

# Discussing care decisions at the internal medicine outpatient clinic: A conversation analysis

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## ABSTRACT

**Objective:** Explore how often, when and how care decisions are discussed during consultations at an internal medicine outpatient clinic, and what we can learn from these observations.

**Methods:** Qualitative analysis of 150 video-taped consultations. Consultations involving a discussion of care decisions were analyzed using conversation analysis.

**Results:** 1) Only 21 of the 150 consultations involved a discussion of care decisions; 2) As there is no destined phase for the introduction of the topic of care decisions, the topic is most often introduced at the end of the phase 'treatment and course of the disease'; 3) A lot of interactional effort is needed to create common ground and make relevance clear with extensive justification. Hesitation markers, repairs and hypothetical talk show the precariousness of the topic.

**Conclusions:** Three dilemma's need to be addressed: 1) a slot has to be created to introduce the topic of care decisions; 2) common ground has to be created, possibly over time; 3) the paradox of framing the topic as relevant 'in the future' but 'needs to be discussed now' needs to be attended to.

**Practice implications:** We recommend that physician training should address the three dilemmas. Future research should focus on how to do so.

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## 1. Introduction

In 2014, the Dutch Association of Internal Medicine published a list of ten 'Wise Choices' in internal medicine as part of the nationwide 'Choosing Wisely Campaign' [1–5]. One of these 'Wise Choices' is for doctors to discuss care decisions when talking to patients about their treatment [2]. Care decisions comprise a broad spectrum of topics, including discussions of code status and do-not-resuscitate orders as well as advanced care planning (ACP). In this paper, we focus on patient-physician communication about code status (patient preferences regarding resuscitation, mechanical ventilation and Intensive Care admission) and other possible treatment options such as dialysis, hospital admission and tube feeding.

Previous research has shown that both patients and physicians find care decisions a precarious topic that they tend to avoid [6]. Despite numerous barriers for physicians and patients (e.g. feeling

unskilled; unawareness of the relevance[7–11]), care decisions should be a regular part of patient-physician communication [2] and patients should be engaged in the decision-making process [12,13]. It is argued that timely discussions of care decisions can lead to care that is more closely aligned with patient preferences and involves less health care consumption [14]. This topic is, however, often postponed until the end of life, reflected in the fact that research is conducted predominantly in end-of-life settings [6,11,15–17]. If such discussions are not timely, they take place in far from ideal circumstances, such as an acute setting in the emergency department when time is limited and the patient is severely ill [10]. The outpatient clinic, where patients often consult a familiar physician, seems better suited to such conversations [18]. In this paper, we examine video-taped consultations at the internal medicine outpatient clinic. We counted *how often* care decision conversations occurred within our data. Using conversation analysis (for an explanation of conversation analysis see [19]; for an example, see Erkelens et al. (2020) [20]), we then analyzed *when* (in which phase of the consultations) and *how* the topic of care decisions is introduced. Insight in these patterns could be used to guide future practices.

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## 2. Methods

### 2.1. Study design

This study is part of a larger project aimed at stimulating and improving care decision conversations at the internal medicine outpatient clinic of University Medical Center Utrecht, a tertiary care teaching medical center in the Netherlands. This study was approved by the Medical Ethical Testing Committee Utrecht (MEC 18–465) and registered in the Dutch trial register (NTR 7188).

Eleven physicians (residents and staff physicians) from different specialties of the department of internal medicine participated in this study. A total of 185 of their patients agreed to participate. Randomization software was used to randomly select patients, stratified by gender, who were assigned patient education<sup>1</sup>. Physicians were trained<sup>2</sup> halfway through the study period. This resulted in four groups: 1) physicians before training and patients without patient education; 2) physicians before training and patients with patient education; 3) physicians after training and patients without patient education; 4) physicians after training and patients with patient education. This project involved both quantitative and qualitative analysis. This paper focuses on the results of the qualitative analysis.

### 2.2. Video recordings

The outpatient clinic visits were video recorded for purposes of qualitative analysis. Since the consultation rooms had different set-ups, the extent to which both participants were visible varied. Fig. 1 shows that we set out to record 185 consultations. Thirty-five recordings failed for various reasons, for example camera malfunction, last-minute location change, or camera inadvertently not switched on. This means that the resulting dataset consists of 150 recordings.

### 2.3. Analysis

All video recordings were assessed by one of the authors (SB) to determine whether or not the consultations involved a discussion of care decisions (see our description in Section 1). The recordings in which care decisions were discussed were transcribed verbatim. To identify *when* care decisions were discussed, we used Heritage & Clayman's (2010) framework of phases in physician-patient conversations in acute primary care visits [21], as this institutional context is most closely related to our data. We first identified the phases in our data using a similar bottom-up approach. We identified moments in which the physician and patient themselves make a new phase relevant in the interaction. Two of the authors (SB & TvC) identified these phases independently and then discussed their findings.

To analyze *how* the topic of care decisions was introduced, we analyzed the parts of the consultation involving a discussion of care decisions. Here we used Jeffersonian transcription conventions to show phonetic information and pacing (see Appendix A) [22]. We also described notable non-verbal information (e.g., looking at the computer, typing, or handing over forms).

We began our analysis at the point when either the physician or the patient introduced the topic of care decisions and then looked at the previous and subsequent turns until the topic was concluded.

We focused on the introduction of the topic to gain insight into the interactional implications of certain care decision introductions.

To describe the discussion of care decisions in greater detail, we organized a data session, a common practice in conversation analytic studies. Six conversation analysts analyzed specific fragments using the video recordings and transcripts [19].

## 3. Results

In this section, we show *how often* care decisions were discussed (Section 3.1), *when* -or in which phase of the consultations- care decisions were discussed (Section 3.2) and *how* the topic of care decisions was introduced (Section 3.3).

### 3.1. How often are care decisions discussed?

Care decisions were discussed in 21 of these consultations, conducted by six different physicians. Fig. 1 shows the distribution of these conversations over the four groups and who initiated the topic. Physicians initiated the topic of care decisions in two of the 65 (3.1%) consultations before their training and 15 of the 85 (17.6%) consultations after their training. Of the 85 patients who had not received patient education, none introduced the topic, whilst four of the 65 (6.2%) patients who had received the patient education did.

### 3.2. When are care decisions discussed?

The conversations in our data take place in an institutional setting: during consultations at the internal medicine outpatient clinic. Unlike acute primary care visits, which formed the basis for Heritage & Clayman's (2010) [21] framework of phases in physician-patient conversations, our data consists of scheduled (follow-up) visits. Most of our patients therefore had a known diagnosis, for instance chronic kidney failure or diabetes. In our data we identified roughly the same phases as Heritage & Clayman (see Figs. 2a and 2b), although we also found differences.

In Heritage and Clayman's model the 'problem presentation' (phase 2) is patient-directed, whereas in our data, phase 2 is physician-directed: the physician states the reason for the consultation ('You are here for your three-month check-up on your diabetes') and sets the agenda from that point on until the pre-closing/closing phase (phase 6).

Another difference is that 'data gathering' (phase 3) in our data involves little in the way of history taking/ physical examination; instead, it consists mainly of computer-guided data collection, for instance lab results or blood pressure.

As most patients have already been diagnosed, phase 4 involves evaluating the current state of the patient's condition: is it stable, improving or deteriorating? This is followed by an 'evaluation of the treatment' (continue, start, stop or change). On top of that, in this fifth phase the physician often outlines the 'course of the disease': how he or she expects the disease to unfold (improvement, deterioration or stability, and what consequences will this have for the future?). Phases 3–5 are usually iterative: the physician evaluates different aspects of the diagnosis one after another, including their consequences for treatment and the future.

After discussing all the various aspects of the diagnosis, the physician generally initiates a pre-closing by asking whether the patient has any questions ('That was all I wanted to discuss, do you have any questions?'). At this stage of the consultation, the patient can take the lead. If the patient does not, this phase is followed by the closing.

As can be seen, there is no phase destined for care decision conversations and hence there is no natural slot available for the introduction of this topic within the event.

<sup>1</sup> Patient education consisted of a conversation aid that patients received prior to their outpatient clinic visit along with background information about what care decisions are, patients' rights in this matter, the importance of discussing care decisions, and possible outcomes after certain treatments, such as resuscitation.

<sup>2</sup> Training consisted of an e-learning module with background information that emphasized the importance of care decision conversations, and training with simulated patients in which they provided each other with feedback.

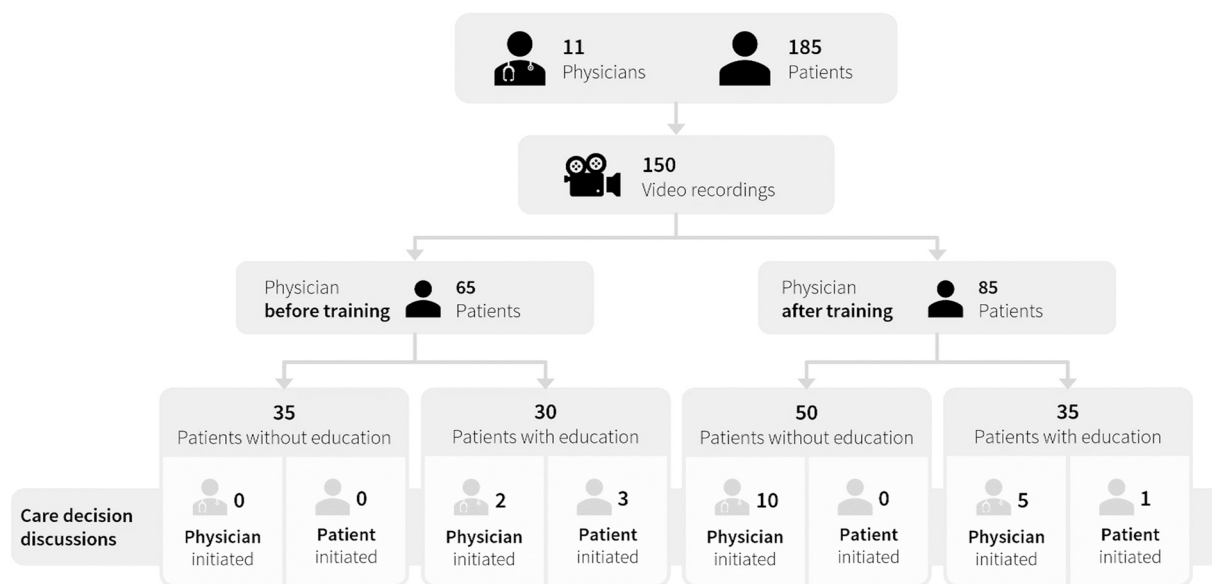


Fig. 1. Diagram of the study.

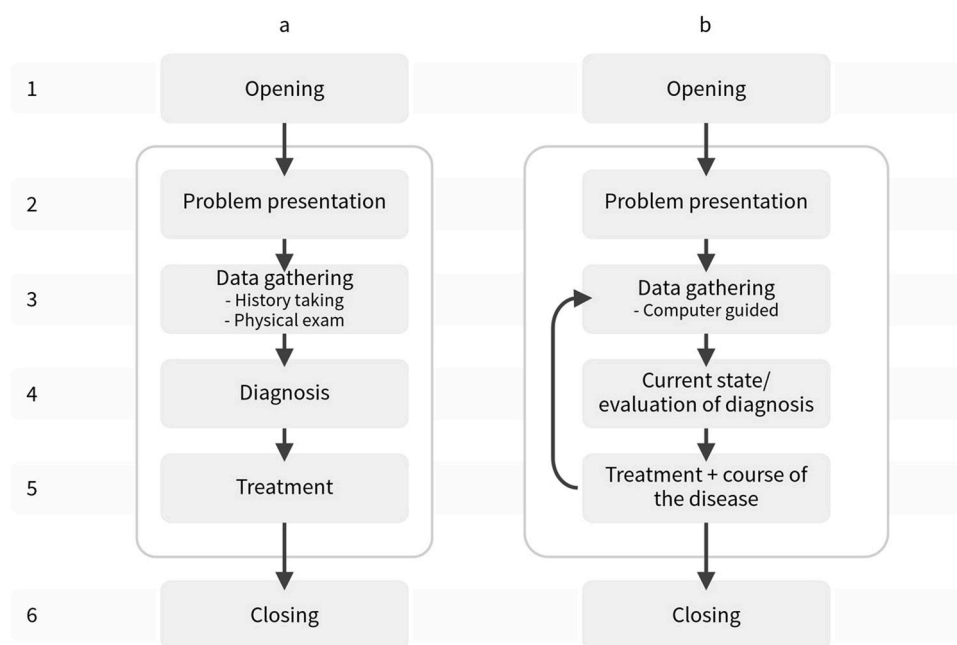


Fig. 2. Phases of the conversation. a. phases in physician-patient conversations in acute primary care visits identified by Heritage &amp; Clayman, 2010[1]. b. phases in physician-patient conversations in scheduled (follow-up) visits at the outpatient clinic of internal medicine.

In the instances in our data, the topic of care decisions is introduced most often at the end of the phase 'treatment and course of the disease'. This was the case in 11 out of the 17 cases in which the physician initiated the topic. In two consultations, the physician introduced the topic even later, in the pre-closing stage or even after the closing and the physician had said, 'hey that's it for now, thanks for coming'. Patients, in their turn, also introduced the topic near the end of the consultation in two out of four patient-initiated cases. In only five out of 21 consultations care decisions were discussed early on in the consultation; four of these were physician-initiated.

### 3.3. How the topic of care decisions is initiated

Because most care decision conversations were physician-initiated (17 out of 21), we focus on the physician-initiated conversations in this section. We provide two illustrative examples from our data. Throughout our data a problem is visible with creating relevance for the introduction of the care decision conversation. Physicians provide several justifications or accounts [23] for this introduction, even when – in the institutional context of a consultation – they have privileged opportunities to ask a

patient health-related questions [24]. Physicians use two distinct strategies: providing external accountability or patient-related accountability. With external accountability, the physician uses sources outside of the patient's health domain as justification for bringing up care decisions. The most frequently used justification is participation in this study or the presence of the camera in the consultation room (10 out of 17 consultations). Other examples include stating that information about care decisions is currently missing in the electronic health record (EHR) or referring to hospital policy on discussing and documenting agreements on care decisions. Patient-related accountability refers to physicians providing justifications connected directly to the specific patient (e.g. a reference to something the patient has said before, the patient's impaired physical condition or a recent event such as surgery). An example of this is *'some people have - because you have also had a heart surgery - have ideas about whether or not they want this'*. In the first example, the topic of care decisions is introduced in the 'treatment and course of disease' phase with use of external accountability.

### Example 1. A typical physician-initiated care decision discussion (external accountability).

The patient (P) is a 64-year-old female with a history of glomerulonephritis and thyroid dysfunction. She is attending her (annual) follow-up appointment with her regular (experienced, male) nephrologist (D). The excerpt starts at the end of the treatment and course of disease phase. Previously in the consultation, the physician and patient discussed kidney function (stable), thyroid function (good), an episode of inflamed molar and urinary tract infection in the past year, and when the patient should contact the physician in between scheduled appointments. Just before this excerpt starts, the physician measured the patient's blood pressure (good to a bit low) and they discussed possible side effects, such as dizziness.	
406	D: I I have now something (.) this already is a fantastic
407	blood pressure,
408	if if >I measure him a few times again< then it is
409	perhaps a bit lower.
410	but if this works [for you?
411	P: [yes.
412	D: then,
413	P: yes.
414	D: then I do not need to know that necessarily,=
415	P: =no.
416	D: U:hm (.) the interesting thing about that camera
417	project is also that the idea is that you-
418	that we also talk about care decisions?=-
419	=not that it is an obligatory subject.=
420	P: =no.
421	D: but if the opportunity arises.
422	and I was, (.) when we were- when I was preparing this
423	consultation realizing that we indeed really have
424	>nothing at all< [written up about it,
425	P: [no. no.
426	D: and I find that (.) in itself a bit unfortunate
427	=cause what if you enter the emergency department and
428	something serious has happened,
429	then <we do not know at all> [if you have=
430	P: [no.
431	D: =an opinion about that.
432	and of course it could be the case that you (.) have
433	already thought about that very carefully.
434	and I would find that <really unfortunate>.
Hereafter, the patient responds that she had not thought about care decisions regarding herself, because she feels very healthy, but did so regarding her sick mother. The physician confirms this "makes sense", but it would still be good to know and document her opinion. The patient states she does not want any treatment limitation at this moment, again confirmed by the physician as "making sense", but she states that this might change over time, especially when her physical condition would deteriorate. This is documented in the EHR, after which the consultation is closed.	

In Example 1, the physician initiates a topic change after closing the topic of 'blood pressure' in line 414. After the patient's negatively formulated agreement 'no' (no need for further information) in line 415, the physician changes the topic with the

hesitation marker 'uhm' in line 416. This turn-initial 'uhm' seems to be marking the physician's editing of the utterance-in-progress [25,26].

The physician now begins an elaborate multi-unit turn [27] (lines 416–434) and produces three accounts for the nomination of the topic: the camera project (lines 416–417), the realization that this information was missing in the system (lines 422–424), and the possibility the patient might have her own ideas (lines 430–434). The multi-unit turn is marked by the aid of various 'rush throughs': 'a practice in which a speaker, approaching a possible completion of a turn-constructional unit, speeds up the talk, withholds a dropping pitch or the intake of breath, and phrases the talk to bridge what would otherwise be the juncture at the end of a unit' [27] (e.g. lines 418–419 and 426–427). The patient uses various 'continuers' (see 'no's in lines 420, 425 and 430), thereby claiming understanding and encouraging the physician to continue [27].

Besides the hesitation marker and multiple accounts, the physician provides for introducing the topic of care decisions, there are also repairs noticeable in lines 417–418 ('that you- that we') and line 422 ('and I was↑ (.) when we were- when I was'). Repairs are generally preceded by a 'trouble source', i.e. something apprehended as a problem [28], and are observed in talk about 'sensitive' issues [16,29]. Furthermore, in line 427, the physician uses hypothetical talk (*what if*). In our data, hypothetical future scenarios are sketched to explore the patient's thoughts and wishes in particular scenarios, such as *'imagine you come to the hospital and are very ill'* or *'what if there is an emergency, let's say, something happens to your heart'*. Across several settings, hypothetical questions have shown to be effective in encouraging patients to engage with difficult issues but at the same time show the 'serious and sensitive' nature of these topics [16].

In the multi-unit turn, the physician does not ask the patient a direct question. He uses declarative utterances designed as 'my side' tellings [30] in lines 423–424 and 429. In a 'my side' telling, the speaker has less access to information than the recipient does. That is the case here because the patient's thoughts and wishes are in the patient's epistemic domain [31,32]. The physician requests information by these my-side telling declaratives [30], after which the patient responds. Her decision (no limitations) is documented in the EHR, and the consultation is closed.

Example 1. is typical of the exchanges in our data. Care decisions are introduced in the 'treatment and course of disease' phase as a final point on the agenda. While the 'last topic' is made explicit in some of the examples in our data (e.g. *one last thing, one more point, I had one last (little/ silly) question*), Example 1 demonstrates a more implicit instance of 'last topic to be discussed'.

The second example shows an example of patient-related accountability to introduce the topic of care decisions.

### Example 2. Topic of care decisions introduced in the data gathering phase patient-related accountability).

This is a consultation between an 81-year-old male patient (P) with chronic kidney damage and his experienced female nephrologist (D). The patient's partner (F) also takes part in the conversation.		
87	D:	((uses blood pressure meter on patient))
88	D:	here it comes,
89	P:	yes.
90	D:	I am actually very happy with these results;
91		it looks proper,
92		uhm (.)
93		it is also (.) so hi, -or so good, actually,
94	P:	yes?
95	D:	that I am not (.) going to give you the information about
96		what if the kidneys stop working,
97	P:	((nods yes))
98	D:	that chance will <in the end> come up at some point,
99	P:	yes,
100	D:	uh(.) and then you would have to go on <dialysis>,
101		I don't know if you know what that is?
102	P:	no,
		((8 lines omitted))
110	D:	and uhm (.) with these values it is definitely not relevant,
111	P:	no.
112	D:	but if it comes- becomes worse,
113		and often is that number; right, that 27 is going towards the:
114	P:	[yes?
115	D:	[let's <goes towards> say 15, then-
116	D:	->"I am going to do it gain okay"<
117		((turns on blood pressure meter again))
118	D:	then it can be. that the dialysis, right, comes in sight.
119		and then of course you should have in ample time, you should
120		get some information about that,
121		what is it exactly, and what does that mean:?
122		[and-uh
123	P:	[yes I have seen that before you see.
124	D:	well I think that that information (start) is really not
125		relevant yet,
126		uhm but it is [already a good,
127	F:	[-i was already afraid of that earlier before we
128		came here
129	D:	[yes.
130	F:	(than I thought like) well; (.) hey;
131	D:	yes.
132		and if we then eh: right,
133		if that <will come> in sight,
134		then we should also elaborately discuss,
135		at your age (0.3) if you would want that. (0.3)
136		right, because you can also say with that bad kidney
137		functioning,
138		then I will actually try with >pills< (0.5) to keep it
139		functioning as long as possible.
140	P:	[yes.
141	D:	and that you then say that the dialysis that you say of that-
142		that it might be a bridge too far:;
143		and that-that-there is something to say [for that
144	P:	[yes::, that is not
145		pleasant of course.
After line 145 the patient and physician continue to talk about various options and their consequences considering the patient's age (>80) and clinical condition (good). The actual decision on whether or not to opt for dialysis is deliberately postponed and they continue the consultation with evaluation of the blood pressure, fluid status, and increasing the diuretics, etcetera.		

In this example, the physician moves from evaluating the good blood results (lines 90–91) to stating it is *not* necessary to give the patient information about care decisions (line 95). The physician uses the 'good' or 'high' blood levels as a way to make the transition to the possibility that the kidney might stop working. In this transition (lines 92–93), we see that the physician edits her speech in progress [26] after a short 'uhm'. This all takes place while the physician is measuring the patient's blood pressure. After a minimal agreement with rising intonation by the patient in line 94, the physician refers to a (possible) future scenario ('about what if') in lines 95–96. By presenting the information about this particular care decision (dialysis) as something that needs not to be discussed right now, the physician attends to two underlying dilemmas: 1) this could have been an appropriate slot to introduce care decisions, but since the blood result is fine it is no longer appropriate; 2) the topic of care decisions is only relevant in the future when things get worse, but, at the same time we should not wait until it is too late. The patient demonstrates understanding with a nodding agreement (line 97), and the physician responds to this by indeed providing further information about future care decisions (until line 143).

The patient's minimal responses throughout this elaborate stretch of talk solicits continued information-giving from the physician, noticeable throughout the entire excerpt. Although the physician introduces all sorts of topics and points for consideration (age, type of medication, hassle), she presents them in an information-

giving format, rather than as items for that discussion at that point in time. The physician emphasizes multiple times that at *this* point, no decision has to be made, and that it is in fact unnecessary to have the information at all (lines 110, 124–125). However, she does provide some information about what dialysis entails (omitted lines), when a decision should be made (not in actual 'time' but in 'lab value') (lines 112–118), that the patient needs to be well-informed before that moment arrives (lines 119–120), that they should *elaborately* discuss the care options (131–139), and that it is a legitimate choice *not* to opt for dialysis (141–143). By presenting all this information - even though she said she did not have to (lines 95–96) - the physician solves two dilemmas: she has created a slot in which to initiate the topic and she prepares the patient for the 'what if' scenario: what if it gets worse. We can also see this as creating common ground: the physician shares the information that matters in making care decisions from a physician perspective [33].

A paradox, however, still remains. The topic is framed as 'relevant in the future' but 'needs to be discussed now'. Elsewhere in our data we also see that the care decisions are framed as not yet relevant (e.g., we see references to it being 'logical' not to have discussed this thus far because of the patient's young age). Although the care decisions become (more) relevant when things get worse, by that point it could also be too late to make certain decisions. At the same time, patients might feel anxious when the topic is brought up in the routine consultation. We call this the relevance paradox. Because the



topic is introduced as ‘not yet relevant’ in this example, postponing the actual decision is a logical consequence. In [Example 1](#), a logical consequence of the physician introducing care decisions as ‘missing information in the EHR’ is to document the decision in the EHR.

## 4. Discussion and conclusion

### 4.1. Discussion

After counting in our data *how often* care decisions were discussed during consultations at the internal medicine outpatient clinic, we used conversation analysis to explore *when* and *how* they are discussed. It is striking how few discussions of care decisions took place: the topic was introduced in only 21 of the 150 video-taped consultations. We established there is no destined phase and therefore no interactional slot for the introduction of the topic of care decisions. Because there is no obvious slot, a lot of interactional effort is needed to introduce the topic. Common ground needs to be created and relevance needs to be accounted for. Hesitation markers, repairs and hypothetical talk furthermore show the precariousness of the topic, as confirmed by previous literature.

Extensive accounts are provided by both physicians and patients to introduce the topic of care decisions. We have noted a difference in implication between external and patient-related accountability.

The data show that there seems to be a dilemma with relevance. General perception is that the care decision conversation becomes relevant when the treatment that is discussed is just around the corner (e.g., an end-of-life setting or acute/severe medical illness). This results in statements like ‘it is actually not yet relevant’, it is discussed ‘just to fill the EHR’, or it is discussed ‘because of study participation’, with diverse consequences. Such statements all attempt to create relevance while contradictory sustaining the ‘not actually relevant yet’ perception. In order for the patient to make a considered decision, it is relevant to have these conversations at an earlier moment during regular consultations. *Discussing* care decisions is relevant far before a decision is made. Therefore, physicians have a difficult task in negotiating the conflicting demands of addressing a precarious topic at a time it is not perceived necessary yet.

In 2014, Parry et al. published a systematic review synthesizing observational evidence about patients-physician communication about future illness progression and end-of-life, summarized as ‘sensitive future matters’ [16]. Although our research takes place in a different context, i.e. a general internal medicine outpatient clinic and not an end-of-life setting, some observations are similar. Parry et al. also observed the occurrence of delays, hesitations, and repeats and the use of “hypothetical questions and talk”. In addition, their “framing of the difficult issue as universal or general rather than individual to this patient” corresponds to the use of external accountability in our study (participation in the study or ‘the system’), and their “linking questions and proposals to what the patient had said or not said” corresponds to the use of patient-related accountability in our study. Indirectness, allusive talk, euphemisms, fishing questions and shifting to the positive [16] were less common in our data, probably because of the different setting.

This study has various strengths and limitations. One of its major strengths is that we focused on care decision conversations in a general outpatient clinic. So far, most research on this topic has been conducted in end-of-life settings [6,11,15–17] despite calls to conduct these conversations at an earlier stage [2,10,18]. Furthermore, we not only assessed whether a conversation about care decisions in fact occurred but explored *when* and *how* these conversations were conducted in this population. Our analysis revealed practices and dilemma’s common in our data and their implications, which will be useful in future training.

The low frequency of consultations involving a discussion of care decisions shows the importance of this study and the need for

further training and education, but it also limited the number of consultations we were able to analyze. Furthermore, the conversations were not evenly distributed over the participating physicians: some had not a single conversation about care decisions while one physician introduced the topic of care decisions in ten consultations. This may have influenced our observations: this physician’s personal preference about how to discuss care decisions could have been interpreted as a common practice simply because we observed it with more frequency. However, because we saw different patterns in this physician’s consultations and similar patterns in the conversations of the other physicians, we do not believe this impacted our analysis.

Because of the small number of patient-initiated care decision conversations, it was difficult to draw conclusions about how patients introduce the topic. It is, however, remarkable that patients almost never do so, perhaps because they believe the physician will take the initiative if and when the topic becomes relevant [11].

### 4.2. Conclusion

We observed that care decisions are rarely discussed during consultations at a general internal medicine outpatient clinic. There is no destined phase in the consultation to initiate this topic, and it involves considerable effort and (external) accountability to create common ground and to solve the relevance paradox. The topic is often framed as an alien, administrative matter.

### 4.3. Practice implications

Although the importance of discussing care decisions has been recognized [2], our study shows that the frequency of these discussions in our dataset of 150 video recordings at the internal medicine outpatient clinic is low. Education and training are therefore needed. Our physician training and patient education program, which focused mainly on emphasizing the importance of care decision conversations, improved the frequency of care decision conversations.

Our analysis illustrates the need to devote more attention to three problems: 1) an interactional slot has to be created to introduce the care decision topic; 2) common ground has to be created and found; 3) the paradox of the topic as ‘relevant in the future’ but ‘needs to be discussed now’ needs to be overcome.

Although our study shows no definite solution, we would like to share ideas to address these problems. A slot can be created by putting care decisions on the agenda at the beginning of the consultation. Furthermore, preparation of the patient can be helpful. All four patient-initiations in our data were by patients that received the patient education. This indicates that these patients considered the topic relevant to bring up. Understanding of the relevance and background information (i.e., what are the treatment options and what choices do patients have with what types of consequences), can be seen as first steps in creating common ground. As discussed before, more common ground needs to be created. Regular discussion of care decisions during outpatient clinic visits could create more common ground over time.

Finally, we recommend incorporating these dilemmas in physicians’ training. This creates awareness among physicians that they should address these dilemmas when discussing care decisions. Future action-oriented research should focus on the best way to do so.

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in study design, data collection, data analysis, preparation of the article, or decision to publish.

### Informed consent and patient details

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

### Ethics approval

The Medical Ethics Review Committee, Utrecht, the Netherlands, MEC 18–465.

### CRediT authorship contribution statement

**Saskia Briedé:** Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Visualization. **Tessa C. van Charldorp:** Conceptualization, Methodology, Formal analysis,

### Appendix A

Transcription symbols used in the examples. The symbols are based on Jefferson's glossary of transcript symbols, which are routinely used in conversation analytic research.

Symbol	Definition and use
(.)	Brief interval < 0.2 s
.,?	Markers of final pitch direction at turn construction unit boundary:
	Final falling intonation (.)
	Slight rising intonation (.)
	Sharp rising intonation (?)
=	End of one turn construction unit and beginning of next begin with no gap/pause in between
↑ ↓	Marked shift in pitch, up (↑) or down (↓)
.hhh	Inbreath. Three letters indicate 'normal' duration. Longer or shorter inbreaths indicated with fewer or more letters.
hhh	Outbreath. Three letters indicate 'normal' duration. Longer or shorter inbreaths indicated with fewer or more letters.
Emphasis	Underlining indicates emphasis. Placement indicates which syllable(s) are emphasized.
word-	A dash indicates a cut-off
< slower >	Decreased speaking rate than surrounding speech by the same speaker
> faster <	Increased speaking rate than surrounding speech by the same speaker
°quieter°	Degree sign indicate syllables or words quieter than surrounding speech by the same speaker
pro::longed	Colon indicates prolonged vowel or consonant, one or two colons common, three or more colons only in extreme cases
[overlap] [overlap]	Overlapping talk
((description))	Double parentheses contain descriptions of non-verbal actions

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