required placing a digital recorder on the desk and pressing record. As such, it was decided that video recordings carried the risks of being unnecessarily invasive and requiring more extensive set up preparations. Indeed, while there might have been interesting considerations of embodied behaviour this was not judged to provide sufficient grounds to relax the delicate handling of sensitive moments. Again, the impact of the limitation here is primarily related to the broader implications of my findings. Although I have a suspicion that patients' preferences both look like and are handled like they are in my analysis, this account cannot consider in detail any potential role or function of embodied behaviour.

The following is not strictly a limitation, and indeed follows from the conversation analytic tradition of unmotivated looking (Psathas, 1995, p. 45), but must be made restated before discussing the results further. That is, the recordings did not always yield talk about patients' preferences. One possible reason for this was that the study recorded post-diagnostic prostate cancer treatment appointments. The issue here is that there can be considerable variability between appointments depending on their position in the decision-making trajectory. Patients do not have the same diagnostic journey nor the same readiness to discuss decisions at that appointment. It is likely that all appointments took place in the same diagnostic clinic, however. Even though the quantity of preference talk was variable, the research makes a strong novel contribution to the SDM and patients' preferences literature. The analysis shows how complicated and messy decision-making is in situ; how preferences can take various forms distinct from the idea of eliciting preferred treatment. Indeed, even where the psychometric approach of survey batteries has been employed it has not been able to tame the messiness and complexity of SDM.

An institutionalised care pathway, such as moving through appointments and clinician-led information exchange, does not change the fact that decision-making is messy and complicated. As such, there was no guarantee that appointments would contain substantial preference talk. I could have, for instance, written an interview schedule and asked former and current prostate cancer patients about their decision-making experiences and preferences. This approach would increase the likelihood that my data contained sustained talk about patients' preferences, but it would not help answer questions about the interactive construction of patients' preferences in situ. The dataset consists of conversations with one group of CNSs in one hospital in the UK. Moreover, these conversations are all with men, and we know from discursive psychology research that healthcare conversations are gendered (Seymour-Smith et al., 2002; Jeffries & Grogan, 2012). In the future it might be instructive to see how these conversations proceed with different clinicians, different stages of cancer, and in different places. For instance, prostate cancer, is not always appropriate for curative treatment, as when the cancer metastasises and spreads then the discussion of options becomes one about managing and living with cancer. Both treatment discussions and talk about preferences have scope to vary substantially even within the broader context of cancer care, then, which is to say nothing of the distinction between inpatient, outpatient, and palliative care interactions.

Finally, there are of course limitations to discursive psychology, as with all approaches to social sciences research. One of the main limitations is the way that discursive psychology approaches research questions that are more typical of mainstream psychology. That is, I would not expect to effectively answer questions about any predictive relationships between the type of interactive conduct captured in my analysis and the quality of SDM thereafter (Wiggins, 2016). As such, if I wished to investigate the effect of a training intervention centred around affective displays of laughter in decision-making appointments, I would not attempt to do so with discursive psychology. Instead, I would require an interaction systems approach, ideally the Roter interaction analysis system (Roter & Larson, 2002) to coherently address this question. Indeed, there is space for an interested researcher to conduct this exact research if they wished to pursue the findings from my third analytic chapter. Furthermore, my focus on the action-orientation of talk ahead of its propositional content also means that my findings are highly specific. As such, while I could broadly discuss the propositional content among my analyses, I could not answer questions about, for instance, the type of preference talk that took place. I would therefore look for researchers in broader qualitative traditions so that we might supplement each other's work in furnishing a full and detailed picture of patients' preferences in situ.

Being an approach to the study of language and social interaction that largely avoids questions of theory and ideology means that the focus of discursive psychology falls squarely on the empirical observation of interactive and discursive practices and acts. Now, this is a particular strength for my specific research, but is restrictive in a broader sense. Even researchers within language and social interaction traditions take broader positions and wish to address "issues of ideology and power in psychology" (Parker, 2002, p. 1). I also remarked earlier that discursive psychology typically avoids research interviews, so if researchers were interested in the propositional content of interviews or focus groups with patients about their experience of treatment decision-making appointments, they would be better suited to an alternative approach such as thematic analysis (Braun & Clarke, 2006).

7.3 Contributions to research and practice

7.3.1 Contributions to SDM research and a focus on patients' preferences

My analysis revealed empirical examples of the disparity between the theorised notions and practical realities of patients' preferences and SDM that the extant literature suggests. For one, patients' preferences were indeed often interactively constructed in situ (Elwyn and Miron-Shatz, 2010) and patients did mobilise distinct discursive devices for construction projects (Wiggins, 2016, p. 146). These observations, then, deviate from the simplistic notion of preference elicitation in SDM models, which is a disparity that Landmark et al. (2016) had already revealed could involve unfavourable paraphrases of patients' stances to occasion on-the-record preferences. Patients' preferences were seen to be responsive to past medical experiences, new information in situ, and claims of entitlement to knowledge (Potter, 1996; Heritage, 2012a, 2012b). As such, preferences were heterogeneous and did not present as a stable phenomenon that could be easily substituted for opinions or attitudes (Elwyn and Miron-Shatz, 2010) or mapped onto a decision-aid (Joseph-Williams et al., 2017).

Together, this analysis contributes both to the SDM and patients' preferences literature and the language and social interaction literature. To the latter it contributes the first discursive psychological study of patients' preferences in situ, bringing a psychological focus to a topic with sustained conversation analytic interest (Land et al., 2017). For the former, the contribution is the first examples of what a constructed preference can look like in practice, and characterisation of some of the ways that preference construction can occur. In so doing, the research extends the work on preferences as constructions by showing how construction gets done publicly, moment-by-moment, through talk-in-interaction. Furthermore, how preferences can look messy or hinted at, especially when construction is an extended or halting process. The unexpected focus on laughter in chapter 6 provided a particularly insightful contribution. For one, the laughter analysis contributed to research into SDM and patients' preferences with the findings about positive preferences and sanctioning progress. Beyond this contribution, the findings are also insightful for both institutional conversation analytic research and research on laughter as a social action.

While SDM literature often treated patients' preferences as stable phenomena rather than constructions (Elwyn & Miron-Shatz, 2010), it did also suggest that preference shaped shared decisions should be made where possible (Elwyn et al., 2012, 2017). Findings from chapter 5, however, revealed that even preference sensitive choices such as prostate cancer treatment decisions (Shirk et al., 2017) did not presuppose simple preference involvement. Rather, patients' preferences were subject to distinct forms of receipt and handling depending on the commitments they entailed. For instance, preferences that suggested a decision-in-principle or were consistent with the clinical recommendation for surgery were often handled as straightforwardly amenable to decision-making business. By contrast, preferences that implied a commitment to avoiding specific side effects or invasive treatment procedures were handled as a challenge or barrier to the decision-making business. Therefore, whether in-between the stages of initial and informed preferences (Elwyn et al., 2017) or in the pursuit of a preference shaped shared decision there might be an underreported negotiation of patients' preferences.

This finding again adds to the work of Landmark and colleagues (2017) by demonstrating that patients' preferences were not simply received into the decision-making process but could be contested if inconsistent with clinical recommendations. While Landmark and colleagues' (2017) findings suggested that terms such as eliciting and checking were insufficient, my results suggest that the notion of preference-shaped may be an oversimplification. A preference being constructed was not straightforwardly treated as sufficient to influence decision-making. Rather, preferences came up against institutional constraints, and when understood as challenging, preferences were precluded from shaping the decision towards "what patients want from their healthcare" (Street et al., 2012, p. 168). Clinical nurse specialists would inoculate themselves, and perhaps move to resist or preclude claims of responsibility for constraints or impediments to preferences, by claiming an inability to guarantee a preference or that individual variability was too high or rule out preferences via medical knowledge when unfeasible.

With the findings from chapter five, there is another possible contribution worth considering, which is that SDM did not consistently follow the path one might expect. In particular, the observation of handling sequences for patients' preferences defied expectations for SDM. These handling sequences often put patients in the position of either choosing between dispreferred options or between available curative treatments and monitoring the cancer. Now, these decisions could technically be considered preference shaped, as patients might prefer curative treatment to monitoring or managing their cancer. However, the position of the patient is functionally one of assenting to the least disprefered treatment option, foregoing curative treatment, or relinquishing deontic authority entirely. The extent of any work concerning preference construction or engagement with a constructed preference was typically a discussion about why it is unlikely, unfeasible, or uncertain. In turn, the notion of a truly preference shaped shared decision comes under question or could at least be considered worthy of further scrutiny. The caveat, of course, is that a decision is considered shared if each party agrees to the course of action, irrespective of whether it is mutually preferred (Charles et al., 1997).

The constraints on the patient were not the only noteworthy disparity between expectation and observation, however, as CNSs were also constrained in the receipt and handling of patients' preferences. When patients expressed a preference to avoid urinary incontinence, or avoid injections in hormone therapy, there was little to nothing that CNSs could do with that preference. On a sequential level, there is an obligation to provide an appropriate response, such as a second-pair part (Schegloff & Sacks, 1973) irrespective of the feasibility of the preference. While on institutional grounds there is an imperative to prevent or minimise risk and ensure that patients make informed decisions. In turn, ruling out unfeasible preferences or making patients aware that they may need to prepare for a different treatment is good institutional practice. Fundamentally, CNSs were unable to bring these preferences to bear on treatment decisions because they were not actionable possibilities. These CNSs, then, were caught between SDM in name and SDM in practice, which came into tension with each other. This tension is likely uncomfortable because it often entailed dispreffered sequential responses pertaining to patients' requests in the form of preference statements.

In terms of the hallmarks of SDM, then, both patients and CNSs were constrained in the aspects that they could perform. The actual work and interactions that occurred were limited and the roles and contributions each party could make was functionally restricted. Obviously, an impossible preference presents an opportunity for intersubjective and sequential breakdown, and there is a need for a device or strategy that allows relatively straightforward exit from such a conversational impasse. In my analysis I observed that while not seamless, CNSs typically appealed to a presentation of doing impartiality, that glossed a discussion of an impossible preference as, for instance, "`just talking about options`" (extract 5.8, line 11). Patients typically were not the ones seeking exit from these impasses, which might reflect either the firmness of their preference or an orientation to the institutional expectation that CNSs lead the interaction. When combined with the tension between sequential and institutional obligations, the CNSs are recurrently put into uncomfortable positions at the intersection of various tensions.

It is worth discussing the phenomenon of patients' impossible preferences and the related act of doing impartiality further. The reason for further discussion is that I wish to suggest patients' impossible preferences posed the issue for decision-making that I expected clinical equipoise to pose. Clinical equipoise is often invoked to mark prostate cancer treatment decisions as being particularly preference sensitive (Shirk et al., 2017). This equipoise exists because there is equivalent effectiveness across curative prostate cancer treatments (Zeliadt et al., 2006; Xiong et al., 2014). An expectation for prostate cancer treatment decisions, then, is that equipoise will present a problem for patients who wish to receive the best treatment. The finding that there were few orientations to clinical equipoise across the decision-making conversations that I analysed was therefore striking. Where equipoise might have presented a problem for CNSs, such as having to explain the absence of a gold standard treatment, the problem was instead often patients' impossible preferences. Indeed, there was evidence of a clinical recommendation for surgery, which was both oriented to and communicated informally by the CNSs. This clinical recommendation therefore helped avoid the potential problem of equipoise by way of providing a point to which both parties could orient and make sense of the suggestion. I must note, however, that CNSs did have to resist giving decision-implicative advice when patients asked which treatment they should get, although this only happened in one recording.

What I instead observed was patients producing impossible preferences that CNSs could neither guarantee the influence of nor sanction for decision-making. In turn, CNSs went on to do impartiality to manage the difficulty of being caught between the sequential obligation to produce a second-pair part response and the institutional obligation to rule out unfeasible options. As mentioned in the previous paragraph, I wish to suggest both that patients' impossible preferences might be a, if not the, primary problem of prostate cancer treatment decision-making and that this is a novel contribution to research. Such a claim is predicated on the belief that, to my knowledge, the issue of impossible preferences is neither prominent in models of SDM nor the SDM literature. While there might be an implicit understanding of impossible preferences, this is something that ought to be clear and central in any SDM discussion. Furthermore, I would also suggest that there is no reason in principle to suppose that impossible preferences and doing impartiality might not transfer to other tumour sites.

For one, the reduced prominence of clinical equipoise, and evidence for a clinical recommendation brings my findings closer to other cancers that are marked less by preference sensitivity. Second, it is reasonable to suggest that clinicians both wish, and attempt, to make the best decisions for patients. Decisions that reflect and are shaped by what patients want. However, when patients voice an impossible preference, this presents a real problem for clinicians who can do little to nothing with the preference and are constrained in how to respond. Not only is it difficult to make the decision in concert with the patient's preference, but it is also difficult to respond in a way that satisfies the sequential and institutional obligations that are in tension with each other. It is not, then, a leap to imagine that other cancers might present similar scenarios when clinicians attempt to face down impossible preferences while facilitating preference shaped shared decisions.

A striking and very interesting point here is that treatment decision-making, in many instances, includes the weighing of uncertainty. I previously referred to this uncertainty as raw uncertainty, which differs from the imaginary notion of precise risk that clinicians might wish that they could give to patients. For instance, a 50% risk of incontinence but a 90% chance of cure. Indeed, to remain with the example of incontinence in extract 5.7 the patient was simply told that there is a risk of incontinence and that the CNS could not be more specific. As with impossible preferences, uncertainty was met with doing impartiality since CNSs were constrained in their possible responses to patients' requests. As such, the degree of risk was not a frequent topic in the decision-making conversations that I analysed. This absence is notable because it is a factor that might influence the construction and subsequent role of patients' preferences in the treatment appointments. In models of SDM risk is typically associated with options and subsequently information about risk tends to get communicated at those points of the appointment. The three talk model, for instance, located risk communication in the section of option talk dedicated to describing patients' options (Elwyn et al., 2012, p. 1364). Patients can probably access information on risk outside of appointments, but this does not change the fact that the understanding of risk in the conversations was imprecise.

Crucially, the authors remarked that they "lack a measure to assess proficiency in risk communication" (Elwyn et al., 2012, p. 1366). Risk communication was therefore deemed an area that might improve with more specific and refined instruments. The issue of assessment is one that I am mindful to engage with on its own terms and I will therefore not suggest a particular standardised tool. Rather, while measurement assessments might be practicable tools for clinicians, it is worth recalling that standardised pathways to decision-making have not proved particularly fruitful, especially regarding patients' preferences. Clinicians, then, might simply need to be encouraged to do their best when communicating the risks to patients and attempt to soften this raw uncertainty by discussing the practical reality and consequences further with patients. Indeed, perhaps being especially responsive to the points that patients react or respond to, to tailor the communication to the points that patients make relevant and important. A possibly critical consideration, however, is that clinicians might not wish to be held accountable for negative side effects, especially when they cannot speak with statistical certainty. Shared decision-making, then, might be a means to ensure that the responsibility of the outcome rests with the patient. Indeed, the findings from chapter 5 revealed much in the way of appeals to doing impartiality as a device that CNSs used to present side effects as consequences that they might not be held accountable for.

I have written previously about clinicians possibly engaging more with patients about aspects such as uncertainty and the options here are indeed limited. My earlier suggestion was to attempt further discussions of the hopes, fears, and uncertainties that patients bring to the appointment. In turn, clinicians could go beyond some of the more limited or contingent explanatory talk about, for example, side effect likelihoods and try to get to the heart of what animates a preference towards a treatment or effect. This discussion might look something like extract 4.7 where the patient details their adverse experience with invasive surgery. Although the sequence is not occasioned by talk about risks, the patient uses the interactional space afforded to them to provide rich detail about their preference to avoid surgery and receive radiotherapy. By contrast, the extract 5.7 discussion of incontinence is an example of an opportunity for clinicians to get to the heart of the issue. Indeed, to possibly come upon a point of insight that is particularly instructive, reassuring, or convincing for the patient. While such a discussion would not lead to perfect risk communication nor guarantee a preference-shaped decision, it would increase patient involvement, offer more opportunities to provide tailored risk communication, and foreground the issues important to the patient.

7.3.2 Contributions to the study of laughter in healthcare interaction

Laughter might have been a surprising subject for my final analytic chapter, but the findings contribute to both the conversation analytic and the SDM and patients' preferences literature. First, the distribution pattern of laughter production was distinct from the typical one established in West's influential monograph on healthcare communication *Routine*

Complications (1984). That is, unlike in West's and subsequent authors' work, I observed that CNSs would both actively invite and reciprocate laughter rather than rarely take up invitations. This finding is noteworthy because previous research suggests that healthcare professionals treat invitations to laugh as inappropriate and typically decline them (Haakana, 2001, 2002). One explanation offered for this declination was that the institutional role might be characterised as possessing a professional quality that renders laughter hearable as unprofessional (Haakana, 2002). Indeed, Haakana reported in that same study that practitioners instead produced smiley voice as an emotive alternative. In cancer consultations also practitioners were not routinely seen to treat invitations to laugh as appropriate nor did they typically reciprocate laughter (Beach & Prickett, 2017).

One potential parallel for my findings, however, is a study of gynaecological appointments, where the author observed reciprocal laughter and verbal play between patient and practitioners as resources for the prosocial function of face-saving work and the accomplishment of the appointment goals (Ragan, 1990). There might be a similarity, then, when one considers the intimacy of anatomy involved with prostate cancer and gynaecological appointments. In turn, there might be similar scope for laughter to serve prosocial and face-saving functions in prostate cancer treatment appointments. Perhaps most notable in my findings, however, is simply that CNSs did not typically orient to laughter as inappropriate or unprofessional. Indeed, not only did CNSs initiate and reciprocate laughter, but they engaged in buffer topics (Jefferson, 1984) to soften potential delicate moments thereby using laughter as an interactional resource for decision-making business. Crucially patients did not typically orient to CNSs' laughter as inappropriate or unprofessional either, which suggests that there may be cases or moments where laughter can straightforwardly serve a decision-making purpose.

Another contribution to research on laughter in healthcare interactions that is consequential also for SDM is the possible preference work of laughter. That is, the analysis in chapter 6 suggested that patients' laughter could approximate a positive preference in its function of sanctioning sequential progress. I found that in sequential positions where an acknowledgement token or alternative display of affirmative recipiency was expected, the patient could instead laugh. At these junctures, the functional requirement from a healthcare institution perspective would be a clear affirmation that there is no problem with the business at hand. While a clinician could attempt to prompt this affirmation via a question, this is not necessarily straightforward considering the heterogeneous and ongoing construction of preference. Therefore, the production of laughter could serve as a display that there is no trouble and no threat to "what patients want from their healthcare" (Street et al., 2012, p. 168). In turn, an unobtrusive way of sanctioning progressivity might also be relevant for checking or re-establishing the current state of developing preference work. Furthermore, as the idea of preferences as unfolding constructions might sound challenging, having this approximate positive preference could be a useful guide for clinicians. Although this insight is a snapshot of preference work it does contribute to filling out the idea of preferences as constructed in practice, by working from the ground up and tracking candidate examples.

7.4 Recommendations

Patients drew on various resources to construct their preferences that ranged from prior lifeworld experiences to new information in situ. Further to these resources, patients also used distinct discursive devices such as category entitlements (Edwards & Potter, 1992), reported speech (Holt, 1996), and emotion categories (Edwards, 1997). As such, preferences were heterogeneous and did not take the same shape across patients despite the recognisable similarity of arising in situ from an interactive construction process. Crucial, also, is that I do not have enough cases to confidently assert that there are successful and unsuccessful patterns of preference construction. If replicated, these findings suggest that while patients' preferences can draw on previous experiences, including previous medical experiences, they ultimately become constructed, and recognisable as preferences in situ. In turn, while we might suggest that encouraging patients to formulate their preferences as clearly as possible might be a useful solution, we can neither take this for granted nor presume effectiveness.

For one, patients produced preferences at different points in the appointments, some only being formulated in response to new information. Indeed, the core of the argument that preferences are constructed is that these preferences develop over time and are responsive to new options and information (Elwyn & Miron-Shatz, 2010). Therefore, while it might be instructive if patients were able to provide clear preference formulations, it might not always be advantageous. For one, I demonstrated that patients' preferences received as challenging were often handled in a way that precluded their influence on the treatment decision in chapter five. We would also need, then, what might be referred to as reflexive interviewing on the part of CNSs that allows for both sustained active listening and continued engagement with the opportunities for preference talk and formulations that indicate preference construction. Therefore, the notion of preference elicitation might not be understood as singularly conducive to getting a preference from a patient. Rather, the preference would be attended to over the appointment, and perhaps into other appointments, in its incipiency and various shapes.

Of course, this might not be simple in practice, as asking CNSs to be more reflexive interviewers might sound nebulous. Indeed, it is necessary to clarify that by reflexive interviewing, I mean being attuned to the ongoing interactive work of construction that patients are engaged in throughout the appointment and being responsive in tailoring the information that patients receive in response. Therefore, I would also recommend providing examples of, and a guide to, the ostensibly messy and halting ways that patients construct preferences. Being able to see the pieces of talk-in-interaction, and discursive resources, that comprise the construction of preferences could be crucial for making this claim intelligible and the recommendation actionable. In being a more reflexive interviewer there is also space to draw on the findings of my final analytic chapter. That being, the production of laughter as sanctioning progressivity by approximating positive preference and managing potentially delicate or sensitive moments.

I observed that laughter was not routinely treated as inappropriate by CNSs but rather understood by the parties as useful for the business at hand. Indeed, the finding that CNSs participated in buffer topics and utilised the “time out for pleasantries” (Jefferson, 1984, p. 351) they afford is a positive one. As Ragan (1990) reported in her study of gynaecological appointments the production and reciprocation of laughter can serve prosocial and face-saving functions. When one considers that prominent side effects of prostate cancer include erectile dysfunction and urinary incontinence, there might be recourse to consider laughter as a resource to serve similar functions. The suggestion is not that laughter ought to be used to deflect or be inappropriately produced without relevant sequential or institutional occasioning. Rather, the use of buffer topics (Jefferson, 1984) in the appointments and laughter as a resource for managing potential delicate moments imply that laughter could be functional for decision-making business while remaining sequentially and professionally appropriate.

Within conversation analysis there is a form of training called the Conversation Analytic Roleplaying Method (Stokoe, 2014) that uses real examples of institutional interactions as educational materials. The benefit of that approach is, of course, that it moves away from simulated talk to observations of what observably occurs in these encounters and what they look like in practice. With patients' preferences having little in the way of empirical observation there would be a clear benefit in providing examples of and insights about the construction of preferences and their subsequent shape in situ. This exposure to observations and examples might help establish familiarity with the notion of preferences as constructed and awareness of the forms that construction and preferences can take. Without providing examples the idea of construction may continue to sound vague or difficult to visualise. Similarly, simply showing examples without exposition does little more than suggest proof of concept. It is the combination of examples from practice and an intelligible characterisation of the interactive work and consequences in situ that might prove useful. As with any recommendation rooted in language and social interaction, however, it is worth remembering that there is no conversational magic bullet to fix issues definitively (Pilnick & Dingwall, 2011). Indeed, there would remain much to do if the desire was to improve the quality of patient preference involvement in decision-making and accomplish routine SDM.

I now wish to discuss the appropriateness of the term patients' preferences and the main reason for this is that patients were not always able to have what they wanted. In turn, it was unlikely that they could make a truly preference-shaped shared decision regardless of any collaborative work that might follow. One of the striking findings of my research was that patients' preferences were received and handled differently depending on the commitments they entailed and their sequential implications. The result of this receipt and handling pattern was that patients with ostensibly complex or challenging preferences were told their preferences were unfeasible and unable to influence treatment decision-making. Preferences received as challenging entailed a sequence, often extended, to account for the receipt of this preference as difficult or unfeasible. One tentative suggestion would be to attempt more engagement with patients about their preferences and alternatives when they are more complicated or a challenge for the encounter. This, of course, would be in the context of providing an alternative to or going further than the interactive work of explaining why the preference is unfeasible.

Going beyond explanations of why a preference is challenging and discussing the reality of the situation with the patient and their concerns and questions. For instance, if patients display, or state outright, a dispreference towards incontinence, such as in extract 5.7, then attempt to discuss this issue further with the patient. Of course, the patient may not wish to go into detail, but I would consider an attempt at further preference-specific discussion more proactive than attempts at impartiality and matter-of-fact glossing of something as sensitive as side effects. Of course, I accept that a preference to avoid incontinence is an impossible preference and as such there are very real constraints on what can practically be accomplished. Furthermore, the fact that CNSs do inform patients that they may or may not experience specific side effects is clearly valuable information relevant for any preference-shaped decision that might incorporate patients' preferences. That said, when we return to extract 5.7, we see a breakdown in intersubjectivity tied to the misalignment between the patient's firm preference and the CNS's attempts at doing impartiality (lines 10-14). Indeed, the breakdown is only restored by the CNS's discursive act of packaging incontinence as one of the category-bound activities side effects of the category prostate cancer (Sacks, 1992, vol. 1, p. 248-251); remarking that it is unfortunate, but side effects are bound up with prostate cancer.

Of course, it is crucial to explain to patients why their preference might be unworkable or unattainable. That said, an explanation for why a preference is unfeasible does little to bring patients closer to a preference-shaped decision. Patients might, then, still report disappointment with their choice, or even decisional conflict in having to choose between two dispreferred options. Therefore, when a patient voices their strong dispreference towards incontinence, for instance, one could go beyond explaining why this might be unfortunately unavoidable. For example, ask the patient if they wish to discuss the preference further or to expand on what they consider to be its potential impact. Patients might not always take up the offer but providing this opportunity for outreach might be valuable for increasing patient involvement as a counterpoint to the limited influence of their stated preference. Engaging further with patients about the reality of their decision-making preferences may provide an opportunity to reduce decisional conflict or increase a sense that their preference has shaped or contributed to the decision-making encounter. That is, shifting the dynamics of the conversation by moving away from the felt preferences to objective knowledge in the hope that this is ultimately useful or meaningful for engaging with the patient's preference. Examples might include leaving a patient feeling particularly well informed or engaging in dialogue that answers hitherto unspoken questions about the impact of their probable treatment option.

If we accept the claim that concepts such as preference elicitation have insufficiencies and that there are institutional constraints on patients' preferences, then we must address what that means for modelling and implementing SDM. I have argued that preferences are crucial to SDM partly because of their prevalence in models and definitions (Makoul & Clayman, 2006) and partly because there are many occasions where the choice is broader than treatment or no treatment. Now, if we accept that patients' preferences are indeed constructed in situ, and do not take the form that clinicians might imagine, then this creates an issue for modelling and attempting SDM. In particular, the issue is that the handling of patients' preferences can reasonably be expected to follow from the conceptualisation and modelling of the concept. This, then, means that patients' preferences need to be clearly defined as constructions in models of SDM and characterised accordingly. That is, to provide an explanation of what the term constructed means in relation to patients' preferences and the context of treatment decision-making. Additional information such as the heterogeneity of both construction projects and preference formulations, pending further empirical evidence, would make further insightful additions.

Indeed, in chapter 5 I proposed a candidate definition of patients' preferences that was specifically responsive to the assertion that they are constructions (Elwyn & Miron-Shatz, 2010), and I will restate that candidate definition here. Patients' preferences are constructed phenomena that they render visible in their healthcare encounters responsive to their healthcare values, available treatment options, and information from their clinician. Moreover, these constructions are comprised of such wide-ranging discursive devices as appeals to prior medical experiences, characterisations of previous medical appointments, and invocations of emotional and cognitive states as explanatory components. Being a provisional definition based on a single dataset, albeit supplemented by extant theoretical and empirical literature, this definition might mutate before it ever, if it ever, gains traction. There is, then, substantial space for refinement and development both in terms of specificity and lucidity but also responsiveness to and grounding in further empirical observational research on patients' preferences in situ in treatment appointments.

Without clinicians acting as institutional gatekeepers, patients' preferences simply exist in the abstract awaiting rulings as to any possible influence on final treatment decisions. In this regard, we are fortunate that a contemporary model, the Implement-SDM model (Joseph-Williams et al., 2019) is perhaps the best placed to adopt this usage and transition successfully. For one, the Implement-SDM model subsumed a simple but practicable guide to SDM as entailing intuitive stages of talk originally proposed in the three talk model (Elwyn et al., 2017). As such, the insertion of a definition of patients' preferences as constructions in the decision talk section, being focused on preferences, would be sensible and unintrusive. Secondly, the acknowledgement of deliberation as being a key process for the evaluation of the pros and cons of treatment options is helpful here. Again, this characterization can be expanded to include patients' preferences as a key aspect of this deliberation process and linked closely to the pros and cons of treatment options. The use of an empirical observational approach, albeit at a less granular level of detail, also lends the Implement-SDM model (Joseph-Williams et al., 2019) readiness to adopt this usage.

In largely taking on and developing the three talk model (Elwyn et al., 2017), the Implement-SDM model also makes use of initial and informed preferences. This conception of patients' preferences is also amenable to my observation that preferences were indeed constructed in situ and would not require substantial change. Of course, my finding that preferences can be constructed haltingly or even hinted at is hard to account for in any standardised fashion. On this point I would suggest that this characterisation of patients' preferences as potentially haltingly or even obliquely constructed is included in models of SDM. Furthermore, that clinicians are encouraged to be alert to these forms of preferences and processes of construction where possible. I also believe that it would be instructive to provide illustrative examples of the ways that patients accounted for preferences and indicative decisions. For instance, it might be easier to understand that a patient characterised a previous appointment in a particular way to indicate that they have an informed preference if this is possibility is suggested in SDM materials.

One of the advantages that the three talk model had was an acknowledged that SDM entails a "complex dynamic interpersonal communication process" (Elwyn et al., 2012, p. 6) and "a fluid transition between different kinds of talk" (p. 6). In extending the three talk model, the Implement-SDM model (Joseph-Williams et al., 2019) continues to hold these communication processes as central and therefore retains this advantage. Of course, neither model is a language and social interaction model of SDM despite the commendable acknowledgement of complex communicative practices and processes in SDM. Indeed, while I expressed support for these models in chapter 1 and have made frequent reference to them throughout the thesis, I did not endorse them unequivocally and without critique. Chief among these critiques was the absence of an empirical grounding in the observable interactive conduct of parties to a decision from real examples of treatment appointments in the three talk model. The Implement-SDM model began to address this concern with the use of empirical qualitative analysis, but the incorporation of language and social interaction research has been slow. As such, there is both encouragement and apprehension as my contributions might be well received but join other largely unheeded language and social interaction insights. As the authors suggested that the Implement-SDM model might subsequently form the basis for training and implementing SDM I wish to discuss it further.

The first point is that the expansions of the conduct and stages of talk in the three talk model (Elwyn et al., 2017) observed by the authors (Joseph-Williams et al., 2019) are instructive for better understanding SDM as a distributed process occurring across phases. This distribution of decision-making fits with Rapley's (2008) argument that decision-making is distributed and my observations of distinct orientations to decision-making as a process, act, or requirement. Furthermore, I commend the authors for focusing on attempts to accomplish SDM in situ rather than presuming SDM occurs and attempting an operationalised quality assessment. This approach to the research is admirable for prioritising empirical observational evidence ahead of theoretical conceptualisations, which I suggest is underutilised in SDM models. Joseph-Williams and colleagues (2019), then, make an insightful contribution to studying and understanding SDM while also encouraging continued engagement with an empirical observational focus on in situ conduct. In demonstrating support for the three talk model (Elwyn et al., 2017) and also highlighting the additive value of in situ empirical observation, the work makes a promising contribution. In turn, I wish to see further empirical insights built into the overwhelmingly theoretical area of SDM models and subsequent models grounded in empirical analysis.

Given the ultra-empirical focus of my research, I wish to see continued engagement with SDM through an empirical observational lens but with increased granularity and specificity. A clear focus on the actual talk produced during the stages of talk observed and interrogation of the link between that talk and the actions accomplished. I believe that most interested parties are aware of the general philosophical principle of collaboratively agreeing an, ideally, preference-shaped decision underpinning SDM (Charles et al., 1997). By contrast, I suggest fewer might be able to speak confidently on the interactive conduct consequential for involving patients' preferences in treatment decisions and potentially facilitating or impeding SDM. Absent detailed knowledge of the interactive machinery of SDM and construction of patients' preferences in situ, we risk relying on non-empirical conceptualisations of conduct. To reiterate, I commend the qualitative work performed and simply wish for further engagement and increasingly fine-grained detail. I consider a fine-grained focus on interactive detail key for empirically interrogating actual SDM attempts, as they occur, away from the expectations of theory. For instance, this approach revealed the distinct patterns of receipt and handling for patients' preferences per their sequential and institutional implications in chapter 5.

That said, there is space both for an encouraging response to my suggestions and for a clear reminder that the talk assigned to these three distinct stages of talk can and do occur throughout the entire appointment. Indeed, in my dataset, patients that presented firm preferences often did so at the beginning of the appointment and constructed them as informed rather than initial preferences (Elwyn et al., 2017). Across these considerations and suggestions, it is worth recalling that decisions are considered shared if each party agrees to the course of action, regardless of whether the option is mutually preferred (Charles et al., 1997). As such, the concept of SDM might be understood as varying between the illnesses, conditions, and clinical settings. Indeed, variations between pre-dialysis and breast cancer decision-making conversations were reported in the Implement-SDM model (Joseph-Williams et al., 2019). For example, we would expect to see extensive engagement with and involvement of patients' preferences in preference sensitive decisions such as prostate cancer (Sommers et al., 2007). By contrast, preferences might figure less in decisions between treatments with equivalent effectiveness. The goal of SDM would be shared across these conversations but the extent of preference involvement might differ.

On the topic of clinical equipoise, this remains a key point when we consider decision-making for prostate cancer treatment. I expected clinical equipoise to pose a problem for decision-making, but I instead observed that trouble occurred when patients produced an impossible preference that constrained the CNS's options. In turn, CNSs responded by doing impartiality, which fulfilled the sequential obligation to respond and the institutional obligation not to sanction unfeasible preferences. Of course, the trouble is between what that patient wants, but is unfeasible or impossible, and that CNS's inability to give the patient what they want while being obliged to respond. By contrast, I observed evidence of a clinical recommendation for surgery as the initial treatment, which might reduce the problem of equipoise. I note, however, that while a clinical recommendation for surgery was observed, CNSs resisted patients' attempts to solicit a best treatment. In my dataset, a plausible alternative to the problem of equipoise might be the problem of patients' impossible preferences. To expand, when a patient prefers to avoid needles (extract 4.6) or states that incontinence is intolerable (extract 5.7), there is no answer for this impossibility comparable to the clinical recommendation.

Clinical nurse specialists can do little with impossible preferences and this might be a factor in their doing impartiality. Patients, then, are constrained in the extent to which their preference can influence their ultimate treatment, and CNSs are similarly constrained in means of involving patients' preference. I have suggested previously that CNSs might attempt further engagement with patients about preferences they find impossible. I would suggest that it could be valuable if patients were given interactional slots and spaces to tell their stories and prompted to give accounts even if these slots are not taken. My reasoning is that even if a shared decision cannot fully incorporate the patient's preference, because of impossibility, the stories and accounts around the preference can involve the preference meaningfully and give a sense of involvement to the patient. For example, we saw storytelling in extract 4.7 used to give voice to concerns, experiences, and the practicalities of post-treatment life. In turn, it might help reduce decisional regret and leave patients less likely to feel that they were insufficiently involved in the decision-making process. The decision is therefore made more fully in the spirit of SDM as an ethical and admirable idea rather than procedural box-ticking.

7.5 Future directions

The findings that I report provide novel contributions to both the SDM and language and social interaction literatures. That said, these findings cannot and do not stand as a comprehensive statement on patients' preferences. I would argue that a comprehensive statement is unfeasible because of the scope of encounters where patients' preferences are relevant. Furthermore, the heterogeneity of preferences and preference construction projects observed suggest there is a wealth of possibilities. As it stands, then, my research stands as the first discursive psychological study of patient preference construction, and one of the few studies of in situ patient preference work. There remains much to investigate to attempt a comprehensive answer to the question of how patients' preferences influence treatment decision-making. Indeed, despite the insight my findings provide, there are also further questions that they prompt. There are questions about SDM at large which merit further consideration and future research, which I will consider later. To begin this section, however, I will propose some suggestions for further research into patients' preferences.

To extend the research agenda that I have staked out, I believe it is necessary to continue with language and social interaction research. For one, the notion that patients' preferences are constructed has a solid basis (Elwyn & Miron-Shatz, 2010) and I provide context-specific examples of constructed preferences and construction projects. Therefore, one particularly important avenue for future research is the interactive construction of patients' preferences. Building on my research into prostate cancer, preference-sensitive treatment decisions would be an ideal area to pursue due to a reasonable expectation of preference talk. If we were to observe the interactive construction of preferences, then we would begin to know more about the robustness of preferences as constructed in situ and their forms. This means ascertaining just how generic and reproducible the phenomenon of preference construction is in situ and across contexts. Of course, there might also be insight as to whether the machinery of construction itself has stable and reproducible features, beyond its unified outcome of constructing a preference.

While preference-sensitive diseases might be the most pertinent contexts for understanding preference construction, preferences remain a core essential element of SDM more generally. As such, the follow-up research would necessarily broaden out to other contexts where options and choice exists, and by extension the possibility of making a preference-shaped shared decision. An interesting, and perhaps stubborn, impediment to this machinery of preference might exist in treatment discussions for less preference-sensitive diseases. For instance, when a treatment decision needs to be made and the impossible preference must be addressed before a decision is endorsed. The context of decision-making and orientations to patients' impossible preferences might be markedly different in non-preference-sensitive diseases. This difference could be that while patients' impossible preferences might impede decision-making progress; patients' preferences might also be more tightly constrained by the presence of a gold standard treatment. The issue of clinical equipoise did not come out prominently in my findings, but this does not entail that reduced preference sensitivity in other decision-making contexts wouldn't prove influential for decision-making.

Although this next point is not strictly an empirical one, it is a hope I have for the future of SDM and patients' preferences. That is, that further discussion can be had about the merits and appropriateness of the term preferences in the context of SDM. It is hopefully clear from the rationale and aims for my research that I believe there needs to be a far more central role for language and social interaction research and findings in SDM. Both as part of the research agenda that drives the development of SDM and as the components and related characterisation that makes SDM intelligible and actionable. While this is a belief that I made clear from the beginning, the need for a discussion about the term preferences arose from my data and subsequent analysis. Obviously, the findings of my study would require replication across other preference-sensitive decision-making contexts before making any bold claims. When one considers that the literature shows inconsistent definitions (Street et al., 2012), poor and infrequent attempts to incorporate patients' preferences (Couët et al., 2015), and little relationship between preferences and treatment decisions (Sommers et al., 2008; Scherr et al., 2017) then the case grows stronger. Moreover, when one adds the conversation analytic work that reveals how patients' preferences can be undermined during elicitation (Landmark et al., 2016) there is certainly grounds for further discussion.

Due to the scale of SDM as a research topic and the healthcare aim, there is significant scope for future research. Further to the directions already outlined, there is also the potential to explore the handling of dispreference and uncertainty. My research began to hint at both notions, particularly around the aspect of side effects, and they appear viable research topics. However, a full investigation would require its own substantial work to do justice to those topics. It would, of course, be instructive to characterise the ways that expressions of dispreference were handled, since these are intimately linked to preferences and perform similar pragmatic functions. Uncertainty would form a proximal topic to preferences based on my observations from this dataset but would be relevant to and useful for SDM. For instance, fellow researchers might ask what role uncertainty has in constructions or formulations of preference. Furthermore, what impact does the handling of uncertainty have on patients' preferences and the decision-making business of the appointment. Naturally, the handling of dispreference could receive similar treatment and questions of this nature be just as easily applied to that investigation. In any case, both topics and sets of questions would be excellent directions for future research. Moreover, both directions could make useful contributions to the study of SDM as it happens in situ. In turn, expanding and enriching our understanding of SDM with their potential consequences being practical implementable strategies for clinicians.

Additional scope exists for research into laughter, particularly in healthcare settings and specifically cancer care appointments. Wayne Beach has been influential in the study of cancer care from the conversation analytic perspective (Beach, 2003, 2004) and has recently investigated the role of laughter. While I echoed Beach and Prickett (2017) in observing that laughter often functioned to soften a delicate or poignant moment, the pattern of laughter distribution I observed was notably different. Indeed, the prevalence and function of CNS laughter was closest to Ragan's (1990) work on gynaecological appointments in being prosocial, potentially face-saving, and often a shared action. As such, not only would it be insightful to further investigate the role of laughter in cancer appointments to check my findings, but to explore laughter in personally sensitive treatment appointments. By personally sensitive, I mean illnesses or issues that relate to intimate anatomy or effects such as the cervix and vagina or prostate and penis. This additional sensitivity factor would be interesting for an explanation of how exactly laughter serves a function, and how that function can be responsive to the institutional situatedness of the appointments. Naturally, research into laughter and its function can be expanded for other professions. Perhaps some promising candidates might include mediation or legal counsel, as examples of serious encounters where one might expect to observe delicate or poignant moments.

My final suggestion for future research directions focuses squarely on practical application and clinical implementation. This direction is research into training clinicians, in this case CNSs, in the handling of patients' preferences and approach to SDM. I have previously mentioned the Conversation Analytic Roleplaying Method (Stokoe, 2014), with fair grounds for caution about communication training as a universal fix (Pilnick & Dingwall, 2011), and discussed interaction analysis systems at length in chapter 2 (Roter, 1977). The suggestion, then, is to engage in a programme of intervention research that draws on and marries the respective strengths of these instructive approaches. Despite their methodological differences, the Roter interaction analysis system (Roter & Larson, 2002) and the Conversation Analytic Roleplaying Method (Stokoe, 2014) are both well-established programmes with demonstrable track records of empirical contributions. In turn, my suggestion would pull together these unique strengths and scopes into a collaborative and multifaceted intervention research programme fixed on the feasibility and utility of the insights generated and subsequently tested. There are two ways of running this programme and it could be tried in either order depending on whether prioritising academic or practical evidence.

The first order is to generate an insight such as the finding from chapter 6 that laughter was relevant for both preference construction and SDM and prepare a suitable proposal for an intervention study. For example, per Roter's (1977) classic study, developing an intervention for patients and clinicians that provides information about and encourages appropriate laughter. The intervention can then be subjected to random trialling and if results are positive then there are two distinct but complementary evidential bodies plus preliminary practical support. An approach like this has been advocated for by researchers interested in language and social interaction and experimental psychology (de Ruiter & Albert, 2017; Albert & de Ruiter, 2018). The reasoning behind this advocacy being that the experimental approach often disregards the context of a discovery while, for instance, conversation analysis builds this context into its findings (de Ruiter & Albert, 2017). Taken together, then, a theory or intervention developed out of a combination of the two would be robust, significant, and both grounded in and close to the ways that the phenomena function in everyday life. In terms of academic rigour this approach might be the best choice as the collaborative evidential body may be significant in convincing relevant stakeholders.

In terms of clinical priority, I would suggest that the reflexive interviewing mentioned in section 7.5 would be an intervention to prioritise. Again, it would be quite possible to combine an intervention for increasing the presence or quantity of reflexive interviewing with the naturalistic study of the conversations that implement the intervention. Such an intervention, be it a script or tool for use in the appointment, could outline operationalised instance of phenomena or practices considered to demonstrate or typify reflexive interviewing and subsequently be measured and assessed by both quantitative and language and social interaction benchmarks. A similar combined approach would certainly be advantageous for attempts to improve the treatment decision-making process for prostate cancer patients, while I continue to advocate strongly for more language and social interaction research to build a characterisation of patients' preferences as empirical analytically tractable phenomena.

That said, there is a more straightforward way of focusing directly on application and that is to feed into clinicians directly by tailoring the insights from an empirical observational study such as this one. There would be a clear pipeline, then, between the insights generated from the findings and the clinicians and their work implementing them to attempt SDM. Again, there are two ways that this application work could be attempted. One is to characterise the insights and provide examples of the forms and consequences of the interactive actions to give interested clinicians. This approach is likely closer to the idea of communication training that could be delivered in a short institutionally run training event. A more reflective alternative would be to provide clinicians with audio or video data examples of the interactive behaviour and insights that would be characterised by a language and social interaction study. In a similar fashion to how clinicians would take video recordings home with them to make notes and study, they could do this with the insights and interventions being suggested for SDM practice.

In either case the focus would be on familiarising clinicians with the insights and suggestions for how to implement them in clinical practice. Observation of subsequent appointments with clinicians who received the insights could then be undertaken and the interactions investigated in a similarly fine-grained microanalytic manner. This would also represent a logical extension of the work that the Implement-SDM model performed when it analysed consultations with practitioners trained in SDM skills derived from the three talk model (Joseph-Williams et al., 2019). Of course, the judgement on effectiveness would differ markedly from the other approach previously proposed and would need to be made abundantly clear. A combined approach could be taken later but the primary focus would be on empirical observation rather than statistical significance. As such, we would be looking to direct observation of appointments for outcomes and again be detaching from more operational measures of SDM and some of their issues, which I discussed in chapter 1. The two approaches exist in proximity, however, because I believe that both orders of approach are similarly feasible and hold potential for additive contributions differing simply in their primary focus being either immediately academic or practical.

As may have become apparent throughout this thesis, it is not particularly easy to reduce the discursive constructive work into a neat road map. Moreover, there remains much work to be done before we have reliable additive SDM tools. Although, there are promising signs with preference assessments (Shirk et al., 2017) that might be bolstered by language and social interaction research. While this research is not presupposing any specific knowledge of healthcare communication or implementation training, the language and social interaction research can be combined with numerical coding or quantitative aspects of study design. For instance, Stivers (2015) makes the case that conversation analysis already performs a kind of coding where the distributional evidence of phenomena occurs in building collections of phenomena. There is also evidence of successful interweaving of coding and conversation analysis studies such as Heritage and colleagues' (2007) study of using some versus any in addressing patients' additional concerns. Moreover, conversation analysis and multivariate analyses have been successfully combined to reveal that inappropriate prescribing in paediatric encounters occurred more frequently when clinicians believed parents expected antibiotics (Mangione-Smith et al., 2006). As such, there is clear scope to take this programme forward and demonstrations that such an approach can generate robust instructive findings. All of which is promising and should be seized upon in service of advancing our understanding of patients' preferences and SDM in ways facilitative of routine implementation and accomplishment.

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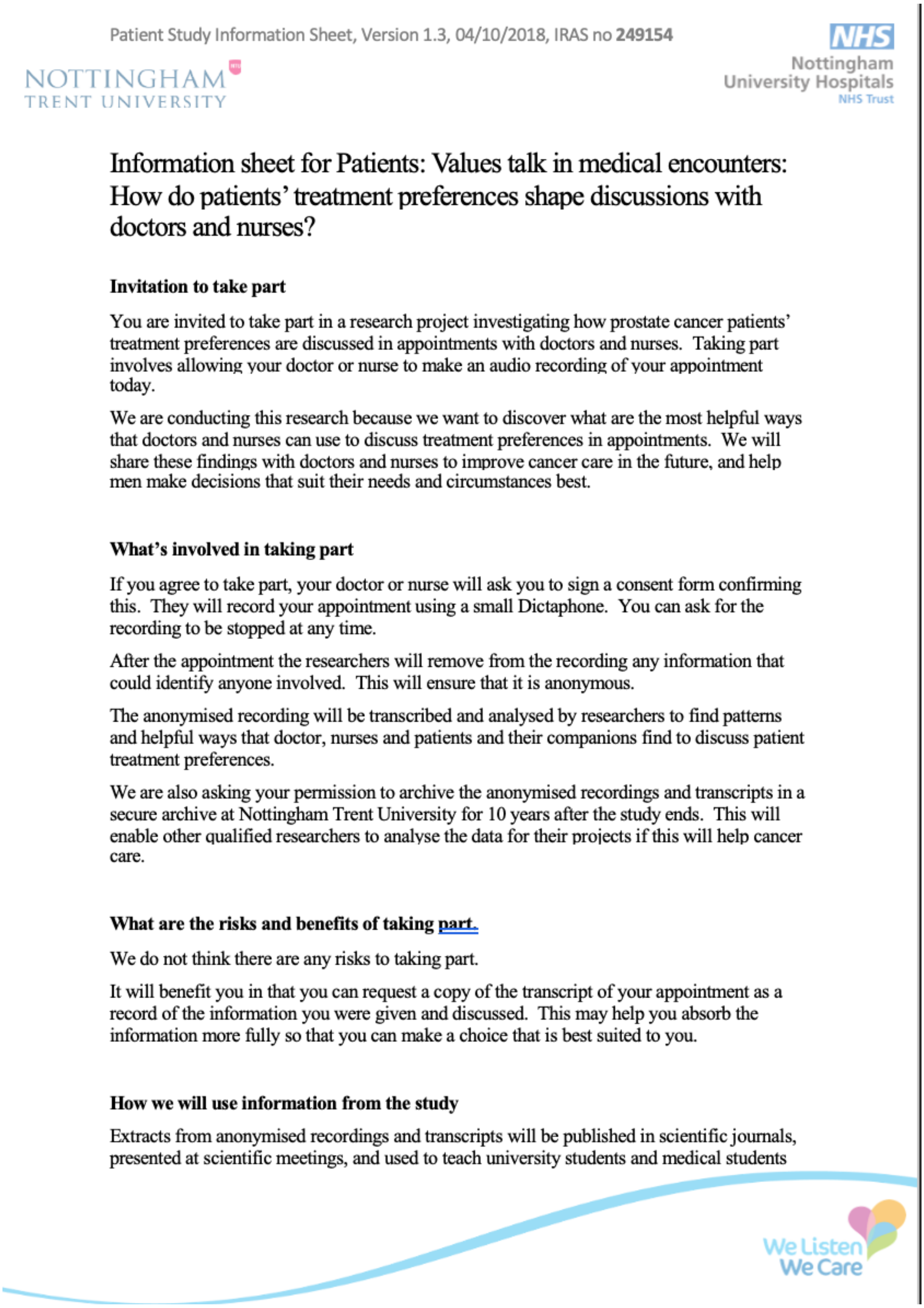
Appendices

Appendix A

Information sheet given to patients



NOTTINGHAM
TRENT UNIVERSITY

NHS
Nottingham
University Hospitals
NHS Trust

Information sheet for Patients: Values talk in medical encounters: How do patients' treatment preferences shape discussions with doctors and nurses?

Invitation to take part

You are invited to take part in a research project investigating how prostate cancer patients' treatment preferences are discussed in appointments with doctors and nurses. Taking part involves allowing your doctor or nurse to make an audio recording of your appointment today.

We are conducting this research because we want to discover what are the most helpful ways that doctors and nurses can use to discuss treatment preferences in appointments. We will share these findings with doctors and nurses to improve cancer care in the future, and help men make decisions that suit their needs and circumstances best.

What's involved in taking part

If you agree to take part, your doctor or nurse will ask you to sign a consent form confirming this. They will record your appointment using a small Dictaphone. You can ask for the recording to be stopped at any time.

After the appointment the researchers will remove from the recording any information that could identify anyone involved. This will ensure that it is anonymous.

The anonymised recording will be transcribed and analysed by researchers to find patterns and helpful ways that doctor, nurses and patients and their companions find to discuss patient treatment preferences.

We are also asking your permission to archive the anonymised recordings and transcripts in a secure archive at Nottingham Trent University for 10 years after the study ends. This will enable other qualified researchers to analyse the data for their projects if this will help cancer care.

What are the risks and benefits of taking part.

We do not think there are any risks to taking part.

It will benefit you in that you can request a copy of the transcript of your appointment as a record of the information you were given and discussed. This may help you absorb the information more fully so that you can make a choice that is best suited to you.

How we will use information from the study

Extracts from anonymised recordings and transcripts will be published in scientific journals, presented at scientific meetings, and used to teach university students and medical students

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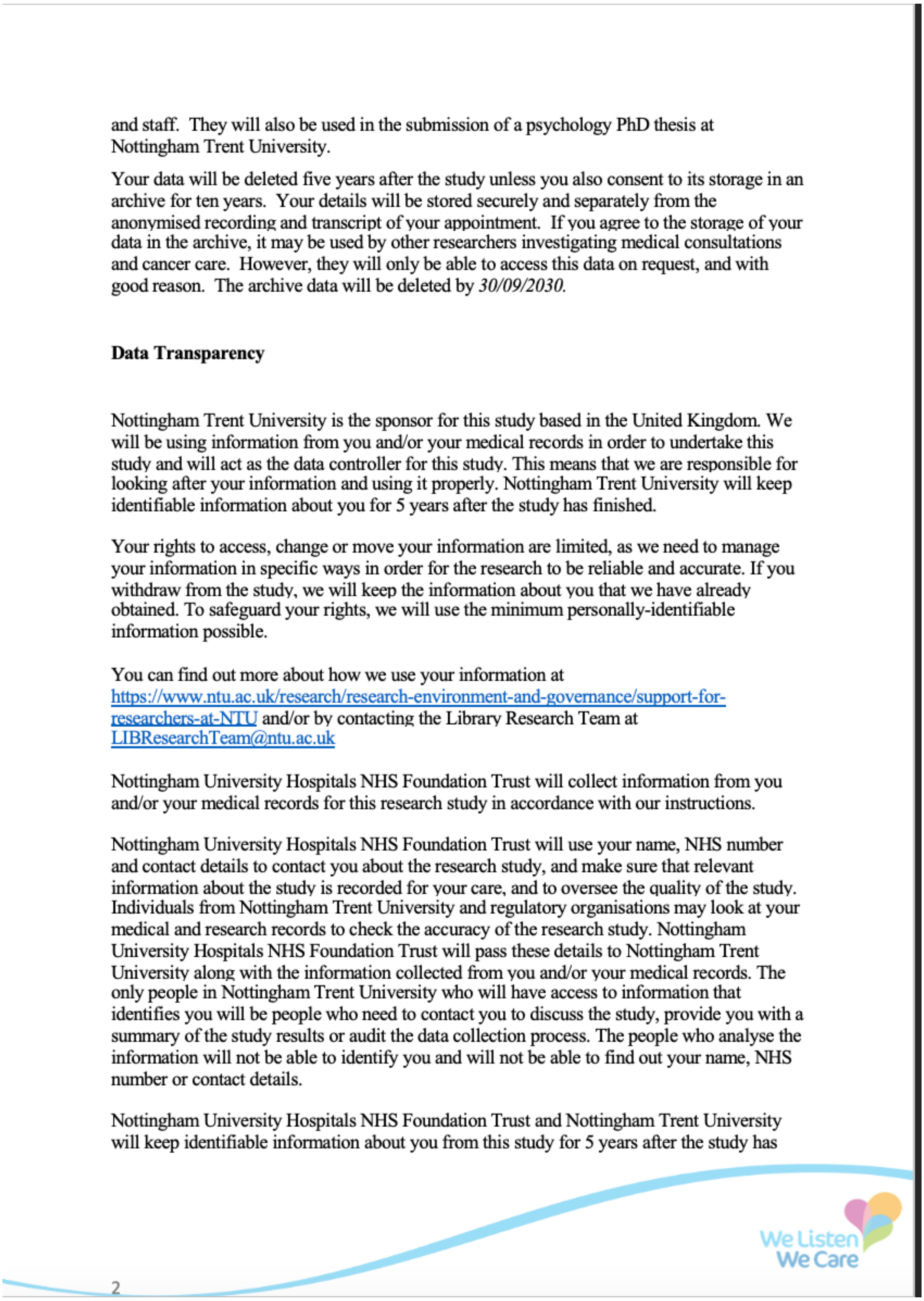

and staff. They will also be used in the submission of a psychology PhD thesis at Nottingham Trent University.

Your data will be deleted five years after the study unless you also consent to its storage in an archive for ten years. Your details will be stored securely and separately from the anonymised recording and transcript of your appointment. If you agree to the storage of your data in the archive, it may be used by other researchers investigating medical consultations and cancer care. However, they will only be able to access this data on request, and with good reason. The archive data will be deleted by *30/09/2030.*

Data Transparency

Nottingham Trent University is the sponsor for this study based in the United Kingdom. We will be using information from you and/or your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Nottingham Trent University will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.ntu.ac.uk/research/research-environment-and-governance/support-for-researchers-at-NTU and/or by contacting the Library Research Team at LIBResearchTeam@ntu.ac.uk

Nottingham University Hospitals NHS Foundation Trust will collect information from you and/or your medical records for this research study in accordance with our instructions.

Nottingham University Hospitals NHS Foundation Trust will use your name, NHS number and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from Nottingham Trent University and regulatory organisations may look at your medical and research records to check the accuracy of the research study. Nottingham University Hospitals NHS Foundation Trust will pass these details to Nottingham Trent University along with the information collected from you and/or your medical records. The only people in Nottingham Trent University who will have access to information that identifies you will be people who need to contact you to discuss the study, provide you with a summary of the study results or audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.

Nottingham University Hospitals NHS Foundation Trust and Nottingham Trent University will keep identifiable information about you from this study for 5 years after the study has

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finished.

Nottingham Trent University will collect information about you for this research study from clinical care team staff. This information will include your name, NHS number, contact details, and health information, which is regarded as a special category of information. We will use this information to discuss taking part in the study with you and provide you with a summary of the study results.

Your information could be used for research in any aspect of health or care and could be combined with information about you from other sources held by researchers, the NHS or government.

Where this information could identify you, the information will be held securely with strict arrangements about who can access the information. The information will only be used for the purpose of health and care research, or to contact you about future opportunities to participate in research. It will not be used to make decisions about future services available to you, such as insurance.

Where there is a risk that you can be identified your data will only be used in research that has been independently reviewed by an ethics committee.

How to withdraw from the study

Taking part is voluntary and you can withdraw from the study by asking the doctor or nurse to stop the recording. If you decide to withdraw after the recording, we will keep the information about you that we have already obtained. You do not need to give a reason to withdraw.

Finding out more about prostate cancer

If you want to know more about prostate cancer, we recommend you speak to your healthcare professional who can then advise you. You could also go to the Macmillan Cancer Information and Support Centre or the Maggie's Centre, both are located at Nottingham City Hospital and staff could direct you to these.

If you have any questions or would like more information, please contact Charles Baker or Dr Mike Rennoldson on their details below.

Chief Investigator: Charles Baker, charlie.baker2012@my.ntu.ac.uk

Supervisor: Dr Mike Rennoldson, +44 (0)115 848 4360, mike.rennoldson@ntu.ac.uk

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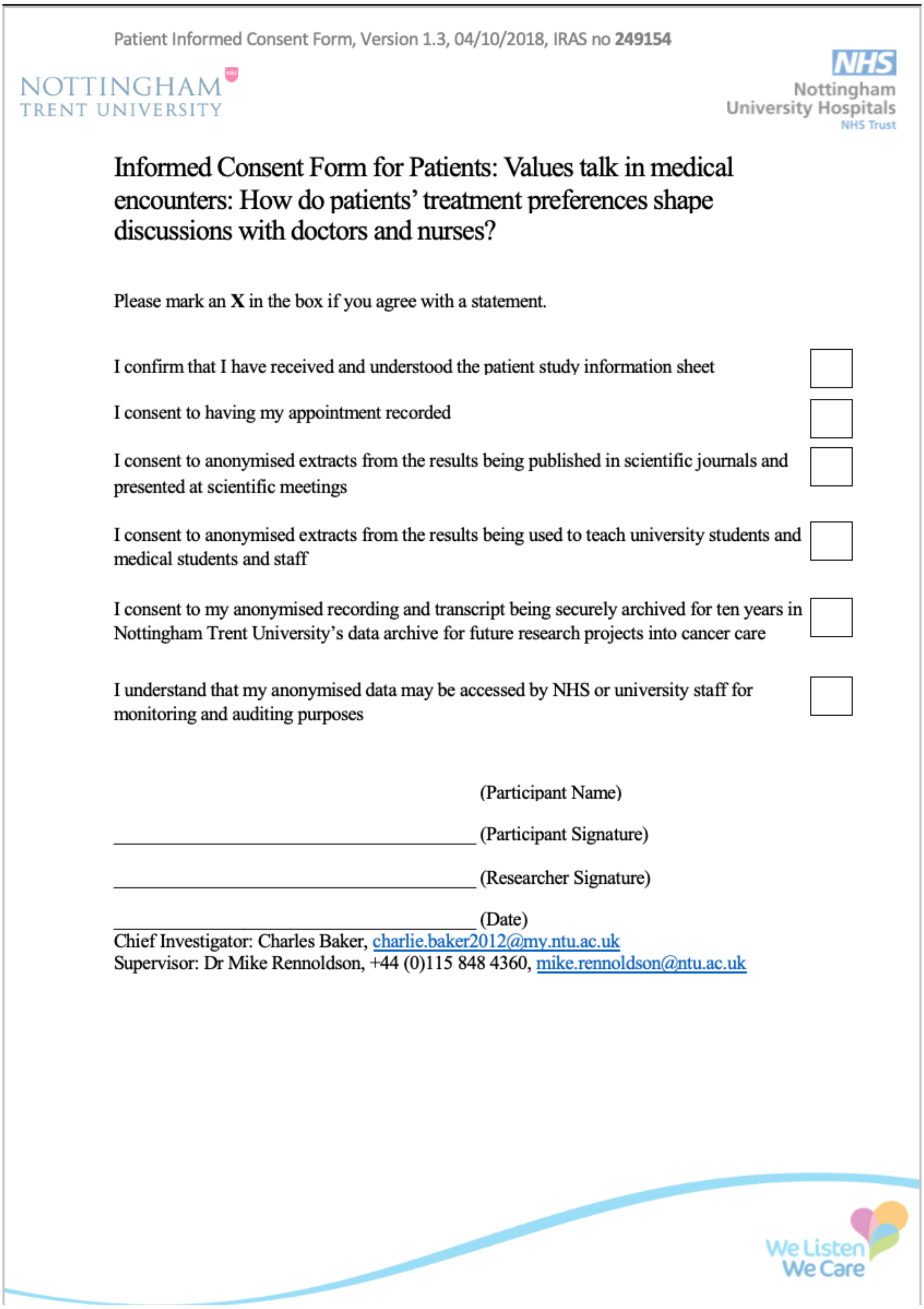
Appendix B

Consent forms given to patients



Patient Informed Consent Form, Version 1.3, 04/10/2018, IRAS no **249154**

NOTTINGHAM
TRENT UNIVERSITY

NHS
Nottingham
University Hospitals
NHS Trust

Informed Consent Form for Patients: Values talk in medical encounters: How do patients' treatment preferences shape discussions with doctors and nurses?

Please mark an **X** in the box if you agree with a statement.

I confirm that I have received and understood the patient study information sheet ☐

I consent to having my appointment recorded ☐

I consent to anonymised extracts from the results being published in scientific journals and presented at scientific meetings ☐

I consent to anonymised extracts from the results being used to teach university students and medical students and staff ☐

I consent to my anonymised recording and transcript being securely archived for ten years in Nottingham Trent University's data archive for future research projects into cancer care ☐

I understand that my anonymised data may be accessed by NHS or university staff for monitoring and auditing purposes ☐

(Participant Name)

____ (Participant Signature)

____ (Researcher Signature)

____ (Date)

Chief Investigator: Charles Baker, charlie.baker2012@my.ntu.ac.uk
Supervisor: Dr Mike Rennoldson, +44 (0)115 848 4360, mike.rennoldson@ntu.ac.uk

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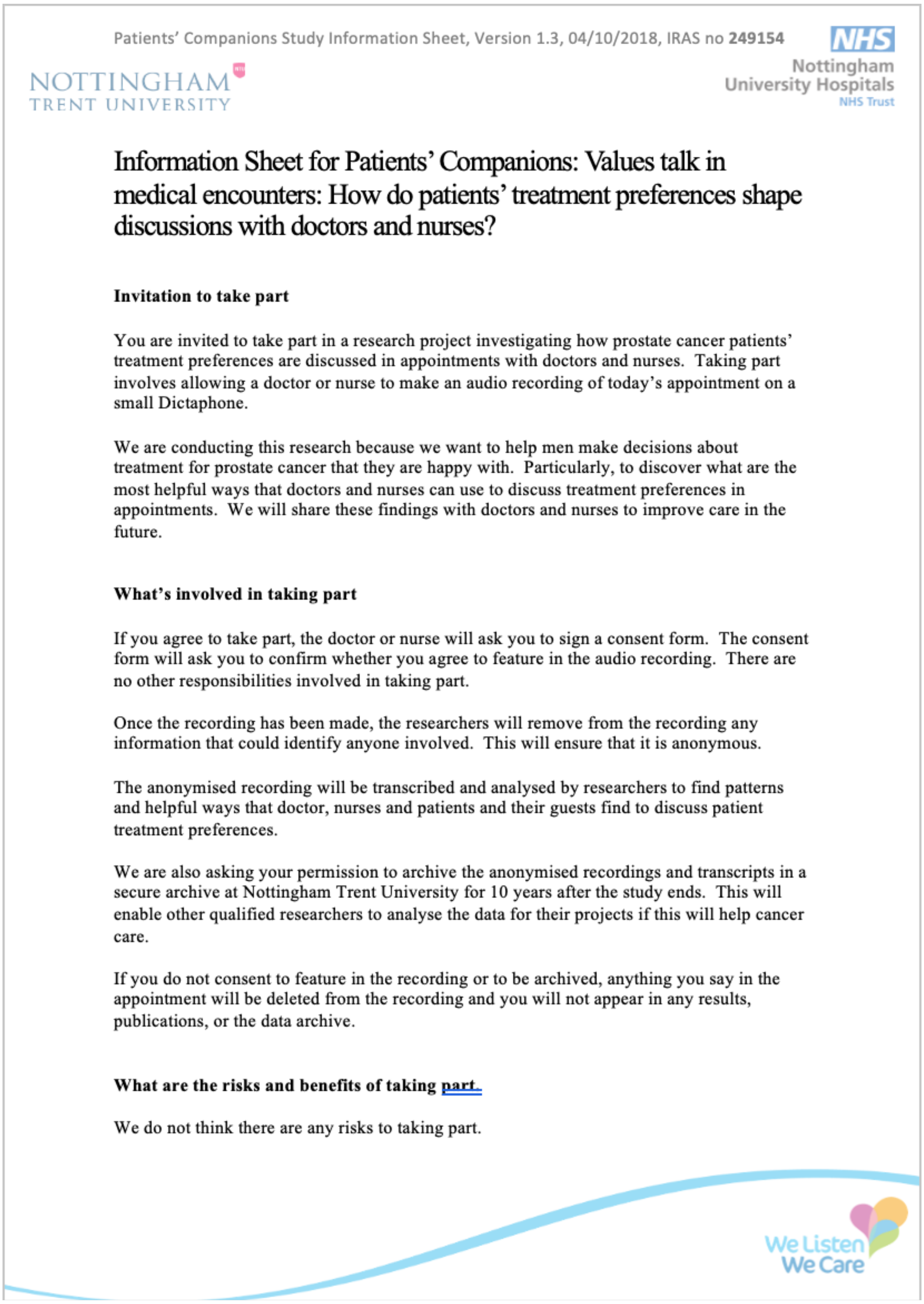
Appendix C

Information sheets given to patients' companions



Patients' Companions Study Information Sheet, Version 1.3, 04/10/2018, IRAS no **249154**

NOTTINGHAM
TRENT UNIVERSITY

NHS
Nottingham
University Hospitals
NHS Trust

Information Sheet for Patients' Companions: Values talk in medical encounters: How do patients' treatment preferences shape discussions with doctors and nurses?

Invitation to take part

You are invited to take part in a research project investigating how prostate cancer patients' treatment preferences are discussed in appointments with doctors and nurses. Taking part involves allowing a doctor or nurse to make an audio recording of today's appointment on a small Dictaphone.

We are conducting this research because we want to help men make decisions about treatment for prostate cancer that they are happy with. Particularly, to discover what are the most helpful ways that doctors and nurses can use to discuss treatment preferences in appointments. We will share these findings with doctors and nurses to improve care in the future.

What's involved in taking part

If you agree to take part, the doctor or nurse will ask you to sign a consent form. The consent form will ask you to confirm whether you agree to feature in the audio recording. There are no other responsibilities involved in taking part.

Once the recording has been made, the researchers will remove from the recording any information that could identify anyone involved. This will ensure that it is anonymous.

The anonymised recording will be transcribed and analysed by researchers to find patterns and helpful ways that doctor, nurses and patients and their guests find to discuss patient treatment preferences.

We are also asking your permission to archive the anonymised recordings and transcripts in a secure archive at Nottingham Trent University for 10 years after the study ends. This will enable other qualified researchers to analyse the data for their projects if this will help cancer care.

If you do not consent to feature in the recording or to be archived, anything you say in the appointment will be deleted from the recording and you will not appear in any results, publications, or the data archive.

What are the risks and benefits of taking part.

We do not think there are any risks to taking part.

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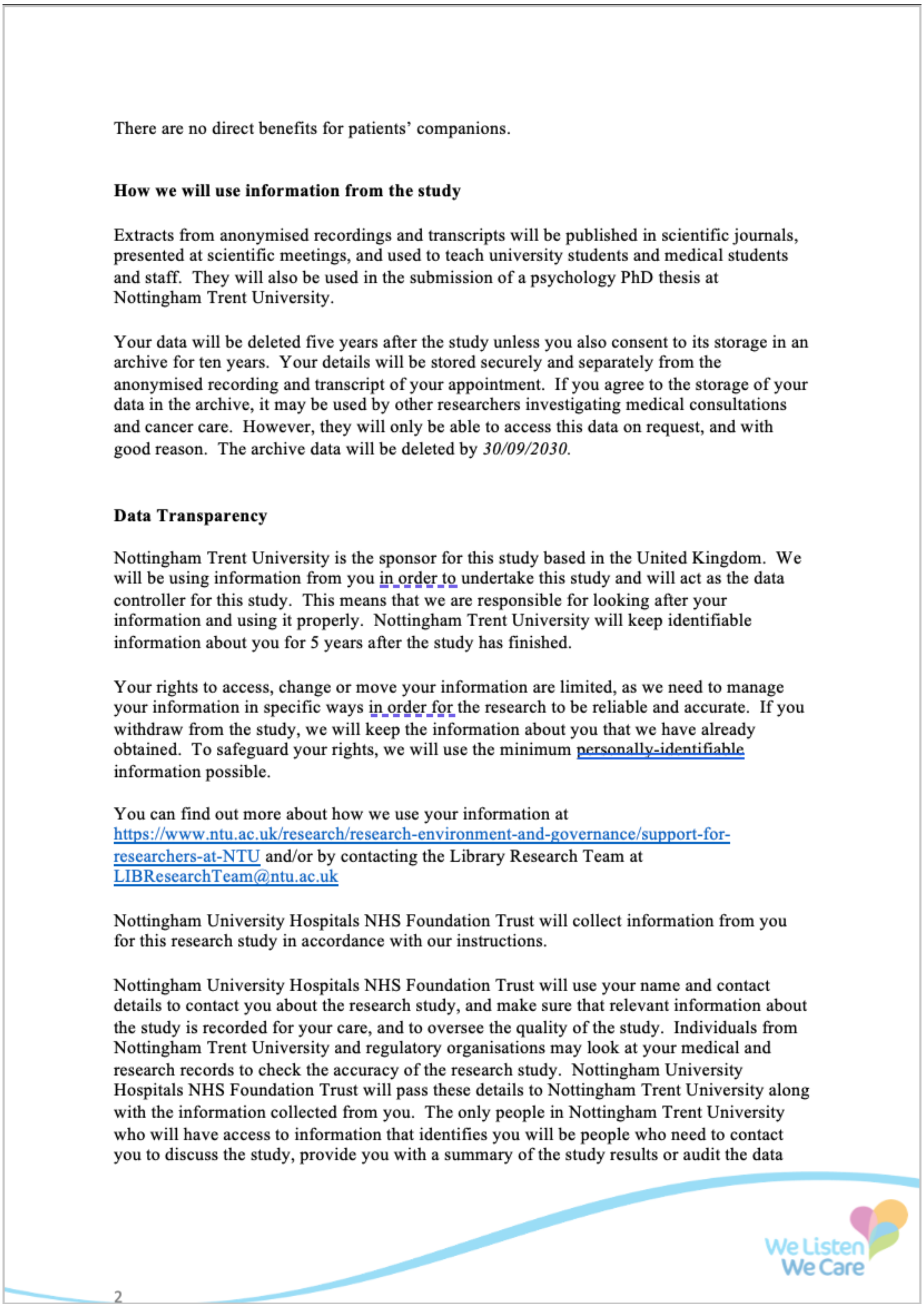


There are no direct benefits for patients' companions.

How we will use information from the study

Extracts from anonymised recordings and transcripts will be published in scientific journals, presented at scientific meetings, and used to teach university students and medical students and staff. They will also be used in the submission of a psychology PhD thesis at Nottingham Trent University.

Your data will be deleted five years after the study unless you also consent to its storage in an archive for ten years. Your details will be stored securely and separately from the anonymised recording and transcript of your appointment. If you agree to the storage of your data in the archive, it may be used by other researchers investigating medical consultations and cancer care. However, they will only be able to access this data on request, and with good reason. The archive data will be deleted by *30/09/2030.*

Data Transparency

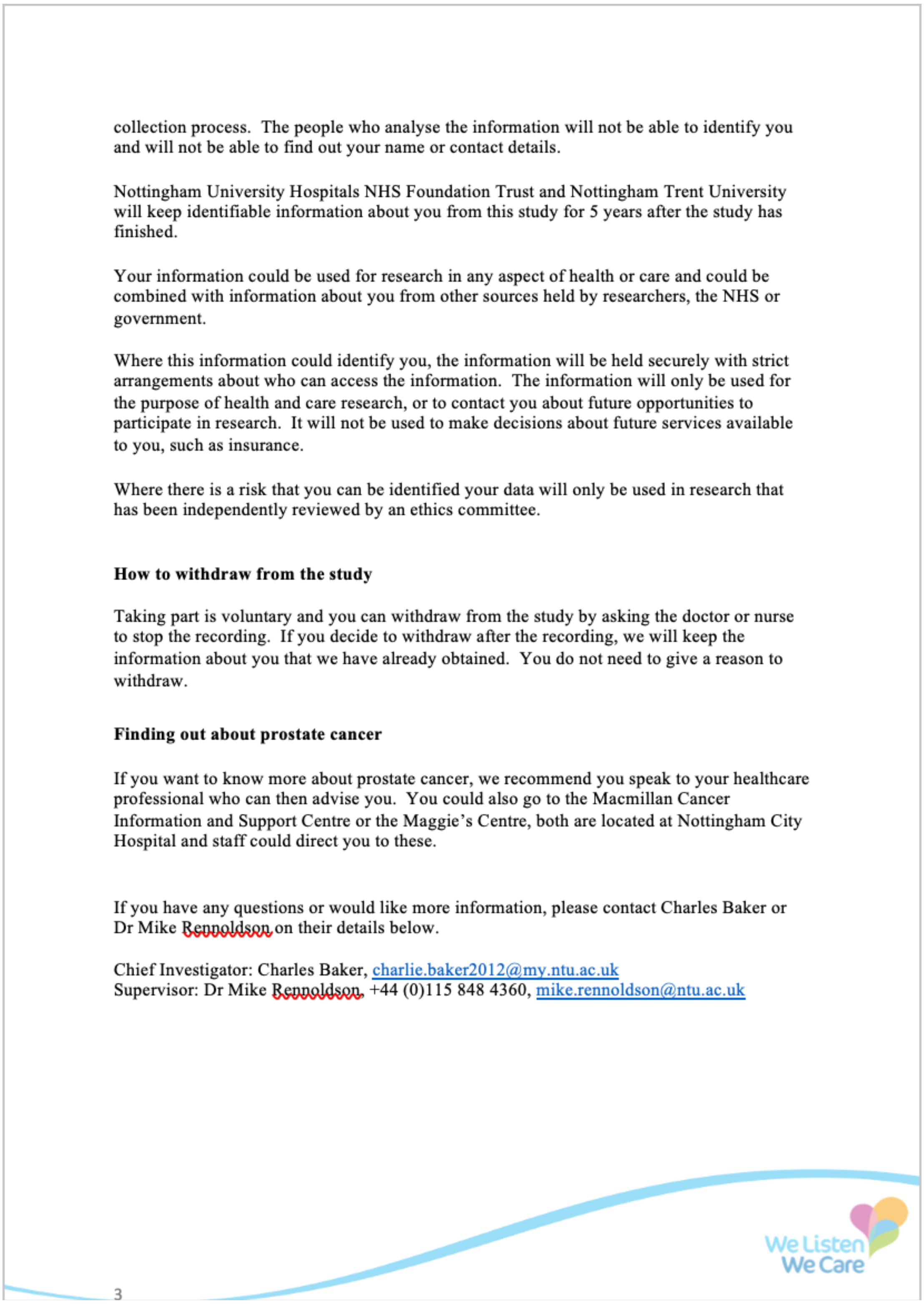
Nottingham Trent University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Nottingham Trent University will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.ntu.ac.uk/research/research-environment-and-governance/support-for-researchers-at-NTU and/or by contacting the Library Research Team at LIBResearchTeam@ntu.ac.uk

Nottingham University Hospitals NHS Foundation Trust will collect information from you for this research study in accordance with our instructions.

Nottingham University Hospitals NHS Foundation Trust will use your name and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from Nottingham Trent University and regulatory organisations may look at your medical and research records to check the accuracy of the research study. Nottingham University Hospitals NHS Foundation Trust will pass these details to Nottingham Trent University along with the information collected from you. The only people in Nottingham Trent University who will have access to information that identifies you will be people who need to contact you to discuss the study, provide you with a summary of the study results or audit the data



collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Nottingham University Hospitals NHS Foundation Trust and Nottingham Trent University will keep identifiable information about you from this study for 5 years after the study has finished.

Your information could be used for research in any aspect of health or care and could be combined with information about you from other sources held by researchers, the NHS or government.

Where this information could identify you, the information will be held securely with strict arrangements about who can access the information. The information will only be used for the purpose of health and care research, or to contact you about future opportunities to participate in research. It will not be used to make decisions about future services available to you, such as insurance.

Where there is a risk that you can be identified your data will only be used in research that has been independently reviewed by an ethics committee.

How to withdraw from the study

Taking part is voluntary and you can withdraw from the study by asking the doctor or nurse to stop the recording. If you decide to withdraw after the recording, we will keep the information about you that we have already obtained. You do not need to give a reason to withdraw.

Finding out about prostate cancer

If you want to know more about prostate cancer, we recommend you speak to your healthcare professional who can then advise you. You could also go to the Macmillan Cancer Information and Support Centre or the Maggie's Centre, both are located at Nottingham City Hospital and staff could direct you to these.

If you have any questions or would like more information, please contact Charles Baker or Dr Mike Rennoldson on their details below.

Chief Investigator: Charles Baker, charlie.baker2012@my.ntu.ac.uk
Supervisor: Dr Mike Rennoldson, +44 (0)115 848 4360, mike.rennoldson@ntu.ac.uk

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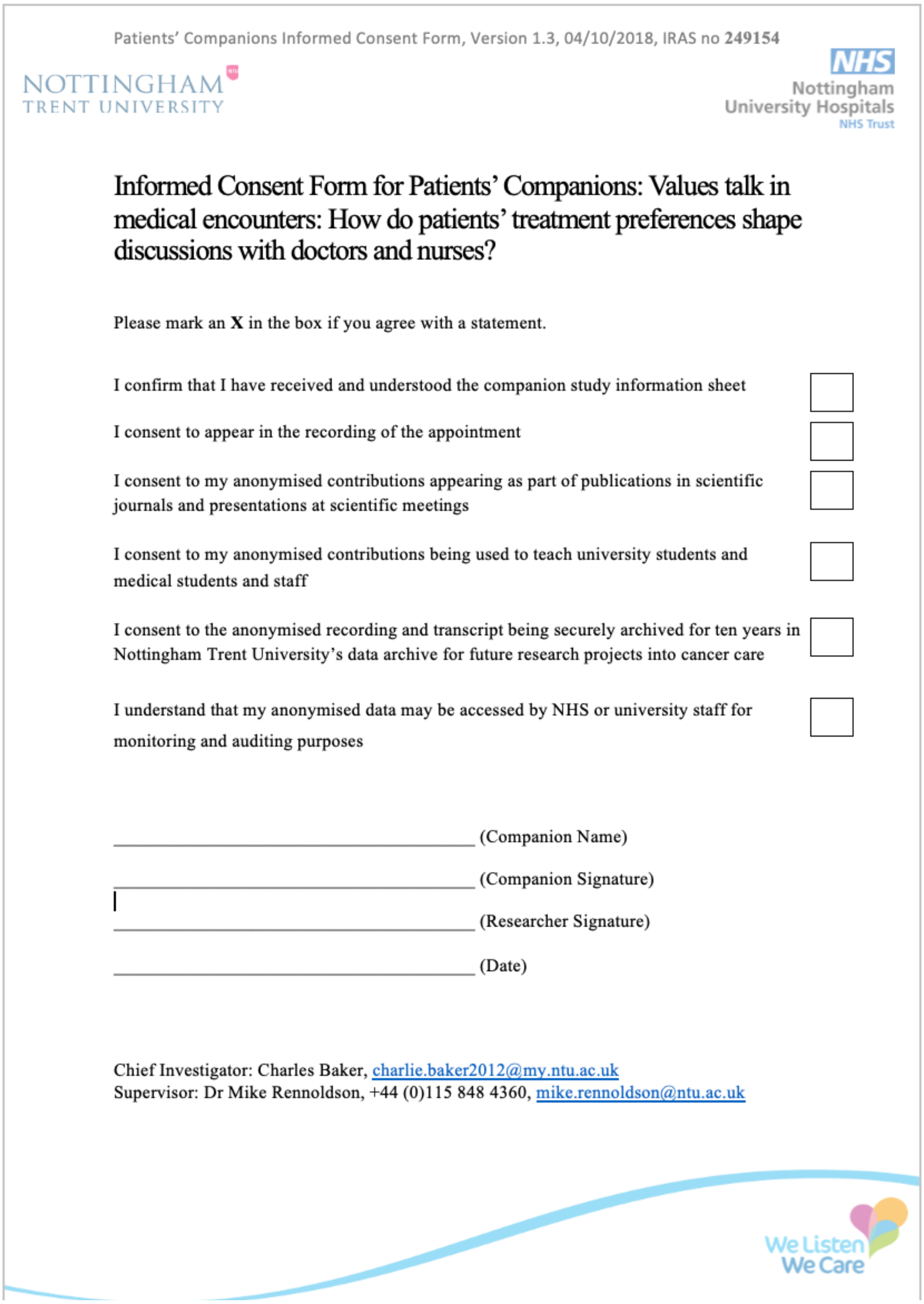
Appendix D

Consent forms given to patients' companions



Patients' Companions Informed Consent Form, Version 1.3, 04/10/2018, IRAS no **249154**

NOTTINGHAM
TRENT UNIVERSITY

NHS
Nottingham
University Hospitals
NHS Trust

Informed Consent Form for Patients' Companions: Values talk in medical encounters: How do patients' treatment preferences shape discussions with doctors and nurses?

Please mark an **X** in the box if you agree with a statement.

I confirm that I have received and understood the companion study information sheet ☐

I consent to appear in the recording of the appointment ☐

I consent to my anonymised contributions appearing as part of publications in scientific journals and presentations at scientific meetings ☐

I consent to my anonymised contributions being used to teach university students and medical students and staff ☐

I consent to the anonymised recording and transcript being securely archived for ten years in Nottingham Trent University's data archive for future research projects into cancer care ☐

I understand that my anonymised data may be accessed by NHS or university staff for monitoring and auditing purposes ☐

______________________________ (Companion Name)

______________________________ (Companion Signature)

______________________________ (Researcher Signature)

______________________________ (Date)

Chief Investigator: Charles Baker, charlie.baker2012@my.ntu.ac.uk
Supervisor: Dr Mike Rennoldson, +44 (0)115 848 4360, mike.rennoldson@ntu.ac.uk

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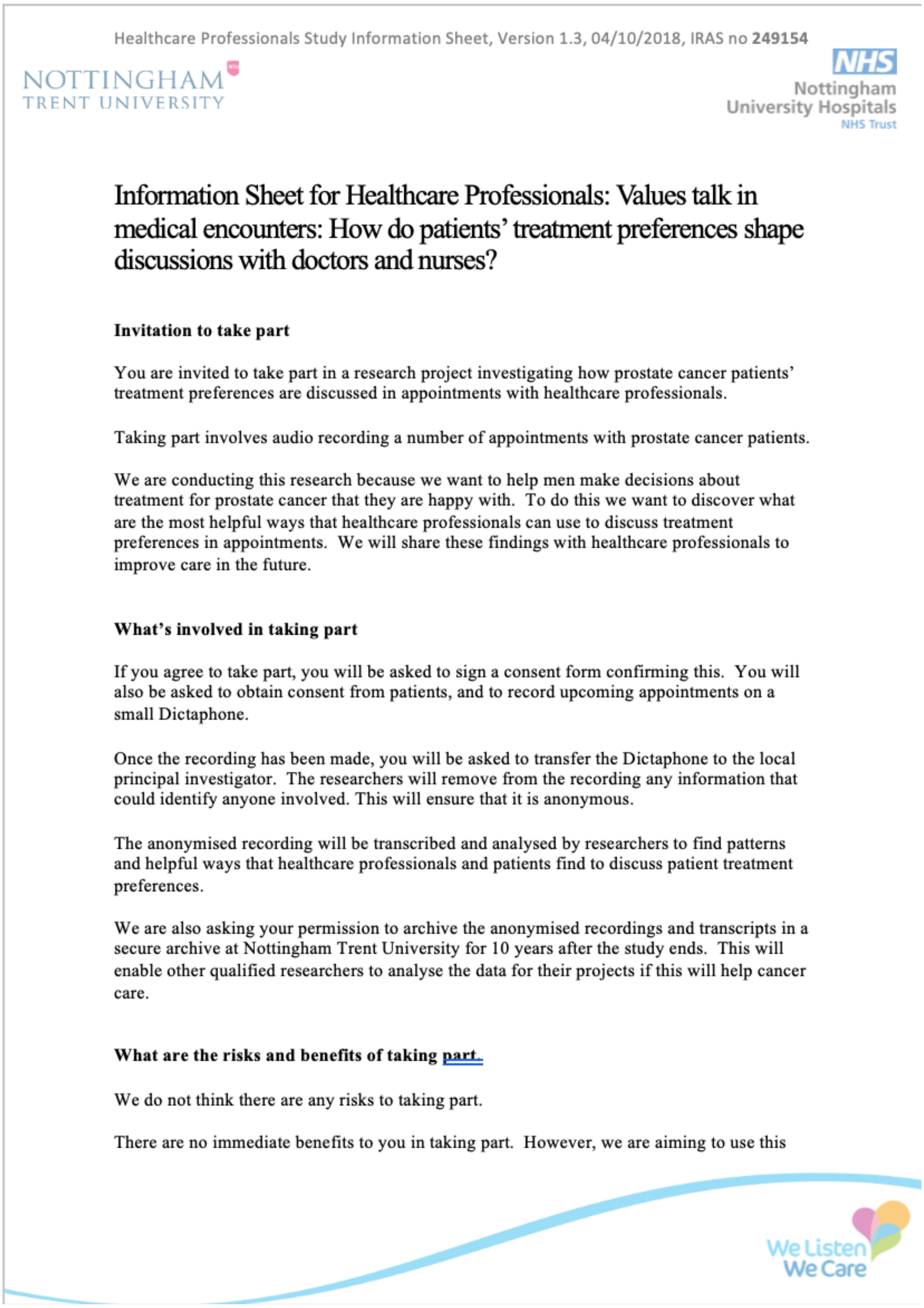
Appendix E

Information sheet given to practitioners



Healthcare Professionals Study Information Sheet, Version 1.3, 04/10/2018, IRAS no **249154**

NOTTINGHAM
TRENT UNIVERSITY

NHS
Nottingham
University Hospitals
NHS Trust

Information Sheet for Healthcare Professionals: Values talk in medical encounters: How do patients' treatment preferences shape discussions with doctors and nurses?

Invitation to take part

You are invited to take part in a research project investigating how prostate cancer patients' treatment preferences are discussed in appointments with healthcare professionals.

Taking part involves audio recording a number of appointments with prostate cancer patients.

We are conducting this research because we want to help men make decisions about treatment for prostate cancer that they are happy with. To do this we want to discover what are the most helpful ways that healthcare professionals can use to discuss treatment preferences in appointments. We will share these findings with healthcare professionals to improve care in the future.

What's involved in taking part

If you agree to take part, you will be asked to sign a consent form confirming this. You will also be asked to obtain consent from patients, and to record upcoming appointments on a small Dictaphone.

Once the recording has been made, you will be asked to transfer the Dictaphone to the local principal investigator. The researchers will remove from the recording any information that could identify anyone involved. This will ensure that it is anonymous.

The anonymised recording will be transcribed and analysed by researchers to find patterns and helpful ways that healthcare professionals and patients find to discuss patient treatment preferences.

We are also asking your permission to archive the anonymised recordings and transcripts in a secure archive at Nottingham Trent University for 10 years after the study ends. This will enable other qualified researchers to analyse the data for their projects if this will help cancer care.

What are the risks and benefits of taking part.

We do not think there are any risks to taking part.

There are no immediate benefits to you in taking part. However, we are aiming to use this

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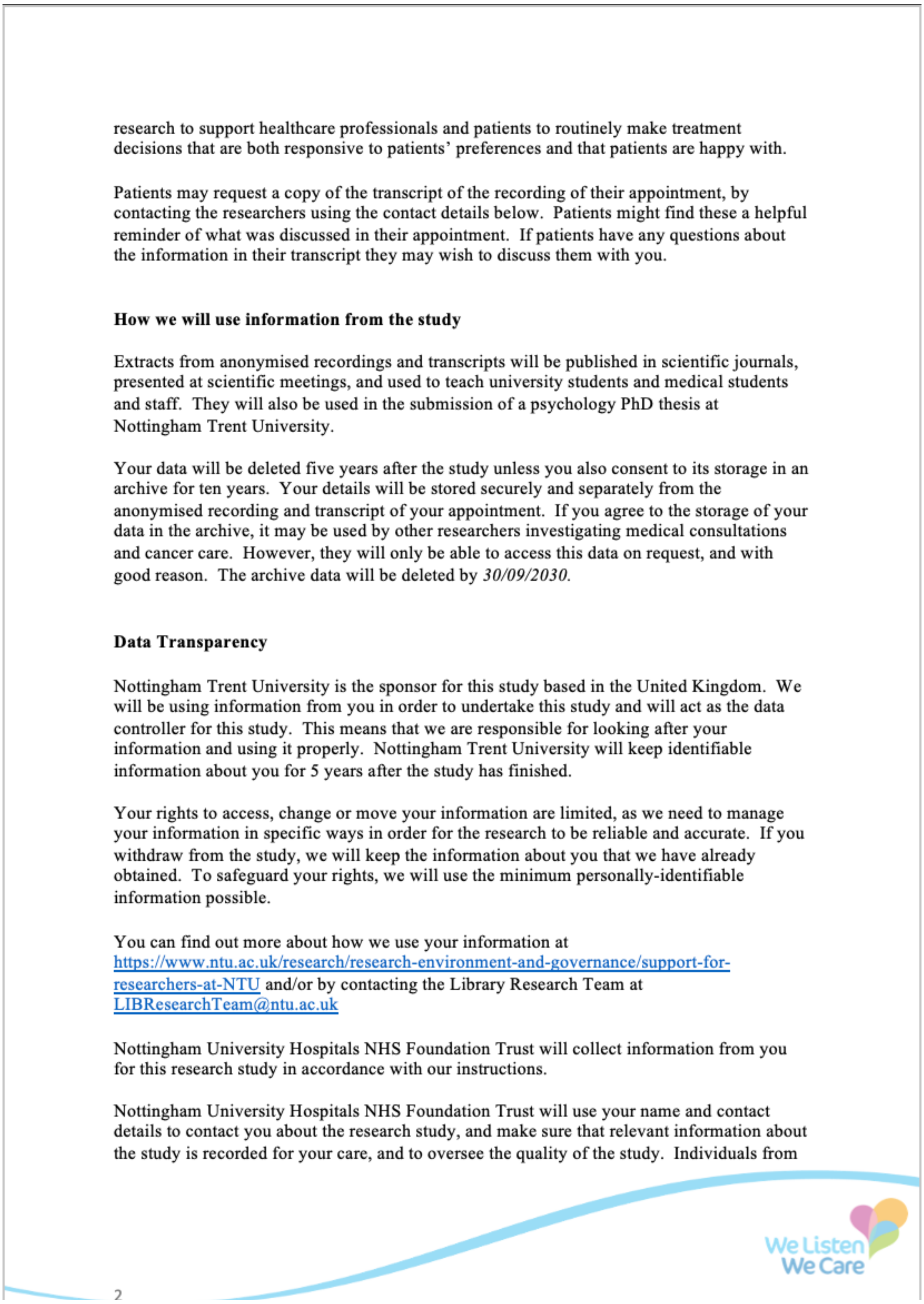

research to support healthcare professionals and patients to routinely make treatment decisions that are both responsive to patients' preferences and that patients are happy with.

Patients may request a copy of the transcript of the recording of their appointment, by contacting the researchers using the contact details below. Patients might find these a helpful reminder of what was discussed in their appointment. If patients have any questions about the information in their transcript they may wish to discuss them with you.

How we will use information from the study

Extracts from anonymised recordings and transcripts will be published in scientific journals, presented at scientific meetings, and used to teach university students and medical students and staff. They will also be used in the submission of a psychology PhD thesis at Nottingham Trent University.

Your data will be deleted five years after the study unless you also consent to its storage in an archive for ten years. Your details will be stored securely and separately from the anonymised recording and transcript of your appointment. If you agree to the storage of your data in the archive, it may be used by other researchers investigating medical consultations and cancer care. However, they will only be able to access this data on request, and with good reason. The archive data will be deleted by *30/09/2030.*

Data Transparency

Nottingham Trent University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Nottingham Trent University will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.ntu.ac.uk/research/research-environment-and-governance/support-for-researchers-at-NTU and/or by contacting the Library Research Team at LIBResearchTeam@ntu.ac.uk

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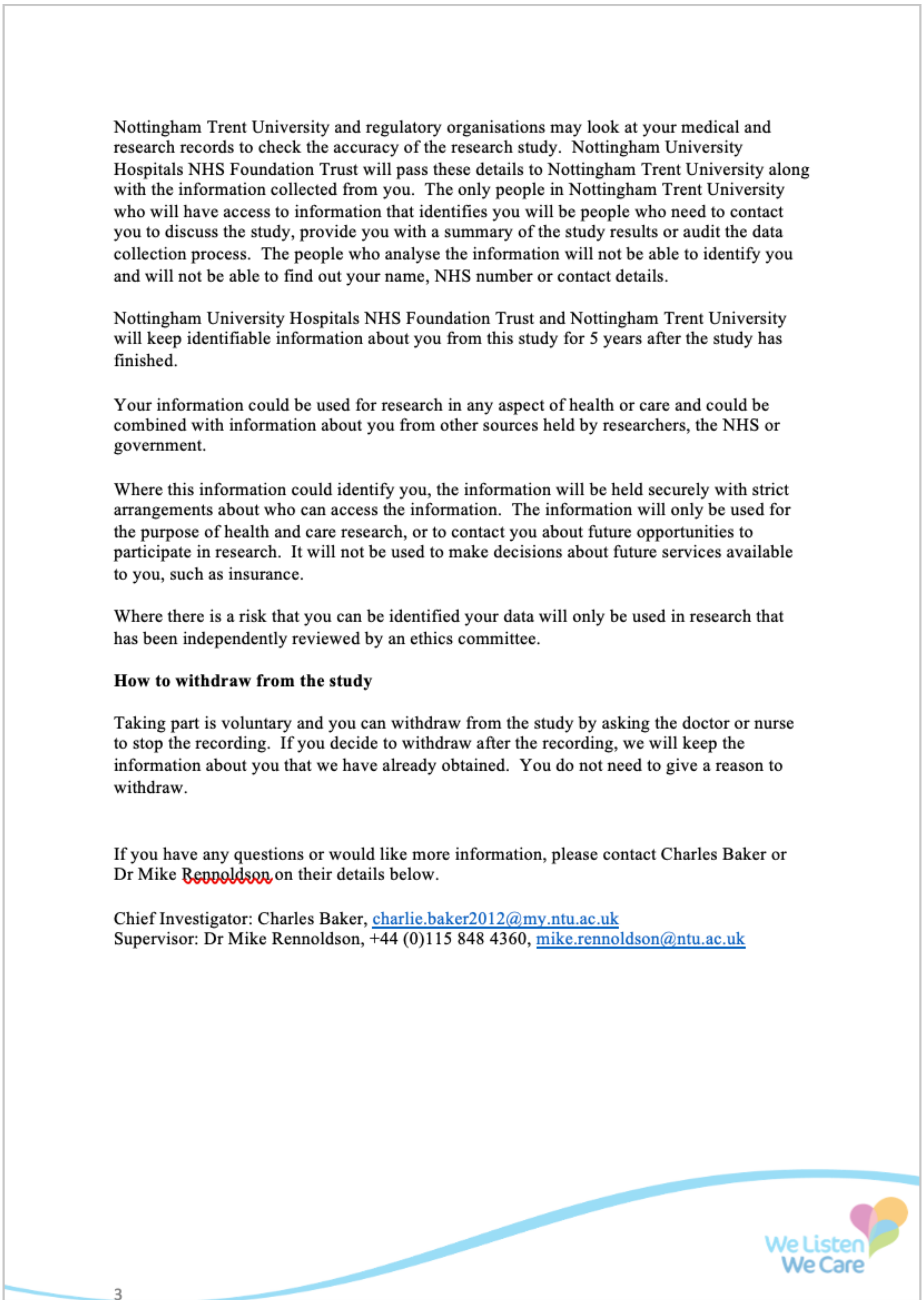

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Nottingham University Hospitals NHS Foundation Trust and Nottingham Trent University will keep identifiable information about you from this study for 5 years after the study has finished.

Your information could be used for research in any aspect of health or care and could be combined with information about you from other sources held by researchers, the NHS or government.

Where this information could identify you, the information will be held securely with strict arrangements about who can access the information. The information will only be used for the purpose of health and care research, or to contact you about future opportunities to participate in research. It will not be used to make decisions about future services available to you, such as insurance.

Where there is a risk that you can be identified your data will only be used in research that has been independently reviewed by an ethics committee.

How to withdraw from the study

Taking part is voluntary and you can withdraw from the study by asking the doctor or nurse to stop the recording. If you decide to withdraw after the recording, we will keep the information about you that we have already obtained. You do not need to give a reason to withdraw.

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Supervisor: Dr Mike Rennoldson, +44 (0)115 848 4360, mike.rennoldson@ntu.ac.uk

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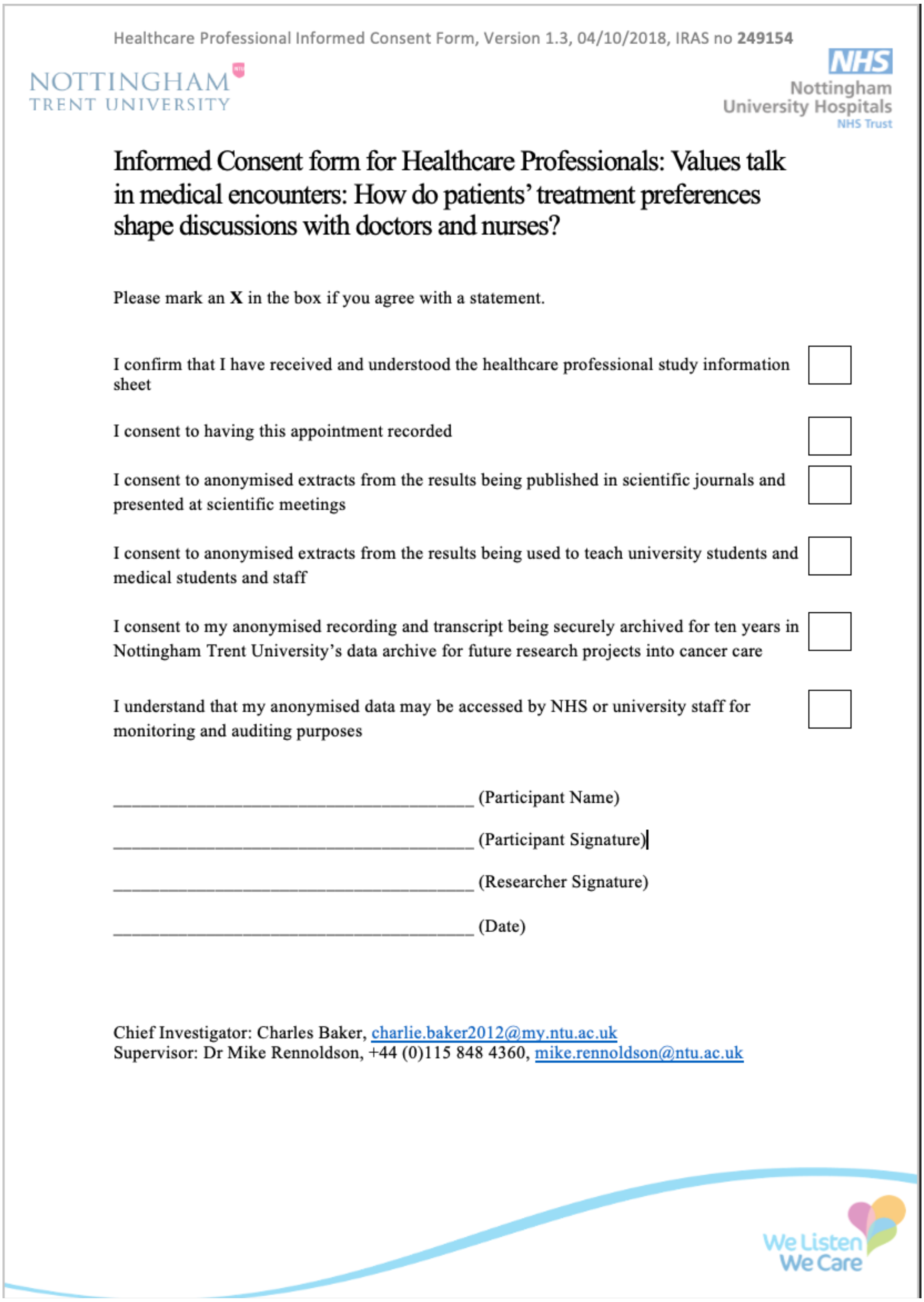
Appendix F

Consent forms given to practitioners



Healthcare Professional Informed Consent Form, Version 1.3, 04/10/2018, IRAS no **249154**

NOTTINGHAM
TRENT UNIVERSITY

NHS
Nottingham
University Hospitals
NHS Trust

Informed Consent form for Healthcare Professionals: Values talk in medical encounters: How do patients' treatment preferences shape discussions with doctors and nurses?

Please mark an **X** in the box if you agree with a statement.

I confirm that I have received and understood the healthcare professional study information sheet ☐

I consent to having this appointment recorded ☐

I consent to anonymised extracts from the results being published in scientific journals and presented at scientific meetings ☐

I consent to anonymised extracts from the results being used to teach university students and medical students and staff ☐

I consent to my anonymised recording and transcript being securely archived for ten years in Nottingham Trent University's data archive for future research projects into cancer care ☐

I understand that my anonymised data may be accessed by NHS or university staff for monitoring and auditing purposes ☐

____ (Participant Name)

____ (Participant Signature)

____ (Researcher Signature)

____ (Date)

Chief Investigator: Charles Baker, charlie.baker2012@my.ntu.ac.uk
Supervisor: Dr Mike Rennoldson, +44 (0)115 848 4360, mike.rennoldson@ntu.ac.uk

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Appendix G

Jefferson Transcription Conventions

The following are based on and taken from Jefferson (2004) except for the final convention which is my own

(0.2) Numbers in parentheses indicate time gaps in tenths of seconds

(.) A full stop in brackets denotes a pause smaller than two tenths of a second

[Words] Square brackets represent concurrent speech with the left bracket indicating onset and the right bracket the end of overlapping talk

= Equals signs indicate contiguity between utterances, such that speech is latched and there are no pauses between interlocutors

> < More than and less signs are markers of notable changes in the pace of speech. When pointed >inwards< utterances are produced quicker and when pointed <outwards> the production is notably slower

£ A pound sign is used for representing smiley voice, which means that the interlocutor is smiling while speaking

: Colons indicate that an utterance is being prolonged with more colons meaning greater prolongation

.h A full stop preceding a lower case “h” indicates an audible inbreath and the more “h”s there are the longer the inbreath

h A “h” with no full stop preceding represents an audible outbreath and the more “h”s there are the longer the outbreath

- A hyphen indicates a glottal stop as the interlocutor cuts off their production

(h) A “h” within brackets indicates either breathiness within the utterance or laughter particles interpolated with the utterance

Words Underlining a word indicates that it is being emphasised

↑ ↓ Up or downwards pointing arrows indicate marked shifts in the pitch of a production

( ) Empty brackets indicate inaudible productions that could not be transcribed

(Words) Words within brackets indicate a best guess at uncertain productions that could not be transcribed confidently

((Words)) Words within double brackets are descriptions of non-verbal context such as background noises

° ° Words enclosed within degree signs indicate notably quieter productions than the surrounding speech

WORDS Capital letters indicate that a production was produced at a notably higher volume and can be used for either individual letters or entire words

. A full stop marks falling intonation at the end of an utterance

, A comma indicates slight rising intonation at the end of an utterance

? A question mark represents sharp rising intonation at the end of an utterance rather than a question

Word Italicised words represent information that has been redacted to deidentify the interlocutor and mark these words as distinct from other material presented