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Introducing "A Question That Might, Perhaps, Scare you": How Geriatric Physicians Approach the Discussion About Cardiopulmonary Resuscitation with Hospitalized Patients

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ABSTRACT
Decisions about the relevance of life-sustaining treatment, such as cardiopulmonary resuscitation (CPR), are commonly made when a patient is admitted to the hospital. This article aims to refine our understanding of how discussions about CPR are introduced, to identify and classify the components frequently occurring in these introductions, and discuss their implications within the overarching activity (discussing CPR). We recorded 43 discussions about CPR between physicians and patients, taking place during the admission interview. We applied an inductive qualitative content analysis and thematic analysis to all the encounter content from the launch of the conversation on CPR to the point at which the physician formulated a question or the patient an answer. We identified this part of the encounter as the "introduction." This systematic method allowed us to code the material, develop and assign themes and subthemes, and quantify it. We identified four major themes in the introductions: (i) agenda setting; (ii) circumstances leading to CPR (subthemes: types of circumstances, personal prognostics of cardiac arrest); (iii) the activity of addressing CPR with the patient (subthemes: routine, constrain, precedence, sensitivity); and (iv) mentioning advance directives. Our findings reveal the elaborate effort that physicians deploy by appealing to combinations of these themes to account for the need to launch conversations about CPR, and highlight how CPR emerges as a sensitive topic.

Decisions about the relevance of life-sustaining treatment are commonly made when a patient is admitted to the hospital. A life-sustaining treatment is any treatment whose purpose is to prolong life without reversing the underlying medical condition, including mechanical ventilation, cardiopulmonary resuscitation (CPR), dialysis, artificial nutrition and hydration (Berlinger et al., 2013). In theory, decisions should be based on a trade-off between the expected benefits and risks of the procedure, whilst reflecting both patients' preferences and physicians' medical judgment about whether attempting CPR would result in a medically futile act (Elwyn et al., 2012). This implies an active dialogue between the physician and the patient, which is why the relevance of attempting CPR is routinely discussed with patients upon admission to the hospital (Hall et al., 2019). Prior research shows a clear tendency of older adults to not desire to prolong life through available medical treatments (Borrat-Besson et al., 2022; Sterie et al., 2021). However, in clinical practice, definitions of medical futility vary and there are yet no established criteria to determine when attempting CPR would be futile (Beck et al., 2022). These anticipatory decisions are all the more important for older patients, who, due to their age and comorbidities, are more at risk of developing health conditions warranting the need of one or more life-sustaining treatments, and yet, for whom certain of these interventions might have a poor result. Such is the case of particularly CPR, for whom survival is low (estimated at less than 28% for patients aged over 70 years by the most optimistic (Hirlekar et al., 2017) and even as low as 11% by others (van Gijn et al., 2014)) while associated to the risk of neurological problems and a long rehabilitation period. Given this, deciding whether or not CPR is relevant is not only a decision about what is medically feasible but also a reflection about patient's values and the meaning of quality of life, which highlights the need for delicacy.

Patient-physician communication about the relevance of cardiopulmonary resuscitation

Prior studies on patient-physician communication about the relevance of CPR (also referred to as the patient's "code status") reveal that hospital physicians rarely discuss the risks and chances of survival, use vague vocabulary to do so and are often elusive in sharing medical recommendations (Anderson et al., 2011; Deep et al., 2008; Sterie et al., 2021, 2022, 2022; Tulsky et al., 1995). Patient participation in the decision is influenced by a physician's understanding

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of the alternatives and the latter's assessment of the patient's clinical state (Becerra et al., 2011; Hurst et al., 2013; Perron et al., 2002). Discussions about CPR are a cause of ethical difficulty for physicians (Becerra et al., 2011; Hurst et al., 2013; Perron et al., 2002), which is confirmed by our own findings (Sterie et al., 2022). The most interest within the attention that this topic has gained over the past decades has been drawn toward the main components of the discussion about CPR: explanations about cardiac arrest and CPR (Sterie et al., 2021; Tulsky et al., 1995); reference to prognosis and outcomes (Einstein et al., 2015; Tulsky et al., 1995); formatting questions about decisions (Pecanac, 2017; Pecanac & Yanke, 2020; Sterie et al., 2022); framing the discussion as targeted toward "goals of care" instead of only CPR (Downar & Hawryluck, 2010); and offering recommendations in favor or against CPR (Einstein et al., 2015; Sterie et al., 2022).

Aspects such as how CPR discussions are initiated or introduced, and how physicians transition to discussing CPR after having discussed an unrelated topic ("agenda setting", Gobat et al., 2015) might have understandably been considered to be of less interest, in spite of their important role, especially in conversations about these sensitive topics. Several studies show that agenda setting improves patients' outcomes and experiences (Hood-Medland et al., 2021), as well as a physician's understanding of patient needs and organization (Rodriguez et al., 2008), and lowers the number of unaddressed concerns that patients introduce at the end of the visit (Dyche & Swiderski, 2005). Findings about agenda setting in medical encounters focused on CPR or similar decisions related on end of life are often presented incidentally, alongside the focus on a more ample phenomenon (such as decision-making). Deep et al. (2008), for example, showed through an interview-based study of resident physicians that 42% of their participants reported using a "disclaimer," supposedly aimed at normalizing the need to discuss CPR with the patient (e.g., "I don't want to scare you with what I am about to talk with you [...]"). Using natural data (recordings of CPR discussions between physicians and patients), Anderson et al. (2011) note that in 78% of cases, physicians tell patients that they discuss the code status with all patients (e.g., "We ask everyone these questions when they come into the hospital"). Pecanac (2017) looked at how decision-making about the relevance of life-sustaining treatments (including CPR) was initiated in conversations between clinicians and healthcare proxies. She identified several mechanisms for the "transition" into talking about decision-making, of which the one most employed was the "perspective-display sequence" (previously identified by Maynard (1991)), through which clinicians ask surrogates for their view (or "perspective") and afterward give their assessment by incorporating this view. Consequently, physicians avoid disclosing a decision that is medically relevant in terms that might be perceived as too abrupt, and fit their assessment to involve and build on what surrogates think and say. One resource that physicians recurrently employed to launch the perspective-display sequence was the reference to prior discussions about the relevancy of life-sustaining treatment or similar wishes. Nevertheless, the content of how physicians introduce discussions about decisions concerning the relevance of life-sustaining interventions has not been systematically and exhaustively studied.

We contribute to existing literature on medical communication about end-of-life decision making by focusing exclusively on how conversations about CPR are introduced and initiated. To achieve this, we identify and classify the components frequently occurring in introductions and discuss their implications with the overarching activity (discussing CPR). We equally strive to show that introductions are an important part of CPR discussions, with physicians drawing on a wide array of communicational resources and means which have been underexplored in literature on this topic.

Materials and method

Setting and participants

The study took place in the geriatric rehabilitation facility of a university hospital in Western Switzerland (francophone region). Participants were patients who were in the process of being admitted and resident physicians who dealt with their admission. Written informed consent to audio-record admission interviews was obtained from physicians (at the beginning of the study) and patients (1–2 days prior to admission). In order to minimize bias, participants were told that the study aimed to investigate physician-patient communication, without specifying the focus on CPR beforehand. Patients had no cognitive problems that would impact their decision-making capacity, as determined by a physician's assessment of their medical file (RJJ or ERT).

In the setting in which we collected the data, it was hospital policy that decisions about whether or not CPR should be attempted in case of cardiac arrest should be made as soon as possible. In order to respect patient autonomy, these decisions were officially part of the routine topics at admission interviews. Yet, in several cases, physicians didn't address CPR in their admission interviews (Sterie et al., 2021). All the patients that participated to our study had been transferred to the geriatric facility from another service within the same hospital. This means that in the prior days or weeks, they had already participated to another admission interview in their prior service and might have been exposed to the discussion about CPR. This was a recruitment criterion in our study, due to the fact that the regional ethics commission required that patients be informed of the study 24 hours before being recorded.

Data collection

We recorded 43 physician-patient admission interviews between June 2017 and January 2018. All interviews were conducted in French. Personal data was erased from the audio files and participants' voiceprints were blurred using voice conversion software (Audacity) in order to maintain confidentiality. The audio recordings were preceded by 10 ethnographic observations (ACS).

Fifty-one patients and 17 physicians gave consent to their admission interviews being recorded. Forty-three conversations involved a discussion of the patient's resuscitation wishes. The parts of interaction which focused on CPR were selected and transcribed.

The project was approved by the regional research ethics commission (2017–00229).

Data analysis

The introductory segment was comprised of all the encounter content from the launch of the conversation to the point at which the physician formulated a question or the patient an answer (as shown in our previous publications (Sterie et al., 2022), patients sometimes formulate answers preemptively, in anticipation of a question that actually never comes). A preliminary observation of this part of the CPR conversation revealed that introductions were often very rich, containing several references to various elements related to the activity (discussing CPR) and its content (topic of CPR itself), with which patients only seldomly engaged. This inspired us to use a combination of inductive qualitative content analysis (Schreier, 2013) and thematic analysis (Braun & Clarke, 2012). We chose these approaches combined because they allow to identify, locate, and describe reoccurring patterns throughout the data, and condense them into themes and sub-themes.

Initially, ACS (a sociologist) and OW (a linguist) identified all introductions in the conversations recorded on the basis of verbatim transcriptions. Working in parallel, they read through the data several times, identified the components encountered in the introductory segments (what physicians refer to), and coded this information. Codes were developed inductively and identified a variety of types of information (e.g., how cardiac arrest is described) and activities (e.g., referring to the fact of being in the process of asking a question). Both authors developed an initial coding framework containing the preliminary codes developed inductively and the conversation extracts associated to the codes. Codes were compared, discussed and reviewed. On the basis of the reviewed coding framework, all transcripts were then coded into themes and subthemes by ACS. Themes were not mutually exclusive of each other and could occur in tandem. Interpretation of themes and subthemes was developed in tandem between ACS and OW, with input from RJJ (professor in palliative care, neurologist and ethicist) and ERT (a medical doctor specialized in geriatrics). Each theme and subtheme were associated to quotations from conversations. Coding, theme and subtheme development, and interpretation was done in French. While our focus has been on how physicians formulate introductions, we equally looked at whether the themes and subthemes that we identified could also be located in patients' discourse. We refer to these cases occasionally in a way that sheds light on the relevancy that particular themes might have in this context.

The quotations used in this paper were translated from French to English by ACS and proofread by another collaborator.

Results

We identified four major themes in the introductions: (i) agenda setting; (ii) circumstances leading to CPR (subthemes: types of circumstances, personal prognostics of cardiac arrest); (iii) the activity of addressing CPR with the patient (subthemes: routine, constraint, precedence, sensitivity) and (iv) mentioning of advance directives.

Agenda setting

Physicians used an "agenda setting" formulation in 34/43 (79%) conversations that announces that a new topic will be initiated and is part of the official agenda (Table 1).

The function of "agenda setting" is to announce a list of topics that will be discussed during the encounter and defines its trajectory. It, thus, allows participants to align on content, the consequences of the encounter, and relational rules or roles (Gobat et al., 2015). It is most often used at the start of a clinical encounter, but as Gobat et al. (2015) note, it can also be included during the encounter, especially when a realignment between participants is needed. Thus, the presence of agenda setting resources in the majority of our data points to the fact that CPR is considered as a new item in the encounter, distinguishable from the ones before, and potentially one that had not been announced at the start of the interview (since it has to be stated here) but needs to be introduced before approached, and, therefore, might be heard as unexpected by the patient otherwise. In many cases, agenda setting can be particularly detailed, as physicians are attentive to contextualizing the topic as "just one more" or "the last one," providing not only a sense of continuity within the encounter (as a suite of questions) and attentiveness to explaining and rendering the activity flow explicit (Robinson & Stivers, 2001) but also a consideration toward it, contributing to lengthening it and potentially burdening the patient. As discussed in our previous work, an interesting paradox is the fact that indexing an upcoming question is not always followed by a question, since physicians sometimes stop short of actually formulating it (Sterie et al., 2022).

Circumstances leading to CPR

One of the items that was prevalent in introductions was the reference to cardiac arrest as the circumstance that might make CPR relevant (36/43 or 84% of conversations). Reference to cardiac arrest was variable throughout the data. Table 2 shows an inventory of these occurrences.

Table 1. Agenda setting formulations.

	Number of occurrences	Example
Simple initiation	12	"I will ask you a question"
Another question	11	"Just one more question"
An initial or closing question	9	"One of the first questions I have;" "And just one last question"
Uptake on the patient's reference	2	"That's exactly my next question"

Table 2. Types of circumstances leading to CPR.

	Number of occurrences	Example
Cardiac arrest	34 (61%)	"If you have a cardiac arrest," "If your heart stops"
Loss of consciousness	4 (7%)	"If you are unconscious," "If you cannot say what you wish for"
Serious circumstances	13 (23%)	"In case of serious complications"
Undetermined circumstances	5 (9%)	"If something happens"

Formulations in which a physiological cause is made explicit were the most recurrent (68%). They typically concerned a heart problem, specified as either “cardiac arrest” or put in lay terms (“heart stops”), though in one case, the physician mentioned a “lung arrest” and four times, loss of consciousness. Physicians may also have been more equivocal, referring to “serious complications,” an aggravating yet vague formulation that builds upon the patient’s situated understanding of the seriousness of their own condition and their imagination. Taken individually, some of these subthemes may concern generic life-threatening and urgent conditions that require life-sustaining treatments (for example, the reference to “loss of consciousness” also applies for stokes). However, they also typically occur alongside other elements of the discussion, brought on by the patient or the physician, which explicitly refer to cardiac arrest or resuscitation (“if there is a serious complication, and when I talk about serious things, it’s really serious things, I mean if, it can happen here or elsewhere or not at all, if you have a heart problem, should we resuscitate it?”). None of the physicians referred to the terminology of “clinical death.” Up to three references to cardiac arrest may have been used in one conversation (15 cases), to work out the meaning of cardiac arrest (“if you have a cardiac arrest [. . .], if the heart has stopped”) or give more concrete details (“if something unforeseen happens, a heart arrest, a lung arrest”).

The syntactic construction of these references varies. Exemplarily, 34 of the 36 references were made with the use of the hypothetical “if” (sometimes emphasized with formulas such as “if one day” and “if ever”) and two only with “in case.” Both formulas project the circumstances as hypothetical and conditional for CPR to be undertaken, though the latter can be heard as slightly more circumstantial than the former. We also noted that several tenses were used, fluctuating between the simple present (“if the heart stops”/”if you have a cardiac arrest”) and the past (“if the heart has stopped”/”if you had a cardiac arrest”). Other formulas tended to present cardiac arrest as something sudden (“if the heart came to a stop”/”if all of the sudden”).

Not only was the hypothetical scenario widely used in our data set, but the mere mention of cardiac arrest prompted an early decision from the patient in 25% of the cases (7/36). This was discussed in our previous work (Sterie et al., 2022).

In 15/43 conversations physicians referred to the risk of cardiac arrest happening, thus, touching on personal prognostics (second subtheme associated to this theme). The reference was used to embellish the conjectural character of a cardiac arrest for the specific patient (15 conversations, see Table 3).

Table 3. Prognostics of cardiac arrest.

	Number of occurrences	Example
No chance of happening	6 (14%)	“If you have a heart arrest, it will surely not be the case here”
Low chance of happening	4 (9%)	“It’s a rare situation, but if the heart stops”
Not linked to current health	3 (7%)	“It’s not your case, you’re doing well for now, but if something serious happens”
A question of chance	2 (5%)	“It can happen here or elsewhere”

These references downplay the relevance of the patient being at an actual risk of cardiac arrest. However, their effect is sometimes somewhat paradoxical in situations in which the gravity of the hypothetical situation is also heightened (“you’re doing well for now, but if something serious happens”).

The references to the prognostics of cardiac arrest were initiated by the physician (not as a response to the patient asking or making a comment) in all cases; in two cases, the patient provided a continuer (“uh huh” or “yeah”) after the reference and in one case, the patient picked up on the reference to overtly confirm (see Excerpt 2, “No, no, I’m very happy”).

Addressing CPR with the patient

The third theme that we identified does not relate to the content of the discussion but to the activity in itself: addressing the CPR topic. We identified four subthemes related to this theme: routine, constraint, precedence and sensitivity.

Physicians referred to the routine character of the CPR talk in 22 conversations (42%; Table 4).

When referring to routine projects, the discussion was dissociated of the patient’s diagnostic or age. The agency of the action was often displaced toward the community of physicians (“we ask”), thus, removing any claim of personal authority over needing to address the topic.

Physicians also referred to the discussion as being led under constraint (10 conversations, 24%; see Table 5). This subtheme is very related to “routine,” since routine can be understood as a manifestation of constraint. The essential difference between the two subthemes is that in references to constraint physicians made more explicit the weight of the imposition that they themselves felt, while references to routine were more oriented to explain that discussion CPR is a normal and standard topic in the medical interview.

Constraint can be attributed to the institution or the role of the physician, thus, referring to an implicit code of conduct. This reference allows the physician to distance themselves from the individual responsibility of posing the question, emphasizing a top-down system that they are obeying (Stokoe & Edwards, 2008). It also urges the patient to be

Table 4. Reference to routine.

Reference to routine	Number of conversations	Example
A question asked to everybody	18 (42%)	“We ask all the people who arrive at the hospital,” “A question that we ask each patient who is hospitalized”
An administrative matter	4 (9%)	“It’s an administrative question,” “We have another standard question”

Table 5. Reference to constraint.

	Number of conversations	Example
Institutional constraint	5 (12%)	“We are obliged to ask,” “I follow the order of the computer”
Professional constraint	5 (12%)	“As physicians, we need to know”

Table 6. Reference to precedence.

	Number of conversations	Example
Certainty that the question has been asked previously	11 (26%)	"Surely my colleagues have already asked you the question," "Someone already asked you"
Relative certainty that the question has been asked previously	6 (14%)	"I suppose someone already asked you"
Physician admits to repetition	3 (7%)	"Excuse me for asking again"
Physician enquiries whether patient had thought about CPR	2 (5%)	"Have you ever thought about whether [. . .] the doctors should resuscitate you?"

attentive and conform, and conveys the legitimacy of the upcoming action.

Physicians displayed an expectation that the patient had already been asked about CPR at the previous hospital admission in 51% of the conversations (22 conversations; see Table 6).

In this particular context, patients' files contain information including whether and when CPR was last discussed. The expectation of a patient having discussed CPR in the not so distant past is also built on the fact that all patients admitted to this facility were actually transferred from another department of the same hospital in which the CPR discussion was also mandatory. And yet, hospital policy requires that CPR must be discussed and reassessed at each patient admission, in order for it to be responsive to the patients' evolving condition and their autonomy to change their preference.

Reference to precedence was made with a varying amount of confidence, which may be induced by the type or quality of information available (in some cases, the prior CPR decision was documented in vague terms). However, only two of the physicians asked the patient to confirm this presumption or elaborate on it, in these cases, the use of the reference being that of a perspective-display invitation (Maynard, 1991).

Precedence is something to which patients also orient, whether physicians refer to it or not, for example, in the following excerpt, in which the patient's medical file at the moment of the interview had a previously documented code status in favor of CPR:

Excerpt 1: Conversation C24

Physician: *Then, we have another standard question that we ask everyone. If your heart stops,*

Patient: *Yes, someone already [. . .] four times.*

Physician: *Right, right, everyone asked this.*

Patient: *Four times.*

Physician: *And what would you say?*

Here, the patient's statement of the precedence of the discussion is implicitly an acknowledgment of having recognized the topic of the discussion by virtue of how it is initiated, before the topic was even mentioned by the physician. Importance was given by the patient not to the precedence itself but to its recurrence (since he repeats "four times").

In another case, the absence of precedence was a problem for the patient, whose medical file indeed did not contain any information about a prior code status or discussion about CPR:

Excerpt 2: Conversation C14

Physician: *Tell me, I have a question that we ask all people who come to the hospital.*

Patient: *Yes, tell me.*

Physician: *In case of a complication, there won't be any complication, you've come for the pain.*

Patient: *No, no, I'm very happy.*

Physician: *If you have a cardiac arrest, if your heart stops beating. Would you want us to resuscitate you? It means doing an electric shock.*

Patient: *Oh my God! It's the first time, it's the first time that someone has asked me this question.*

Throughout the unfolding of the introduction, the patient displayed collaboration though not recognition of the topic (similar to the previous excerpt). Upon hearing the topic of the discussion and what is asked of her, she displayed a strong reaction that was immediately accounted for on the basis of not having previously discussed this with anybody else.

Physicians referred to the sensitivity of the upcoming topic in nine conversations (21%; see Table 7).

Table 7. Reference to sensitivity.

Reference to sensitivity	Example
	"A question that might, perhaps, scare you," "It should not anguish you"
	"It's brutal," "A question that is a bit more delicate"

Just as when referring to the prognostics of cardiac arrest, physicians may strongly assert that a negative reaction will happen ("it's brutal"), suggest a negative reaction is not warranted ("it should not anguish you"), or use more hedging about the possible reaction ("might, perhaps, scare you"). Physicians presented the topic as potentially sensitive to the patient in about half of the cases, thus, showing an awareness of different patient subjectivities and a concern for their welfare. As the previous excerpt (Excerpt 3) showed, in some cases, patients displayed sensitivity

at hearing the topic ("Oh my God!"), thus, confirming physician expectations that some might find it delicate to broach this subject.

In the remaining cases, physicians presented the topic as delicate from a more objective point of view, always using the present tense ("it's brutal"). Sensitivity is dealt with as being factual rather than subjective; it does not exclude the physician from experiencing it.

Advance directives

While advance directives was not explicitly a topic that was supposed to be discussed during the admission interview, in a minority of cases physicians questioned patients on whether they might have already established advance directives or a therapeutic representative (9/43 conversations, 21%). This gives way to the patient confirming having done so and sharing their decision regarding CPR in only one case. In the remaining cases, patients denied having advance directives or a desire to complete them, which led the physician to address CPR more directly, such as in the following excerpt:

Excerpt 3: Conversation C7

Physician: *And there's a question that we ask all the time when patients come to the hospital, I don't know if you have advance directives?*

Patient: *No, I don't feel like doing that.*

Physician: *What?*

Patient: *I don't want to fill that out.*

Physician: *All right. So us, as physicians, we are, we need to know what is the attitude that you desire when facing things that could happen when you are in the hospital. It shouldn't happen but if, for example, one day your heart stops and we find you unconscious, would you wish us to do a cardiac resuscitation?*

As the excerpt shows, advance directives are introduced with resources very similar to CPR, here with reference to routine and a relative degree of certainty, which mitigate the potential effect of its introduction as a topic on the agenda. Yet, reference to advance directives is, in itself, also an opportunity to engage with the topic of CPR more tentatively, either by identifying whether patients have already decided about CPR in a formal way (which gives way to asking for that decision) or by identifying a gap in the patient's prior engagement. It is equally an opportunity to move the patient to think about treatment decision making/life-sustaining treatment more broadly, before discussing CPR specifically.

Combos of mitigators

We identified particularly those among the subthemes that have the function of mitigators, such as "agenda setting," "routine," "precedence," "sensitivity," "prognostics" and "constraint," as they work to project the topic as delicate (Schegloff, 2007; Silverman & Peräkylä, 1990). As Table 8 shows, mitigators are frequently encountered in combinations, with the most frequent one having four mitigators.

Table 8. Combos of mitigators.

Number of mitigators	Number of conversations
• None	3
• One	9
• Two	6
• Three	11
• Four	12
• Five	2

Analysis with MaxQDA did not identify any correlations in combinations between mitigators. However, the most frequent combinations for three mitigators were: "Agenda"-"Prognostic"-"Precedence" (three cases) and "Agenda"-"Routine"-"Precedence" (three cases); and of four mitigators: "Agenda"-"Routine"-"Sensitivity"-"Prognostic" (three cases) and "Agenda"-"Routine"-"Sensitivity"-"Precedence" (three cases).

The physician employs five mitigators in the following excerpt.

Excerpt 4 : Conversation C3

Physician: *Miss ((name)), I would now like to know, in our entry form, so in our interview, we have some formatted questions that probably someone has already asked you at the hospital. If the heart beats [. . .] it's brutal but we are obliged to, to, to ask this question so that we know what to do if anything happens. So I would like to know, if the heart stops, what do we do?*

Patient: *If?*

Physician: *The heart stops, what do we do?*

Patient: *Nothing.*

The physician first introduced the agenda setting ("I would like now to know"), then the reference to routine via the administrative ("entry form," "formatted questions"), followed by reference to precedence ("probably someone asked you"), to sensitivity ("It's brutal") and, finally, to constraint ("we are obliged"). The compounded effect of these mitigators is to delay the introduction of the topic so that the patient is prepared to hear, understand and potentially reply to it on the spot. They provide an empathic bracketing of the main activity (discussing CPR) until a secure ground for it is reached. This introductory fragment is laden with repetitions and reformulations, which show that the physician is dealing with aspects that render the topic difficult, most especially the fact that the formatted entry form is not fitted to a discussion about the end of life and its conjuring might be brutal for the patient, even in the context of prior knowledge of the topic. Each mitigator has a job by itself, but they also work as a compound. The

"brutality" (as announced by the physician) of the topic is counterbalanced not only by its open recognition, but also by the reminder that this is a standard interview on admission, that the patient has already dealt with the topic before and that the discussion is a necessity for hospital business.

In her uptake, the patient only orients to the hypothetical clause that makes her response relevant (thus, the progressivity of the interaction) and disregards all the mitigators. This goes to show that at times, even when physicians display a lot of attentiveness toward the patients' needs, patients might instead focus on the progressivity of the interaction.

Discussion

An inductive qualitative content and thematic analysis allowed us to inspect the content of how physicians initiate discussions about CPR, which account for an important part of these conversations. We identified four major themes: (i) agenda setting; (ii) circumstances leading to CPR (subthemes: types of circumstances, personal prognostics of cardiac arrest); (iii) the activity of addressing CPR with the patient (subthemes: routine, constraint, precedence and sensitivity) and (iv) mentioning of advance directives. These themes play several roles: that of bringing about a new topic into the conversation, of downplaying and, at the same time, setting up its importance, and of being a cue to the patient's recognition of what is being discussed and what will be required of them.

The predominance of "agenda setting" (theme 1) reveals that issues of realignment between participants (Gobat et al., 2015) are deemed important by physicians and that this needs to be secured before proceeding further. The CPR is a new topic in the admission interview: it is never set in the agenda at the beginning of the interview (probably because it is too specific), but its specificity requires a recalibration of the discussion, because it goes from anamnesis to decision-making, and patients need to be made aware that they enter a setting with different constraints. As noted in some of our previous work (Sterie et al., 2022, 2022), physicians initiate talk about CPR in an environment that is perhaps not the most conducive for patients to make spontaneous decisions nor for physicians to ensure that these decisions are made in an informed way. The anamnesis format in which CPR is routinely discussed ensures that this topic can also be heard by patients as a "mere" information-seeking activity about a banal aspect of life (such as smoking or alcohol use), and not a critical decisional moment about a life or death issue. By signaling the new topic as such, physicians highlight its specificity and prepare patients for hearing and dealing with it as something different from that which was discussed before.

Reference to circumstances that would make CPR relevant (theme 2) is made with various formulations that range from very specific, such as "cardiac arrest," to vaguer, such as "serious complications." The vagueness of the language employed in these conversations was also noted in other studies (Tulsky et al., 1995). Information needs to be tailored to the understanding of the patient, of which physicians have little prior knowledge. Vague language that is not clinically specific is used to soften talk about potentially distressing subjects and mitigate the demand that it puts on the patient (Adolphs et al., 2007). A reference to "serious complications" is oriented to the gravity but also leaves space for the patient to feed the description about their knowledge of what might be a complication or the complications that they have already discussed.

Throughout the data, CPR emerges as a sensitive topic through the elaborate effort that many physicians deploy in launching these conversations and accounting for them by setting it up as a legitimate agenda item, by referring to prognostics (the limited relevance that cardiac arrest presumably has for the patient), to the routine, repetitive, and institutionally constrained character of this conversational element, and its sensitivity (all subthemes of theme 3). Indeed, combinations of these mitigators were encountered in over 70% of our data. Such "pre-delicate perturbations" are often encountered in doctor-patient conversations about sensitive topics (Pecanac, 2017; Silverman & Peräkylä, 1990). They project the upcoming topic as unexpected and possibly problematic, therefore, needing to be explained (Antaki, 1996; Heritage, 1988; Pomerantz, 1984).

References to limited relevance, routine and institutional constraint in our data downplay the importance of discussing CPR and minimize the threat that this discussion might pose to the patient or the patient-provider relationship. They also reveal implicitly that the act of engaging in such a delicate activity may also be distressful for the physician. We see throughout many of these introductions how physicians build and consolidate their entitlement of discussing CPR by introducing multiple justifications for taking about this topic.

The reference to "precedence" is of particular interest when discussing medical decision-making and medical interaction in general. Heritage and Robinson (2006) argue that interactions between doctors and their patients are often preceded by an exchange of information with other health professionals, and this information is entered in the patient's file prior to meeting their doctor. This context can complicate how encounters are initiated and particularly how doctors solicit patients' problems, since "physicians, who may be somewhat cognizant of patients' problems, must decide how much of that knowledge to display when soliciting patients' accounts of them. Patients, who may assume that their previously disclosed information has been made available to physicians, must decide how much repetition is appropriate when representing their problems" (p. 90). Heritage and Robinson show that, in response to this contextual challenge, patients sometimes explicitly introduce references to the fact that they are repeating themselves even when doctors do not refer to this prior information. In a similar vein, Abe et al. (2023) show how doctors use preexisting information from a medical questionnaire filled in by the patient before the encounter as an interactional resource in soliciting and presenting problems. They particularly argue that patients are more confused when doctors use open elicitors to solicit their problems without mentioning the information obtained through the medical questionnaire (e.g., "Would you tell me what brings you here today?") vs. cases in which doctors refer to the medical questionnaire (e.g., "I've read your medical questionnaire [. . .] Can you tell me again what your trouble is?"). At the same time, the latter are even more successful when specifically formatted as a "licence to repeat information" (Abe et al., 2023, p. 83).

Pecanac (2017) also showed that asking about prior discussions is a resource that physicians use for inviting surrogates to discuss whether life-sustaining treatment is relevant or not (e.g., “Have you ever discussed with him what his wishes would be?”) and disclosing a narrative of this prior discussion. In our data, the physician asserts, with a variable degree of confidence, in 46% of the conversations that the patient may have already discussed CPR before their interview. Nevertheless, with two exceptions, the reference is never employed to obtain a confirmation from the patient, but used mid-turn as the physician continues to initiate talk about CPR. This reference displays an expectation that the patient will recognize the question and its purpose, in order to facilitate a fast retrieval of an decision which has already been made (Pecanac, 2017). Reference to precedence also brings forth a sense of connectedness in hospital work. This account signals the doctor’s wariness of the fact that repeatedly discussing CPR at admissions might be bothersome (Sterie et al., 2022). The physician’s expectation is grounded in the fact that all patients had been admitted to the hospital before their transfer to the rehabilitation unit and are supposed to have already had a very similar medical interview in which the code status decision had to be documented. However, a display of this expectation may be detrimental to the purpose of the conversation. It assumes, for example, that having a prior code status documented means that the topic was discussed and the patient’s attitude has not changed since, though this is not necessarily true. According to our ethnographic observations, physicians sometimes document it based only on the medical evaluation. It is also unclear under which circumstances this decision was made and whether the patient actively participated. Furthermore, mentioning certainty about this prior discussion and while not explicitly making relevant for patients the need to confirm or elaborate does not encourage patients to make a decision based on their current health status, but merely to report one that had already been taken. In this way, physicians disregard their role in aiding some of their patients to decide about CPR at the moment of their readmission.

Very similar to “precedence,” reference to advance directives (theme 4) concerns prior decisions that the patient might have made on the topic of code status. In Switzerland, advance directives are used to document decisions about CPR as well as other life-sustaining treatments; however, they are not that well-known, especially in the Francophonie (Vilpert et al., 2018). Hospital physicians don’t (yet) have an official mandate to encourage or support patients to do their advance directives. In our data, reference to advance directives is always made in the form of a questioning, in which the patient’s participation is required. This can move the patient to think about treatment decision making/life-sustaining treatment perhaps more broadly.

Our data also shows that the discussion takes place in a context of contrastive demands. On the one hand, physicians need to tend to the therapeutic relationship in which they express care and concern for patients’ experiences of what is discussed. Introductions seem to play an important part or be an important resource in tending to the relationship, in prospective terms, by addressing anything that might endanger it. On the other hand, they need to pay specific attention to the progressivity of the encounter, to secure its accomplishment in a time-efficient and productive way.

The originality of our findings reside in the quality of the data. Indeed, naturally occurring interactions give much more profound insight on what actually happen in the discussions, compared to interviews and surveys which can only provide participants’ perceptions and opinions on what could or should happen. Looking at such data allowed us to understand how a sensitive and important topic, such as medical decision-making about a life-sustaining treatment, is introduced as a secondary element into a larger agenda, that of the admission interview. In our data, the CPR decision is just one of the numerous topics discussed between the physician and the patient, yet it is unlike any of them since it does not imply merely an information exchange (such as the history taking) but the joint construction of a decision. By combining content and thematic analysis, our study contributes to the body of literature focusing on the interaction details of transition sequences, by identifying, categorizing and counting reoccurrences of elements that may play display the delicacy of the topic.

Limitations

We acknowledge that our findings are specific to the context in which we collected the data. As explained in the description of our setting, all the patients that participated to the recordings had been transferred from another service, which means that there is a strong possibility that they had already discussed the relevance of CPR in the recent past. It is unclear to what point this information influenced the way in which physicians discussed the topic at a transfer between services and whether similar patterns might be identified in initial admission interviews.

Practice implications and directions for future research

Our findings offer the evidence that physicians invest a lot of work in the introductory segments of discussions about CPR, and that these transitions display a quasi-empathic concern toward more relational aspects that need to be secured before proceeding to a discussion and decisions about life and death. Patients might, at times, be sensitive about these aspects, though not always. Nevertheless, the conversations in our corpus show how physicians address a topic that they consider as sensitive and complex for patients, even before patients signal that. Our findings equally highlight the importance of context, notably the fact that the nature of CPR discussions (oriented toward decision-making) is not suited to that of the encounter (oriented toward the anamnesis and examination), and that engaging patients in talking about sensitive issues in such conditions can be a challenge. Prior research found an association between communication interventions and better patient knowledge about CPR (Becker et al., 2019). We believe that findings such as ours can inform communication skills training programs for physicians that are adapted and responsive to the actual challenges that they encounter.

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