

At the level of context discussed in this chapter, it is possible to relate moment-by-moment grammatical and semantic selections to the logogenetic unfolding of decision-making as one type of context or another. For instance, a decision might be unfolding as unilateral for some time but then might be re-oriented by certain moves, typically made by the patient, ultimately producing a decision that is shared. As Charles et al. (1997) pointed out, there is not just one route to shared decision-making. In HIV medicine, a strategy of re-routing to achieve shared decision-making is in fact a common pathway, as discussed below.

## 5.5 Generic structure and phases

Much of what has been written on generic structure concentrates either on the question of “what it is that leads users of a language to recognise the texts as instances of a particular genre” (Paltridge 1997) or on how the presence or absence of certain linguistic elements identifies a given text as an instance of one genre (or text type) rather than another down to rather delicate distinctions (e.g., an exemplum rather than an anecdote (Plum 1998/1988)). Generic analysis is a powerful way of capturing how the value of the linguistic choices made at any given moment depends on the social function of the whole text and the function of particular moves within that text (Levinson 1979, Hasan 1985a, ten Have 2001). When it comes to discussions between doctors and patients on treatment decisions, the issue is not so much how the participants know/show that what they are *engaging in* is a treatment decision, but more how doctors and patients know, and sometimes show, that they have *made* a decision.

The approach presented here draws on what may be described as three traditions in genre analysis, although there is some overlap between the three:

1. the modelling of contextual phases in terms of shifts in the clustering of particular semantic features, which in turn are recognisable as clusters of lexicogrammatical choices – this approach was developed as an account of written/literary genres (Hasan 1996/1984, Gregory 1985) and has also been applied to service and gatekeeping encounters (Ventola 1987) casual conversation (Eggins and Slade 1997) ;
2. analysis within sociology and linguistics of the global structure of professional interaction as activities or strategies of practice, either in terms of overarching structures or as structures that repeat through instances of interaction (Sinclair and Coulthard 1975, Labov and Fanshel 1977, Levinson 1979, Swales 1990, ten Have 1989, Sarangi 2000); and
3. the characterisation within medicine and health care research of consultations in terms of phases (cf. ten Have 1989, 1991; Charles et al. 1997, 1999a; Elwyn et al. 2001; and others working from a clinical research perspective, dating back to Byrne and Long 1976).

Ten Have (2001) characterises the kind of approach taken in this study, in which medical consultations are treated as ‘a genre’ with its own interactional norms, as the less politically motivated of two opposing traditions in research on doctor-patient communication. This approach claims that it is in the nature of medical consultations as a type of professional-client interaction that features such as turn taking and speech roles are not locally managed and negotiated, as they are in conversation, but are governed by recognizable phase structures, which have asymmetrical turn-taking and role allocation built in (see ten Have 1989, Drew and Heritage 1992). The alternative approach, in ten Have’s view, holds the assumed equity of “ordinary conversation” as the normative model for attentive talk-in-interaction, and focusses on whether doctors invite or allow patients to express their ideas and feelings or discourage them from doing so (e.g., Frankel 1979). One example ten Have cites is how the tendency for physicians not to give “on-the-spot evaluations” and acknowledgments to patient contributions has been construed as

showing lack of attention to patient's ideas and feelings. One might add that the absence of such responses from doctors has been labelled as paternalism (Ainsworth-Vaughn 1998).

It may not, however, be necessary to polarise these two research traditions completely, especially if we take into account Sarangi and Roberts' argument that is necessary to the interaction order and the institutional order to bring the two into the same analytical frame (Sarangi and Roberts 1999). Of course it is not enough merely to state that both schools of thought have a point. It remains necessary to reconsider the detailed findings about interactional asymmetries in the context of an overall sequential framework, as ten Have suggests (ten Have 2001: 254). It is also necessary to consider whether all the observed interactional practices that realize professional-lay genres are necessarily linked to their specialized Fields and activities, and to consider what might be at risk in maintaining consultation styles that are construed by patients (e.g., Ainsworth-Vaughn's interviewees) as inattentive or rude.

This thesis attempts to bring the perspective of generic structure and the perspective of local interactional management together in describing a corpus of consultations which show evidence of both phenomena, and of their interaction. For example, in the present corpus we see considerable flexibility as to who may take the leading role in moving through the different phases, but it is quite common for the bones of a more strongly framed asymmetrical structure to show through, especially at points where the symmetrical roles (particular Tenor settings) cannot support the apparent goals of that particular phase of the consultation (Field settings).

Some light is thus thrown on the important question of how much doctor-patient consultations can converge with ordinary conversation without becoming what ten Have calls 'vulgar' (ten Have 2001: 257; cf. Fairclough 1992; cf. Little, Jordens et al. 2002), although considerably more work is needed in this area. It may prove fruitful to approach the question from the perspective of the instantiation of meaning potential, which can be operationalised by examining the various possible ways of realizing roughly equivalent meaning potential. This helps to focus on the need to

current ways of interacting and speaking, or that “ordinary” conversation is free from Field-specific pressures, and is inherently – or even typically – symmetrical.

As this last point might suggest, it is possible to bring a critical, or political, perspective to a phasal approach. The typification of generic structure always involves idealisation as well as description, and idealisation tends to imply the obligation to comply with certain values. The values which underpin generic typifications are not usually made explicit, although in the debate about shared decision-making explicitness is becoming more common. In ten Have’s view, a sequence is called ‘ideal’ if participants appear to orient towards it, although there may be deviations that appear quite acceptable to the participants (1989: 118). Other notions of idealisation are also possible, including the probabilistic notion of usuality, notions of logical sequence, of optionality, and of optimality – the last being more explicitly concerned with value and preference, often with a socio-political motivation. Most accounts of the phasal structure of medical consultations (and other social processes) incorporate something of each of these ways of idealising. For example, Charles et al. (1997, 1999a) and Elwyn, Edwards and Kinnersley (1999) argue for particular sequencing to change (rather than represent) the status quo, in order to optimise patient autonomy and clinical effectiveness; but their model must still reflect *some* form of actual or likely practice.

A third alternative is modelling the phases of an interaction from the patient’s point of view, to include “moves” such as justifying the visit, directing or redirecting the doctor’s attention, eliciting a recommendation, deflecting attempts to close the consultation and so on. But in the practical and theoretical interest of emphasising that such interactions are interactionally achieved social processes as opposed to sequences of individual actions (Maynard 1991, ten Have 1991, Drew and Heritage 1992), it seems most appropriate to model and label phases as joint activities in which the focus may shift from one participant to another from phase to phase, and that is the approach to the analysis of phases taken in this thesis.

Below I present a proposed global generic structure for the context of shared treatment decision-making in HIV medicine. Initially a number of primary moves or phases are specified, and these are located in a somewhat idealised sequence. The phases are described in terms of their discourse-semantic characteristics. This makes

it possible to specify not just *whether* but also *when* certain lexicogrammatical patterns are likely to contribute to shared decision-making, and when they are likely to constrain it. For instance, in the phase *declaration* it is important that a move be made unilaterally, since the function of this move is for each individual interactant to declare their treatment preference or recommendation. When a doctor declares their preference or recommendation explicitly, the patient generally has an opportunity to challenge it, or to seek justification or clarification. When a patient declares their preference or recommendation, the doctor can similarly challenge or seek clarification or justification. One of the key implications of identifying *declaration* as a specific phase in the context of treatment decision-making is that it is possible to explain why the use of ‘we’ by the doctor at this point in the consultation may constrain shared decision-making, whereas the use of ‘we’ at other points in the conversation is likely to have a very different value. Studies often fail to distinguish these phasal aspects of context and their interaction with semantic and grammatical value, thus making descriptive research and prescriptive materials misleading. Examples include Skelton et al.’s (2002) study of the use of exclusive and inclusive pronouns by doctors and patients, Charles et al.’s (1999b) description of shared decision-making as occurring “when the doctor and patient share all stages of the decision-making process simultaneously and the many training materials that exhort doctors to “use inclusive language”.

### 5.5.1 The Generic Structure Potential (GSP) of HIV treatment decisions

A generic structure of six phases is identifiable in the present corpus of 74 texts. The phases in the model are only semi-discrete and only typically consecutive. In terms of the above discussion of idealisation, this is primarily a *typical*-ideal model, but it contains several important prescriptive proposals, which I will describe as I come to them. My model aims to be more detailed than other models with respect to its description of the kind of meanings each phase involves without being unworkably complicated – that is, it is more semantically oriented.

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The model of generic structure detailed below marks HIV decision-making as very different from certain other contexts such as transactions that are primarily economic (Hasan 1985a), and as quite different from related genres such as HIV counselling (e.g., Peräkylä 1995), but as fairly similar, although still distinct, from contexts such as treatment decision-making in cancer care (Brown et al. in press).

The phases are:

1. Bearings
2. Propose options
3. Amplification
4. Doctor's declaration of position
5. Patient's enunciation of choice
6. Enactment

The phases may comprise long passages or short, may comprise many turns or monologic sections<sup>1</sup>, and may, importantly, be dispersed through a consultation, although the identification of phases is not of course unproblematic (cf. ten Have 2001). Within these phases, we can further identify generalisable moves, or complexes of moves, which take us down to the level of the message or clause. Figure 5.10, below, shows the generalisable structure of phases and moves.

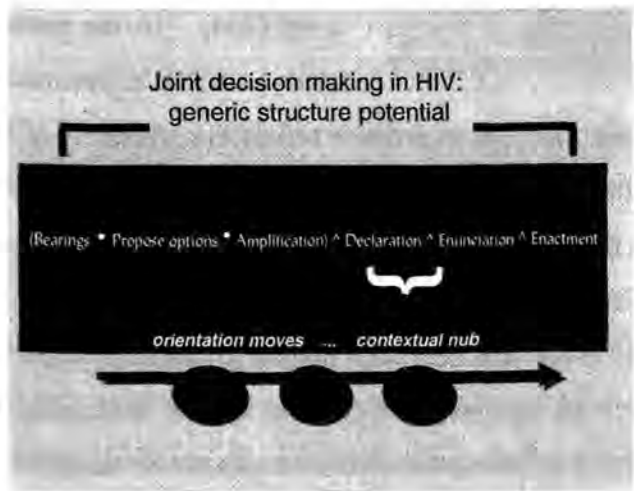


Figure 5.10, to the left, shows the six-phase GSP of HIV decision-making in its typical-ideal sequence. The bracket indicates that declaration and enunciation are the nub of the social

<sup>1</sup> Extended doctor monologue is much rarer in HIV decision-making than in cancer decision-making, on the basis of two data sets studied by myself and co-authors.

process, and occur, all things being equal, separately from each other and in the order shown. Enactment occurs after declaration and enunciation. Before declaration occurs, the phases Bearings, Propose Options, and Amplification occur, but these are less constrained in their sequencing, may occur in dispersed fashion, and may be repeated iteratively. This model of phasing of shared decision-making draws on influential models such as Charles et al. (1999a). For a schematic comparison with Charles et al.’s model, see Figure 5.17 below. The phases in the present model are delineated in terms of major shifts in the contextual and semantic parameters observed in decisions in the corpus. Whereas Charles et al.’s phases tend to be distinguished in terms of topic and goal (i.e., largely in terms of Field), the phases here are distinguished on the basis of Field, Tenor and Mode, at the level of context, and in terms of experiential, interpersonal and textual semantics.

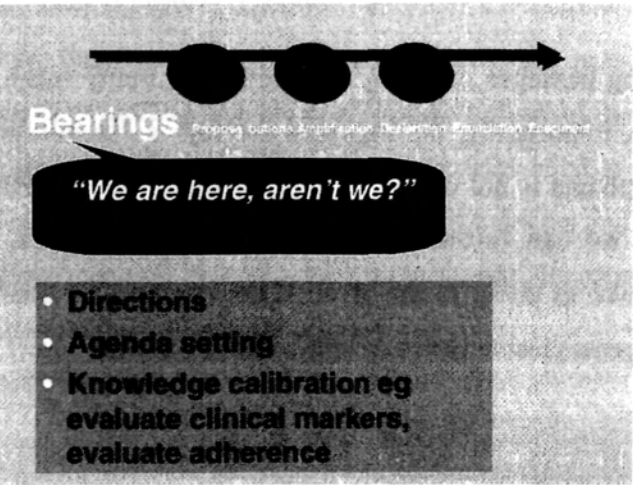


Figure 5.11: *Bearings*. Most types of social processes or social situations that have been described using a generic approach are held to have some kind of orienting move (Labov and Waletzky 1997/ 1967, Hasan 1996/1984). In the present study on HIV treatment

decision-making, I call this phase *Bearings* in order to reflect the semantics of the journey that frequently structures the decision-making talk.<sup>1</sup> This phase includes knowledge calibration between doctors and patients, in particular updating viral load results and other clinical markers and situating them within the history of results on the patient’s record. In HIV medicine this is often a mutual process of reminding and recalling. Shared decision-making models often describe the first phase of treatment decision-making in terms of information exchange. In practice, at least in

<sup>1</sup> One doctor in my study uses the motif “Let’s get our bearings” (Consultation 21, turn 15).

HIV medicine, this phase is not merely the exchange of information. It also functions as a kind of proto-proposal<sup>1</sup>, since it has the crucial role of construing the context as a decision-making discussion. In terms of broad semantic features, the Bearings Phase is likely to feature i) propositional messages (statements, questions) with ii) a realis focus (i.e., a focus on past or present events and states of affairs, anchored in time and space, e.g., through particular tense choices) and iii) a personalising focus (i.e., the events and states of affairs involve the patient and the doctor as differentiated, determinate social actors – see chapters 4 and 6). Where proposals are made within this phase, they will be with regard to actions other than treatment – e.g., “I’ll just look up your viral load” makes a proposal, but not a proposal to treat.

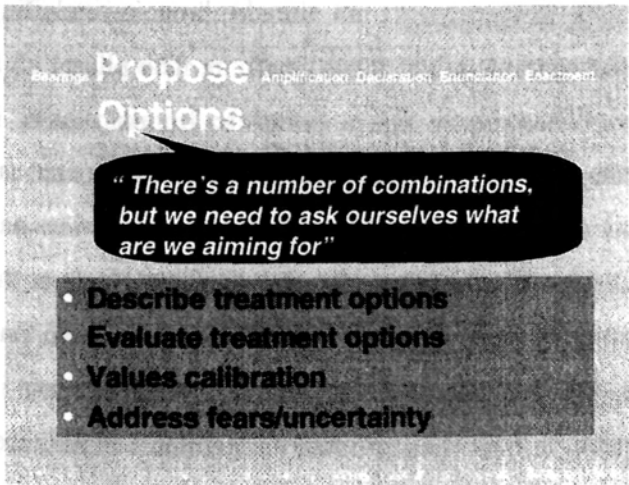


Figure 5.12. The phase *Propose Options* moves the backgrounded semantics of proposal into the foreground. This move sets out the relevant treatment options, including those that the patient may be considering as a result of discussion with friends, HIV support groups etc., and it

should ideally cover potential benefits, side effects, practicalities of administration etc. Discussing these matters in this sequence, rather than detailing side effects after the new regimen has been selected, may be important for establishing the treatment decision as a *choice* among options, rather than as consent/refusal of a particular proposal. This phase may require the calibration of the patient’s values with the doctor’s values as they become pertinent to the discussion. A shift from the phase of Bearings to the phase of Proposing Options tends to entail a move i) from propositions to proposals (offers, commands, requests) with respect to treatment, ii)

<sup>1</sup> Compare with Martin’s (1992) notion of macroproposal. The proto-proposal in Bearings acts as a kind of launch for a macroproposal that may ensue.



from realis to irrealis (to what might be, or what can be, rather than what is) and iii) a generalising focus (e.g., on what treatments do to the generic patient rather than the patient as a specific person).

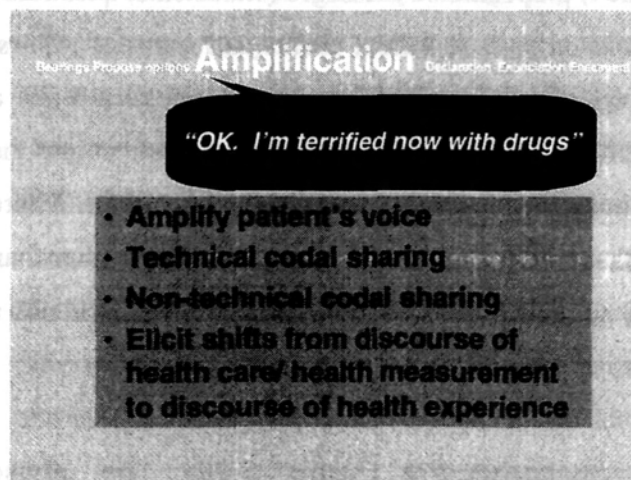


Figure 5.13. *Amplification* is in a sense an optional move. It involves amplifying the patient's voice and structuring in an opportunity for the patient to explore their reactions to the treatment options presented if they have not already done so, including

thinking through what the various options might mean for them. The phasal shift from Propose Options to Amplification is not a complete break: again, it foregrounds elements which may have occurred earlier. It is important that the doctor provide a rationale for such a discussion: i.e., that the treatment choice may be influenced by many factors, some of which may appear unrelated, such as the patient's holiday plans. Semantically, then, Amplification is less restricted than other moves: its key features are i) a personalising focus, ii) an increase in elaboration, iii) a shift or expansion in field to incorporate the patient's experience; and there also tends to be an increase in turn length for the patient.

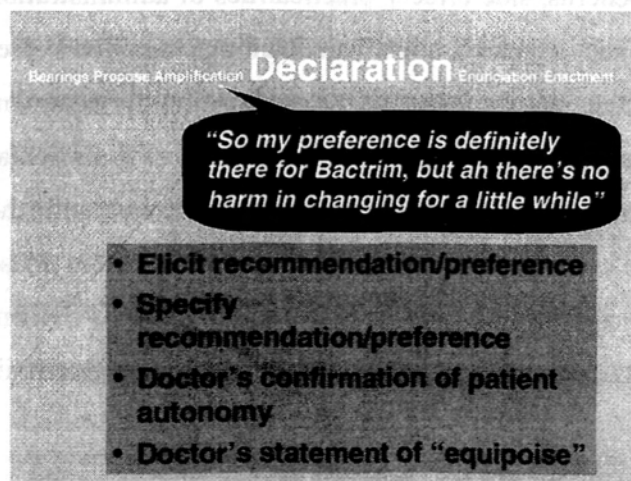


Figure 5.14. The *Declaration* phase is a move in which the doctor makes an explicit treatment recommendation. It is important that there be an explicit declaration because, if not, the doctor's covert preference may or may not be

patient. Such a misunderstanding may subtly coerce the patient into a decision. There are two particularly crucial semantic features which can be taken as recognition criteria for the Declaration move. Firstly, it is important that treatment is represented as *irrealis* (i.e., still hypothetical) at this point, e.g., through a modal finite of obligation such as “I think you *should* start treatment”, rather than the future “You *will be* starting treatment”. Secondly, if the decision is to be a joint responsibility, it is important that this phase is explicitly a unilateral move (or a series of unilateral moves). For example, the doctor should make his or her declaration in the first person, rather than using the second person, in order to avoid representing this move as a consensus already achieved, or assumed. If the patient also declares their preference this should similarly be marked as their own. The Declaration phase thus begins to close down the options, but this closing down is not complete until the Enunciation phase.

The degree to which the Declaration phase is expanded and elaborated depends on parameters of the context. It is made to the level of specificity or delicacy that the doctor feels is justified from their understanding of the options and of the patient’s particular circumstances. It might be as specific as strongly recommending a particular three-drug combination over another combination, or as general as saying that it is time to go on some form of antiviral treatment. The specificity of the recommendation is related to the notion of *equipoise*. Where the doctor does not have a strong belief in the superiority of one option over another, they tend to be more likely to present treatment decisions as involving patient choice and patient responsibility (Elwyn, Edwards, Gwyn and Grol 1999, Plum et al. 1998). Where a clinical trial is one of the treatment options, it is typical for the doctor’s declaration of their treatment recommendation to simultaneously involve a declaration of the patient’s autonomy, and of the doctor’s ‘comfort level’ (as in “I’m happy with either of those choices”) (Brown et al. in press). In a sense this conveys the message that the doctor’s responsibility covers the decision path up to a certain level of detail, at which point the patient’s autonomy begins to have some influence. In the HIV

context studied here<sup>1</sup>, this coupling of patient autonomy with medical uncertainty is not as strong as in some other contexts. In the present corpus, it tends not to be offered in coded form as part of the framework for deciding about treatments. It can, however, be inferred as motivating very different observed reactions to patient non-adherence with prophylactic antibiotics compared with reactions to non-compliance with antiviral drugs.

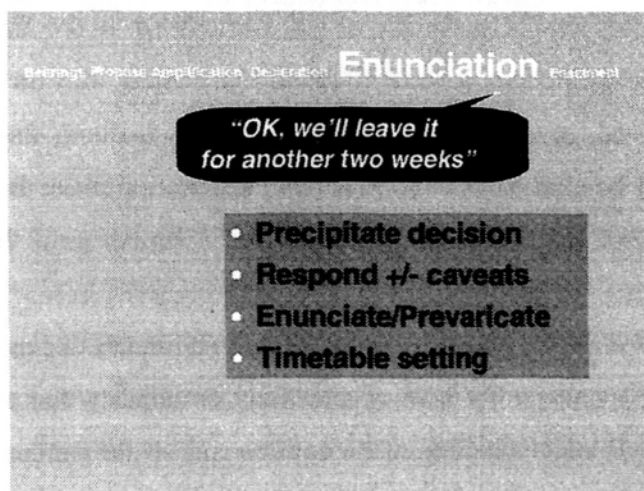


Figure 5.15. *Enunciation* is a move in which the patient articulates their decision. The key difference between Declaration and Enunciation is that Enunciation is, semantically, no longer a conjecture about the hypothetical, but something like what Cloran (1994) calls

the rhetorical unit “plan”. That is, the orientation to the event of treatment is presented as part of a volitional, non-hypothetical future, moving closer to the “here and now”. Semantically it is on the border between proposition (we’ll do x) and proposal (let’s do x). It is important that the decision is actually voiced, indicating that the patient has chosen an option, rather than acceding to or agreeing to the doctor’s framing of a decision. The Enunciation may consist of deferring the treatment decision for a period of time, e.g., to discuss it with others, or to read up; or to delegate the decision, usually to the doctor. In the corpus studied here, doctors at times resist having antiviral treatment decisions delegated back to them, even if they are mounting a persuasive case for a certain course of action. If there is substantial disagreement between the doctor and the patient, or if the patient is not ready to decide, the discussion may move from Enunciation, or from Declaration, back to

<sup>1</sup> In this corpus of consultations, trials were involved but were not as central as in the cancer context which I have studied elsewhere.

Bearings, Propose Options, or Amplification, coming back through the phases, or running them in parallel. In the data studied here there are instances of explicit, elaborated Enunciations, and there are also instances where there is only minimal indication of the patient’s assent. This issue, and the reasons why the criteria for the adequacy of the declaration and enunciation phases must be contextual parameters, will be discussed further below.

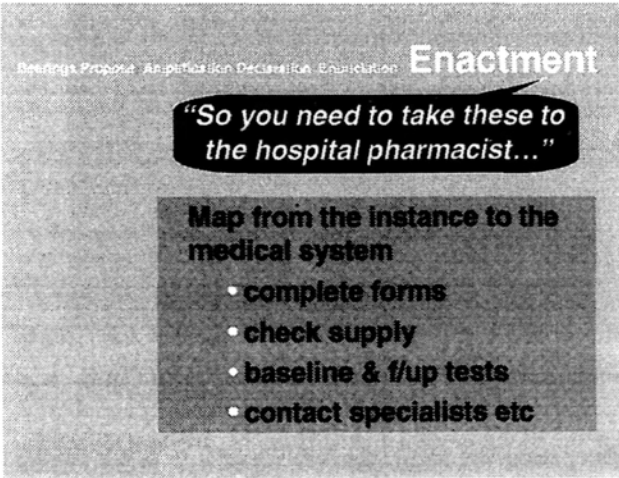


Figure 5.16: *Enactment*. After the doctor and patient have come to a mutually acceptable level of agreement, the decision needs to be implemented. The patient as “instance” must be mapped to the “system” of how that particular treatment regimen works. This includes further

description of logistics, such as filling out forms and making phone calls. The crucial semantic shift here is that Enactment brings the treatment choice into the actual, moving it even further into the here and now than Enunciation did. It is crucial that logistic institutional arrangements (for example, the writing of scripts) are not made before a full opportunity to discuss and reflect on the options has been provided and the patient has reached a clear decision. It is appropriate in this phase to detail information for the particular option chosen which would not have materially affected the patient’s decision, and which would have been too much detail to provide for all the options that were not chosen. It seems from the data that this phase is often used to introduce side effects and constraints on taking certain drugs which arguably *may* have affected the patient’s choice and ought therefore to have been introduced during the phase *Propose Options*.

Figure 5.17 relates the six-phase description used in this study to the three-phase description provided by Charles et al. (1999a).

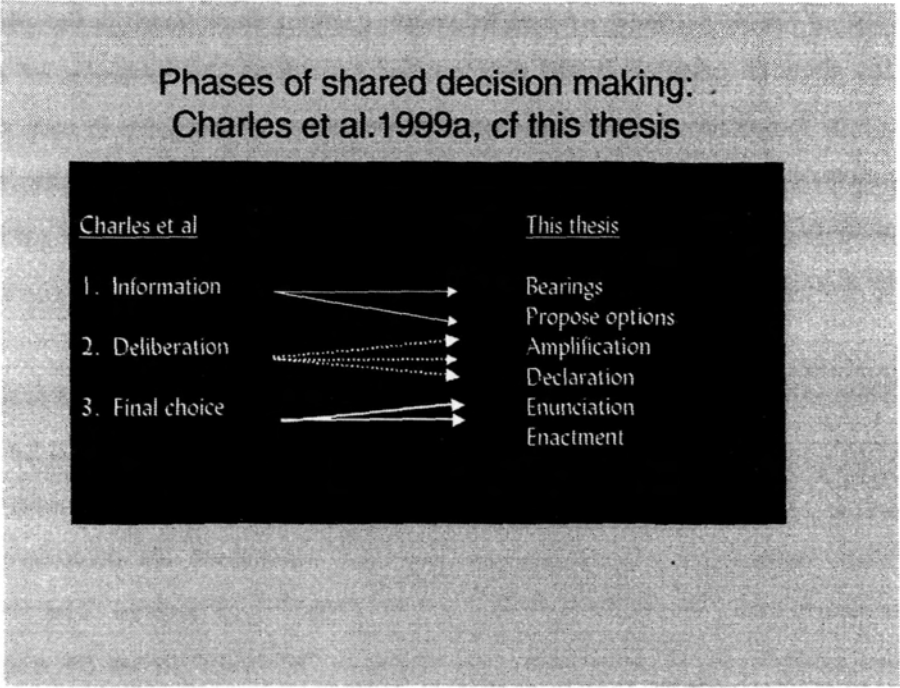


Figure 5.17 Two models of the phases of shared decision-making

Having identified and described these six semi-discrete phases, it is important to emphasise that they will be variably realized in a number of ways.

Firstly, the phases may be minimally realized or expansively realized depending on a number of factors, including the parameters of context described above. For instance, if the Field is novel, especially if it is a discussion about the possibility of initiating HIV treatment for the first time, the Bearings phase is likely to be more oriented towards elaborating the rationale for treating, explanations of the mechanism by which the drugs work, explanations of viral load in the abstract, and unrealistic explanations or what Cloran calls “conjecture”. The choices being proposed in such a case involve two very different potential ways of living which the patient must explore imaginatively, including the possibility of radical alterations to their sense of identity or the balancing of different aspects of the self. In the case of ongoing treatment review, where the question is not whether to treat but whether to change treatments, the Bearings phase is likely to include considerable attention to realistic explanation of what has already happened, although conjecture will probably be involved as well. Some crucial implications for shared decision-making that emanate from the way that decisions unfold as phases are discussed in section 5.4.3.

Secondly, although the presence and sequencing of the phases as outlined above contributes to the creation of a jointly produced decision, the phases, even if conducted in order, may be realized with certain semantic options that facilitate shared decision-making or, alternatively, with options that tend to close it down. To explore these different ways of realizing the phases described, we will need to describe these moves in more delicacy. I will first do this via analyses of specific decision-making texts in section 5.5.2, and then I will identify crucial contrasts in the realizations of each phase, in section 5.5.3.

5.5.2 HIV treatment decisions: additional delicacy in phasing and in realisation

In this section, I revisit Consultation 29 between Trevor and Neil, and examine it in terms of its phasing. The main reasons for presenting the whole text again here are (i) to provide evidence for the claims I have made about the semantic characteristics of each phase, and (ii) to illustrate the incremental and iterative way in which decisions typically unfold. In addition, I aim to show how the actual language of real clinical decision-making can be interpreted in terms of my new model of clinical phases, to allow alternative/critical readings to be proposed, and to allow the statements made below about the patterns of such phases across the corpus to be appreciated and critiqued. Since my approach of using a long text for illustration consumes a good deal of space, it is worth comparing it to the briefer illustrative approach of other authors. Charles et al. (1999a), for instance, use fictional “scenarios” which fall rather neatly into the phases that they describe. Very few papers have illustrated their analyses with real language data in all its complexity, untidiness and resistance to fitting discrete categories.

Figure 5.18 Generic Structure of HAART decision, Consultation 29, Trevor and Neil

Generic phase	Spkr	Turn	Turn text
BEARING5: Update since last visit	P	29_1	Makes only, 'cause of when I took
BEARING5: Update since last visit	D	29_2	Sorry, if we pretend it's not going. And it, you know after about ten minutes it will naturalize things. I shall read it on any case. Um, oh I know, ah... I know, more or the less the overview was that we were wondering, or we were pretty pessimistic
BEARING5: Update since last visit	P	29_3	Direction]
BEARING5: Update since last visit	D	29_4	actual regimen failing.
BEARING5: Update since last visit	P	29_5	Ah
BEARING5: Update since last visit	D	29_6	Weren't we?
BEARING5: Update since last visit	P	29_7	Yes.

BEARINGS: recap decision/enactment plan

BEARINGS

BEARINGS

BEARINGS

BEARINGS: MARKERS: lab results: offer/demand results

BEARINGS: MARKERS: lab results

BEARINGS: MARKERS: lab results

BEARINGS: MARKERS: lab results: offer/demand results

BEARINGS: MARKERS: lab results: offer/demand results

BEARINGS: MARKERS: lab results: offer/demand results

BEARINGS: MARKERS: deliver results

BEARINGS: MARKERS: deliver results

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BEARINGS: MARKERS: situate results

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DECLARE: recommendation  
DECLARE: SDM philosophy

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D 29\_8 And we decided we'd leave it for, we'd give it a little grace period. And then do the viral load again. And depending what the viral load was the second time round, be in a position to make a judgment. Well I don't know what it is, yet. So, [

P 29\_9 ( )]

D 29\_10 I'm on tenterhooks as well.

P 29\_11 Oh

D 29\_12 I've got to look for it. I don't actually know the odds as I'm talking to you.

P 29\_13 Oh, okay.

D 29\_14 .. It may be that we need to phone. 'Cause usually I do know. So it was done, but would rather do it next week, stress. So it was in fact taken on this date. Which is the eighteenth of March. Do you know the um, ((name of hospital)) or either them or

P 29\_15 ((number))

D 29\_16 .. ((conversation on phone))

29\_17 I'm just waiting for them to tell me what er when they were sent out. In the mean time you can look at your results. So the only things you need to look at. You're used to these now

P 29\_18 Mm

D 29\_19 So there's the CD four absolute number that line.. and then the viral load.. is

P 29\_20 Yep

D 29\_21 Now, oh what you need to look at, when you get two figures like that that are reasonably close, this the advantage of the log scale is that we know that anything within point five of each other is not significant. So four point seven three and four point

P 29\_22 Mm

D 29\_23 So that's not significantly different. So we've just got to decide what that means to us in terms of ( ). It's not significantly different to the last measurement.

P 29\_24 Yes, yes, I understand that.

D 29\_25 But, we might decide it's very significant from this.

P 29\_26 Mm-hm

D 29\_27 From the previous one. Hasn't got any worse, let's put it that way.

P 29\_28 No.

D 29\_29 But it hasn't got any better.

P 29\_30 Much better or it's not, not significantly better

D 29\_31 It has to go back to base line

P 29\_32 Yes, that's not actually any better at all really.

D 29\_33 No. ((on phone))...

D 29\_34 Right okay. Neil I think it's fairly clearly, um but we just have to go back through the, through the drugs. Isn't it?

P 29\_35 Mm

D 29\_36 And so.. eh, in, what she got ((number)) there, now that was your number.

P 29\_37 Yes, yes. ((laughs))

D 29\_38 Yes, that's your number. That's your number. Okay. In ah, just to really confuse, you've got to be quick in this business. So, sometime like May or June you went on to zidovudine, 3TC and zalcitabine.

P 29\_39 Mm-hm.

D 29\_40 Okay and that's what you've been on since. And you made that initial ah fantastic fantastical drop from one million to one thousand. Ah, talk about the light fantastic, that was pretty amazing. And maintained it until December, 'cause that, not signifi

P 29\_41 No, no. But

D 29\_42 But we've we've

P 29\_43 It seems to have levelled out a little bit. Well I thought it was only a little while afterwards. Yeah and as you say not significantly different to the

D 29\_44 No

P 29\_45 To that count

D 29\_46 No. See where we looking at, let's take a look at the other. Three point ((mumbling)) Right naught point nine. Log in naught point nine and then ( ) is a ((mumbling)) I mean it's significant.

P 29\_47 Yep

D 29\_48

P 29\_49 Right, yes, yes.]

D 29\_50 So, it's not a disaster. But, clearly if you want us to together, to work towards best practice. The best practice is to get you down below er ten thousand.

P 29\_51 Yep.

D 29\_52 Then there is only one um, one management option, in the absence of inter current infection, which you haven't got.

P 29\_53 H-hmm

D 29\_54 There's only one management option, and that is to fiddle with the drug regime.

P 29\_55 Right, okay. I'm happy to do that.

D 29\_56 Okay.

P 29\_57 Especially with AZT

D 29\_58 Especially with AZT that we what?

P 29\_59 That we change

BEARINGS: Update	D 29_60	How long have you been on AZT, that's the
BEARINGS: Update	P 29_61	Well it's, since when
BEARINGS: Update	D 29_62	Oh I see. It's not a great length of time.
BEARINGS: ADHERENCE: offer/demand adherence/	P 29_63	No. I am a little concerned about some of the things with compliance. Now I do take my medicine every day, but then sometimes things will say delay my evening one until quite late. And then of course, I mean say even ten thirty, eleven o'clock at night
AMPLIFY non-clin values	D 29_64	Is that when you do your power walk at five?
AMPLIFY non-clin values	P 29_65	Yes.
AMPLIFY non-clin values	D 29_66	The one I caught you doing along the main road by ( Tascot)
AMPLIFY non-clin values	P 29_67	Yeah
AMPLIFY non-clin values	D 29_68	With the weights in the hand.
AMPLIFY non-clin values	P 29_69	No, no. No weights.
AMPLIFY non-clin values	D 29_70	I thought I saw you with weights one day, no.
AMPLIFY non-clin values	P 29_71	It might have been some garbage that I picked up.
BEARINGS: ADHERENCE: explain results: evaluate adherence	D 29_72	((laughs)) ( ) that's why I couldn't. I know it was you though. Um, well the point is that as long as your not er missing doses, or missing more than one dose. I don't think it's going to make enough difference for you to destroy your life through
BEARINGS: ADHERENCE: explain results: evaluate adherence/	P 29_73	Sure. I mean mostly it's okay. Mostly I sort of am quite regular. But just occasionally I've been sort of delayed in one way or another and I've just worried oh is that delay sufficient to cause the sort of effect that we're having. In other words th
PROPOSE: list options	D 29_74	Right. Well I think it's unlikely. I think it's unlikely that the um. So what are the choices?
BEARINGS: ADHERENCE: explain results: evaluate adherence/	P 29_75	When people miss several times in a row or something like that.
BEARINGS: ADHERENCE: explain results: evaluate adherence	D 29_76	Yes
PROPOSE: list options	P 29_77	they end up missing
BEARINGS: ADHERENCE: explain results: evaluate adherence	D 29_78	Mm mm.
PROPOSE: list options	P 29_79	Okay.
PROPOSE: list options	D 29_80	Ah, what are the choices? There was a group of people one stage who were pretty ( ) about you had to change all three. If you were going to change anything at all. I never really sort of fell for that, and I've never, and it seems to have fallen by
DECLARE: declare recommendation/pref	P 29_81	Yes, that's right. I'm inclined to agree with that as well.
PROPOSE: list options/	D 29_82	Um, the options are, well let's take them one by one. The zidovudine should we change that? My inclin, my inclination is different to yours, I'm, I wouldn't be inclined actually to change that. But if we did want to change that, we'd change it from zid
DECLARE: declare recommendation/pref/	P 29_83	You did mention it last time
AMPLIFY shared technical code	D 29_84	Did I? Zidovudine to um, it's called stavudine and
AMPLIFY shared technical code	P 29_85	What, I mean what would you
BEARINGS: recap	D 29_86	That's one option. That's option, I'll just go through the options. Um 3TC is sort of a supporting drug, it's a supporting player really um, it's limited there. Supports certainly supports zidovudine and um in the sense that it prevents resistance. Do
PROPOSE: list options	P 29_87	Yeah, yeah.
PROPOSE: list options/ PROPOSE: describe treatments	D 29_88	There's another, we like to have one class of compounds in the reserve reverse transcriptase inhibit inhibitor group
PROPOSE: list options/ PROPOSE: describe treatments	P 29_89	Mm
PROPOSE: list options/ PROPOSE: describe treatments/	D 29_90	And there's another one called a viropin, that's also reverse transcriptase inhibited. That's also considered a bit of a supporting plan. And then we've got the protease inhibitors and so far there are three. There is a fourth about to come on the mark
PROPOSE: list options/ PROPOSE: describe treatments/	P 29_91	Okay
DECLARE recommendation/ preference	D 29_92	I mean, you know, if I just said change you from AZT to d4T, you'd have possibly been happier but you wouldn't be happy if you knew, if you knew it was my second choice.
AMPLIFY shared technical code (technical code includes SDM)	P 29_93	No. No, that's right, I mean yeah I think last time we only briefly touched on it and said "oh well there is this other thing as an alternate to AZT which is less toxic" and I'm a little concerned about the toxicity of that especially since I, I feel th
PROPOSE: evaluate alternatives BEARINGS: evaluate Rx experience	D 29_94	Such as what?
BEARINGS: evaluate Rx experience	P 29_95	Just that, that muscle there. I sort of looked at myself in the mirror you know, sort of looked a bit soft and wrinkly, where it didn't before, you know. Um, and that's
BEARINGS: evaluate Rx experience	D 29_96	I didn't talk about that, you must've read about that one. Saggy butt it's called.
BEARINGS: evaluate Rx experience/ AMPLIFY shared technical code	P 29_97	Saggy butt. Yes, yes or AIDS bum, or something ( )
AMPLIFY shared technical code	D 29_98	AIDS bum could be anything
AMPLIFY shared technical code	P 29_99	That's it, it has been, you know mentioned possibly in the, the HIV sort of things that I've read. Um, but yeah it's not bad enough, to warrant changing from my suspicions on that alone. ( ) If that was your second choice ( )
AMPLIFY shared technical code	D 29_100	Subtle. It's subtle, both got so many options that it becomes a matter of subtlety and I have to say that um if you got a group of AIDS freaks in a room, doctors I'm talking about.
AMPLIFY shared technical code (uncertainty, POV)	P 29_101	Yes ((laughs))
AMPLIFY shared technical code (uncertainty, POV)	D 29_102	There's by no means um . . by no means would there be a fabulous consensus. There would be a certain can. I mean there are certain things that you don't do



AMPLIFY shared technical code  
AMPLIFY shared technical code

AMPLIFY shared technical code  
PROPOSE: evaluate alternatives/AMPLIFY shared technical code

BEARINGS  
PROPOSE: evaluate alternatives/AMPLIFY shared technical code

PROPOSE: evaluate alternatives/AMPLIFY shared technical code  
PROPOSE: evaluate alternatives/AMPLIFY shared technical code

BEARINGS: Update since last visit  
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BEARINGS: Update since last visit

BEARINGS  
BEARINGS  
BEARINGS  
BEARINGS

PROPOSE: evaluate alternatives  
PROPOSE: evaluate alternatives

ENUNCIATE: enunciate part decision/ BEARINGS: Rx experience

BEARINGS: Rx experience

BEARINGS: evaluate Rx experience  
BEARINGS: evaluate Rx experience  
BEARINGS: evaluate Rx experience

BEARINGS: evaluate Rx experience

ENUNCIATE decision/  
BEARINGS: recap decision/enactment plan/

BEARINGS: Update since last visit  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit

BEARINGS: Update since last visit  
BEARINGS: MARKERS: propose obs/ test  
BEARINGS: MARKERS: propose obs/ test  
BEARINGS: MARKERS: propose obs/ test  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit

BEARINGS: Update since last visit  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit  
BEARINGS: Update since last visit

would be a certain con, I mean there are certain things that you don't do.

P 29\_103 Right  
D 29\_104 But when it comes to starting things you can do. People might go in different directions.

P 29\_105 Sure  
D 29\_106 I mean one of the things that people do, is to just add in indinavir, but I personally think if you, if you er think that saquinavir resistance is happening then you should switch it.

P 29\_107 Right  
D 29\_108 I, I can see people who, there is a trial for example going on where you have a number of reverse transcriptase inhibitors and then you put people on two protease inhibitors.

P 29\_109 Right

D 29\_110 I can see some sort of rationale behind that. You know one (providing) resistance to the other. You can't see the rationale behind adding in another one, you might as well switch it. Um, did you meet ( ) when you were here last? New staff member.

P 29\_111 Um,

D 29\_112 Nurse?

P 29\_113 I, I'm not sure.

D 29\_114 No, I mean

P 29\_115 Yeah I can't remember.

D 29\_116 I think I. I think I brought a doctor in to show,

P 29\_117 Yeah, yes.

D 29\_118 To show you to, but eh we've got a new um staff member called Leila who was the clinical nurse consultant at ((Hospital))

P 29\_119 Oh right

D 29\_120 You've heard of that one. Er, and on the AIDS unit and ah, we're using her quite a lot to chat with patients about how to fit in their regimes and, I think you should talk to her about how to rearrange your meals and stuff to take account with indinavir.

P 29\_121 Yes well, this is the other thing to, I don't actually eat three meals a day

D 29\_122 Oh well,

P 29\_123 I only eat one and so

D 29\_124 Well, that's fine

P 29\_125 And so

D 29\_126 That's fine for indinavir cause your meant to have it on an empty stomach.

P 29\_127 Right. Oh okay. ((laughs))

D 29\_128 Um, can I just go over with you. We've more or less decided ( ). Er just wanted to check about your joint pain.

P 29\_129 Um, I noticed a little bit of pain this morning in my knee and my shoulders, but, that's the first day for about like almost since I last was here, that I actually had any pain so. For a while it actually um you know went away almost entirely. I mean s

D 29\_130 Yeah, okay.

P 29\_131 But um

D 29\_132 Well in that case, we've got other things on our plate at the moment so, shouldn't really sort of get wound up with that at the moment. Is that all right?

P 29\_133 Yeah, yep that's fine.

29\_134 ((tape off))

D 29\_135 Guess we don't have any mess in there, ((talking while writing)) number one and I'm just summarising here number one repeat viral load er within naught point five of previous measurement. . . Which implies the support for hypotheses but this particular combo, Australian word "combo" - Combo is failing. Two discussed various options um decided to change the saquinavir to indinavir. Number three I found here so, it's p ( ), I found here um not disappeared but not prominent at this time.

P 29\_136 However, I did notice that the anal wart that was treated, has returned.

D 29\_137 That ( ) the wart ((laughs))

P 29\_138 It's quite annoying actually, I found

D 29\_139 Is it?

P 29\_140 Like yesterday I wiped my arse a bit hard and I actually bled. And I think I might have scraped it or

D 29\_141 Do you want me to have a look at it, in other words?

P 29\_142 I would, I would actually, like you, to check that out.

D 29\_143 Okay

P 29\_144 Just to have a look

D 29\_145 Anything else?

P 29\_146 That's oh, yeah, that came up in the weekend, I don't know what it was, it didn't look like like a cold sore, like herpes outbreak.

D 29\_147 You mean that ulcer on your lip.

P 29\_148 Yeah

D 29\_149 I'll have a look at it as well.

P 29\_150 Yeah, safe

D 29\_151 Okay.

P 29\_152 How to treat ( ) Seems to be going away but it was quite swollen

RECAP: recap decision/enactment plan/

RECAP: recap decision/enactment plan/  
 RECAP: recap decision/enactment plan/  
 BEARINGS: MARKERS: propose obs/ test  
 BEARINGS: Update  
 BEARINGS: Update  
 BEARINGS: Update  
 BEARINGS: Update  
 BEARINGS: Update  
 BEARINGS: Propose agenda  
 BEARINGS: Propose agenda

DIAGNOSE  
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 DIAGNOSE  
 DECLARE: declare recommendation/pref

AMPLIFY shared technical code

AMPLIFY shared technical code/ BEARINGS:  
 MARKERS: propose obs/ test

BEARINGS: MARKERS: propose obs/ test  
 BEARINGS: Update  
 BEARINGS: Update  
 BEARINGS:

BEARINGS:  
 AMPLIFY non-clin values  
 AMPLIFY non-clin values

BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 DECLARE: declare recommendation/pref/ ENACT  
 Treatment  
 BEARINGS: Update

BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 BEARINGS: MARKERS: obs/ test  
 DECLARE: declare recommendation/pref

BEARINGS: Update since last visit/ DECLARE:  
 elicit recommendation / elicit ENUNCIATION

ENACT: check supply 1

ENACT treatment decision: check supply  
 ENACT treatment decision: check supply  
 ENACT treatment decision: check supply  
 ENACT treatment decision: check supply  
 ENACT treatment decision: check supply

D 29\_153 ((Writing and talking)) Four, anal warty, bleeding: number five, ulcer on lower lip. We've got to get these redesigned, I mean these are pathetic. Look that's all the space I've got. I thought you were going to tell me in detail oh and then I turn it ov

P 29\_154 Right

D 29\_155 Right.

P 29\_156 So maybe you were saying that muscle area and see whether you saw

D 29\_157 Okay, oh did you weight yourself?

P 29\_158 Yes, seventy four k.

D 29\_159 All right. Thanks.

P 29\_160 It's only one below, which is not surprising since I'm not eating much.

D 29\_161 ((coughs)) I'll get some gloves

P 29\_162 Yes

D 29\_163 Then I'll look at you lip first. ...

D 29\_164 The pharmacist is out, I just want to have a quick word with her. Turn this to stop. ((turns off recorder))

D 29\_165 The sore on your mouth, it's either one or two things, it's either herpes

P 29\_166 Right, yeah.

D 29\_167 Doesn't look like it

P 29\_168 No, it looked different to herpes and I only get that on the inner side rather than the outside of the lips.

D 29\_169 ((sneeze)) Excuse me. Herpes actually looks on the inner mouth looks sort of like I think the word we use is herpigenus or serpigenus. Like a, like a eh, like a snake.

P 29\_170 Right okay.

D 29\_171 Squiggly. That's more punched out isn't it?

P 29\_172 Yeah.

D 29\_173 It, it, it's, I think it's more what we call a abscess ulcer. Which unfortunately isn't very helpful because it doesn't have a specific etiology.

P 29\_174 Right, it's one of those vague things that

D 29\_175 Yeah, it is one of the things

P 29\_176 Yeah, good. Could be caused by anything

D 29\_177 Strange enough if you get them really badly.

P 29\_178 Yep.

D 29\_179 There's the, this will probably send the 'willies' up you. But, the most effective treatment is Thalidomide.

P 29\_180 Oh, that's all right, I'm not having any children. ((laughs)) Yes I really. Thalidomide is quite a useful drug except in pregnant women.

D 29\_181 Thalidomide was a brilliant anti-inflammatory drug, there was a problem of course. It's used in leprosy. It's still used on leprosy and it turns out to be very good for mouth ulcers as well. Yeah, as you say the only bad thing about Thalidomide is its effect on pregnant women. Okay ... Oh you want me to have a look at that

P 29\_182 Seems to be

D 29\_183 Yeah it is a bit actually. Doesn't usually come on after this is quite so

P 29\_184 This little weepyness.

D 29\_185 Oh that, oh I'm looking at the the uh bulk. What actually happen is this is where it goes.

P 29\_186 All right, so that's sort of yeah. Oh maybe I just thought my bum was tighter than that ((talking at examination table))

D 29\_187 Yeah and lie on your left side facing the wall that way, that's it. Didn't realise you were so vain.

P 29\_188 ((laughs)) What do think I go walking every morning for. The health fix almost set into ( ) reducing fat and so forth

D 29\_189 Oh, this little thing here?

P 29\_190 Yeah.

D 29\_191 Is that what your worried about?

P 29\_192 Oh, it's actually you know some of ( ) it's very irritating.

D 29\_193 Oh, I'll just paint a little bit of stuff on it.

P 29\_194 That's what you did last time it sort of, it sort of subsided. It just came back again. As I said, sort of quite irritating when I, wipe... So is there only the one, I just wasn't sure as well, not being able to see that area.

D 29\_195 Yeah. Oh sorry, correction two.

P 29\_196 Ah-huh

D 29\_197 There's a couple, there's three actually, sorry. ((laughs))

P 29\_198 Yes, I though there might be a couple more

D 29\_199 Rising.

P 29\_200 Rising in the ground

D 29\_201 Okay, next time I might freeze them. Anyway coming back.

D 29\_202 ((moving back to desk))

D 29\_203 ...

P 29\_204 This ulcer seems to be healing up at the moment. Um, should I, d'you reckon I do anything to it or just

D 29\_205 Er, no, nothing at the moment. So those, you need more of the anti-virals, right?

P 29\_206 Yep.

D 29\_207 Bactrim you've obviously got, cause you ( ) into that. And

P 29\_208 But I think

D 29\_209 You still need ( ) pak

P 29\_210 That was the thing I didn't seem to get enough, better make sure.

ENACT treatment decision: check supply  
ENACT treatment decision: check supply

ENACT treatment decision: check supply  
ENACT treatment decision: check supply

ENUNCIATE: recon

diarise

diarise

diarise

diarise

diarise

AMPLIFY shared technical code

AMPLIFY shared technical code

AMPLIFY shared technical code

AMPLIFY shared technical and non-technical/  
diarise

ENACT treatment decision: produce new script/  
authority forms

ENACT treatment decision: produce new script/  
authority forms

ENACT treatment decision: produce new script/  
authority forms

ENACT treatment decision: produce new script/  
authority forms

ENACT treatment decision: produce new script/  
authority forms

ENACT treatment decision: produce new script/  
authority forms

ENACT treatment decision: produce new script/  
authority forms/  
AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

AMPLIFY shared technical code and values

ENACT Treatment supply

END

D 29\_211 And  
P 29\_212 Once again, and have to come in half way through and have to come in specially to get bactrim.  
D 29\_213 Okay. And (erythromycin ) right  
P 29\_214 Yeah. I didn't actually read the erythromycin pack very well and finally read it the other day and said "take on an empty stomach". I was going no wonder it makes me sick, take it with all of the others just before dinner, or just after dinner. So I re  
( )  
D 29\_215 ( )  
P 29\_216 Oh, half a ( )  
D 29\_217 Oh, I'd give them back to us  
P 29\_218 Yep okay  
D 29\_219 Yeah.  
P 29\_220 Didn't know whether that was, safe or what  
D 29\_221 Makes more sense doesn't it. Made a decision.  
P 29\_222 Sure. Well sure, but yes I didn't know that I could actually bring unused medicine  
D 29\_223 I don't know, I'll have to ask the pharmacist.  
P 29\_224 Or, would they dispose of it, I suppose better than having things lying around.  
D 29\_225 You mean you're thinking of selling it on the black market?  
P 29\_226 Well, no but I mean in that, as in you know, sits around in your drawer in a jar, and somebody picks them up and goes oh these look pretty, what do they do. Scoffs a handful and gets really sick or something. I don't know what the saquinavir has side ef  
D 29\_227 I've got various forms to fill in. . .  
P 29\_228 I suppose I have to make my other appointment. For the next one, how far away? two months? or we going to  
D 29\_229 One month.  
P 29\_230 One month. Okay.  
D 29\_231 We'll do viral load again  
P 29\_232 Yeah, okay.  
D 29\_233 Fact. If it's successful really should have an effect within two to four weeks.  
P 29\_234 All right.  
D 29\_235 Noticeable effect.  
P 29\_236 So it's worth coming in for that... Yes, I was not sure, should it just show up within two months or whether, give it a chance. Now the indinavir doesn't have to be taken the same way as the saquinavir?  
D 29\_237 I can't think. . . Apply for it, fit into one of these. . . See if we can find you. What was it ((number)) wasn't it? Here we are, date ceased seventh four ninety seven. Apply for indinavir. I started somebody on all four yesterday, and I just spent ((dob))  
P 29\_238 ((dob))  
D 29\_239 What?  
P 29\_240 ((dob))  
D 29\_241 . . And ( ) a individual application . . . ( ) which just has to be copied on to this and your file on to file ( ) . . . Date is  
P 29\_242 Eighth  
D 29\_243 I've asked you this about four times already. Just go and photocopy this. ((turns off tape)) Going out to lunch with the drug the drug firms. I very rarely have an hour to spare and secondly they bombard you. And so they've got me booked in to go for  
P 29\_244 Right.  
D 29\_245 But that's what they're complaining at, at the desk this morning. Um, so while I'm looking, it's just giving me the opportunity however to count the number of people we've got on. I'm just getting to the right place.  
P 29\_246 So do the drug companies do quite a bit of wooing the doctors  
D 29\_247 Yes, but they don't get very far with us, because we just don't have . . . the the usual thing is, I have to say, is that um they come in and they and you say right, you can have half an hour and then an hour later you're still trying to get them out of th  
P 29\_248 Right, yes. Absolutely convinced they've got you as ah customer  
D 29\_249 Yeah, that's right. Now let's see how many people are on. They'll ask me. Not that many as you can see. One, two, three, four, five, six, seven, eight. Where as saquinavir . . . They'll be hoping to pick up all this.  
P 29\_250 I see  
D 29\_251 One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, twenty-seven, twenty-eight.  
P 29\_252 You've counted some of the people who are ceased.  
D 29\_253 Oh, but that, yeah one or two here, ( ). Right, wunderbah, just got to get the drugs.  
P 29\_254 Yeah.

Figure 5.19 Generic Structure of wart treatment decision, Consultation 29, Neil and Trevor.

BEARINGS: evaluate Rx experience	D	29_130	Yeah, okay.
BEARINGS: evaluate Rx experience	P	29_131	But um
BEARINGS: evaluate Rx experience	D	29_132	Well in that case, we've got other things on our plate at the moment so, shouldn't really sort of get wound up with that at the moment. Is that all right?
BEARINGS: evaluate Rx experience	P	29_133	Yeah, yep that's fine.
		29_134	((tape off))
ENUNCIATE decision/ (HAART)	D	29_135	Guess we don't have any mess in there, ((talking while writing)) number one and I'm just summarising here number one repeat viral load er within naught point five of previous measurement. . . Which implies the support for hypotheses but this particular combo, Australian word "combo" - Combo is failing. Two discussed various options um decided to change the saquinavir to indinavir. Number three I found here so, it's ( ), I found here um not disappeared but not prominent at this time.
BEARINGS: Recap decision/enactment plan/			
BEARINGS: Update since last visit	P	29_136	However, I did notice that the anal wart that was treated, has returned.
BEARINGS: Update since last visit	D	29_137	That ( ) the wart ((laughs))
BEARINGS: Update since last visit	P	29_138	It's quite annoying actually, I found
BEARINGS: Update since last visit	D	29_139	Is it ?
BEARINGS: Update since last visit	P	29_140	Like yesterday I wiped my arse a bit hard and I actually bled. And I think I might have scraped it or
BEARINGS: Update since last visit	D	29_141	Do you want me to have a look at it, in other words?
BEARINGS: MARKERS: propose obs/ test	P	29_142	I would, I would actually, like you, to check that out.
BEARINGS: MARKERS: propose obs/ test	D	29_143	Okay
BEARINGS: MARKERS: propose obs/ test	P	29_144	Just to have a look
BEARINGS: Update since last visit	D	29_145	Anything else?
BEARINGS: Update since last visit	P	29_146	That's oh, yeah, that came up in the weekend, I don't know what it was, it didn't look like a cold sore, like herpes outbreak.
BEARINGS: Update since last visit	D	29_147	You mean that ulcer on your lip.
BEARINGS: Update since last visit	P	29_148	Yeah
BEARINGS: Update since last visit	D	29_149	I'll have a look at it as well.
[turns omitted]			
DECLARE: declare recommendation/pref	D	29_179	There's the, this will probably send the 'willies' up you. But, the most effective treatment is Thalidomide.
AMPLIFY shared technical code	P	29_180	Oh, that's all right, I'm not having any children. ((laughs)) Yes I really, Thalidomide is quite a useful drug except in pregnant women.
AMPLIFY shared technical code/ BEARINGS: MARKERS: propose obs/ test	D	29_181	Thalidomide was a brilliant anti-inflammatory drug, there was a problem of course. It's used in leprosy. It's still used on leprosy and it turns out to be very good for mouth ulcers as well. Yeah, as you say the only bad thing about Thalidomide is its effect on pregnant women. Okay ... Oh you want me to have a look at that
BEARINGS: MARKERS: propose obs/ test	P	29_182	Seems to be
BEARINGS: Update	D	29_183	Yeah it is a bit actually. Doesn't usually come on after this is quite so
BEARINGS: Update	P	29_184	This little weepyness.
BEARINGS:	D	29_185	Oh that, oh I'm looking at the uh bulk. What actually happen is this is where it goes.
BEARINGS:	P	29_186	All right, so that's sort of yeah. Oh maybe I just thought my bum was tighter than that ((talking at examination table))
AMPLIFY non-clin values	D	29_187	Yeah and lie on your left side facing the wall that way, that's it. Didn't realise you were so vain.
AMPLIFY non-clin values	P	29_188	((laughs)) What do think I go walking every morning for. The health fix almost set into ( ) reducing fat and so forth
BEARINGS: MARKERS: obs/ test	D	29_189	Oh, this little thing here?
BEARINGS: MARKERS: obs/ test	P	29_190	Yeah.
BEARINGS: MARKERS: obs/ test	D	29_191	Is that what your worried about?
BEARINGS: MARKERS: obs/ test	P	29_192	Oh, it's actually you know some of ( ) it's very irritating.
DECLARE: declare rec/pref/ ENACT Treatment	D	29_193	Oh, I'll just paint a little bit of stuff on it.
BEARINGS: Update/	P	29_194	That's what you did last time it sort of, it sort of subsided. It just came back again. As I said, sort of quite irritating when I, wipe... So is there only the one, I just wasn't sure as well, not being able to see that area.
DECLARE: ? not happy with Rx			
BEARINGS: MARKERS: obs/ test	D	29_195	Yeah. Oh sorry, correction two.
BEARINGS: MARKERS: obs/ test	P	29_196	Ah-huh
BEARINGS: MARKERS: obs/ test	D	29_197	There's a couple, there's three actually, sorry. ((laughs))
BEARINGS: MARKERS: obs/ test	P	29_198	Yes, I though there might be a couple more
BEARINGS: MARKERS: obs/ test	D	29_199	Rising.
BEARINGS: MARKERS: obs/ test	P	29_200	Rising in the ground
DECLARE: declare recommendation/pref	D	29_201	Okay, next time I might freeze them. Anyway coming back.

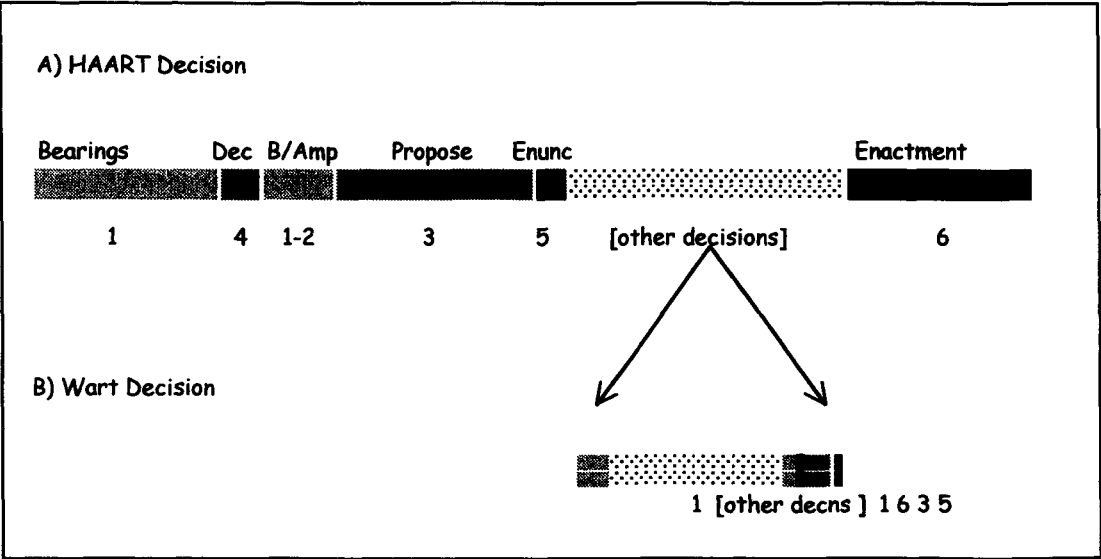


Figure 5.20 Movement from phase to phase in two decisions (HAART and wart)

The phasing of the two treatment decisions discussed is shown in Figure 5.20 above. This representation draws on the banding analysis of Elwyn et al. (2001), though with some differences. Each phase is represented by its ordinal in the six-phase GSP outlined above, and for the HAART decision, since there is space, the phases are named or abbreviated. The length of the each phase<sup>1</sup> is indicated by the length of its respective coloured bar, giving a good indication of relative attention given to each phase. The diagram also shows at a glance the extent to which each instance of decision-making follows the expected phasal sequence, since a “perfect” instance would move from lightest shade (Bearings) to darkest shade (Enactment). Note that the diagram of the HAART discussion supports the view that there is considerable iteration (and transitional phases, which Figure 5.20 does not show), but that the semantic drift overall is in the direction expected.

Examining Figure 5.20 with respect to the HAART decision, it is noticeable that despite this general drift of sequencing the phase *Declaration* appears before the

<sup>1</sup> Length of phase is measured here as the number of turns taken (cf Elwyn et al’s (2001) elapsed time).

phase *Propose Options*. This may seem illogical, and likely to make it difficult for the decision-making to proceed as a shared process. But an examination of the more detailed display of the phasing of this decision in Figure 5.18 suggests that this particular sequencing still serves to support shared decision-making. Figure 5.18 shows that the Declaration move is made by the doctor (turn 50 ff), and it is reasonably directive and unequivocal. However, the Declaration is made only to a certain level of delicacy – i.e., the declared recommendation is for making some unspecified change to the drugs; the changes themselves have not yet been identified. As discussed above, this allows the patient and the doctor to negotiate the details of which drugs to change. After the declaration that some change is necessary, it is the patient who begins elaborating on the recommendation, specifying AZT as the drug he would like to change. The patient's move here (turn 57) can be seen as an attempt to participate in the process of the Declaration. It is not *entirely* successful, since the doctor indicates with his initial lack of agreement, and subsequent stated disagreement, that he does not share the patient's view – attempting a joint Declaration of recommendation is problematic here, and arguably it is inherently so. But this move is not entirely unsuccessful either, since it leads to an examination of the feasibility and relative potential benefit of the patient's suggestion. This is intermingled with the doctor's laying-out of the options as he sees them. Within this instance of the phase *Propose Options*, we can identify, in a more delicate description, the elements *list options*, *describe treatments*, and *evaluate alternatives*. There are also iterative moves back to *Bearings* in order for the patient to recount and evaluate his *treatment experience* with AZT. Both views are taken into account, and the patient appears to have had the opportunity to present his concerns about side effects with AZT, and about compliance with the regimen in general, as relevant to the decision-making about treatment, but decides to weight them as not important enough to argue for a different plan from the one the doctor is recommending.

From this perspective, the decision counts as a shared one. One feature which is of interest, however, and which arguably acts against maximally shared decision-making, is that the terms by which the options are evaluated by the doctor are left vague and implicit. It is largely through the semantics of preference that the alternatives are compared. The doctor identifies and explains his disagreement with

the patient largely in terms of his preference, and in terms of classes of drugs and the rationale of substituting within class, and this is reciprocated in the patient's response (declaration at turn 99). It is not until *after* the patient has downplayed his rationale in favour of the doctor's recommendation that the doctor's rationale is stated, and even when it arrives it must be inferred as something along the lines of: (i) let's change saquinavir because I think you have saquinavir resistance; (ii) let's substitute it rather than adding something else to it because I can't see a rationale for the latter if you're already resistant. The doctor's appeal not to a particular authority but to a range of opinions and lack of consensus has the potential to enhance shared decision-making, since it construes the context as one in which the doctor and patient may have more reciprocal agentive roles, along the lines suggested in discussions of equipoise (see above, and Elwyn, Edwards, Gwyn and Grol 1999). However, locating this discussion of lack of consensus *after* the patient has been persuaded to take the doctor's view may have the opposite effect. The rationale provided for this decision has something of the character of justification rather than motivation, largely because of its placement.

This decision exemplifies a fairly common pattern of achieving shared decision-making in the HIV consultations of this corpus, which we might call the "doctor-scaffolded". While HIV treatment decisions as a whole tend to be incrementally achieved, the doctor-scaffolded type is particularly incremental, with the doctor scaffolding the increments from a general consensus to a very particular one. This type of shared decision-making is often accompanied by explicit increment markers such as the ones produced here, in particular:

29\_54 D ... There's only one management option ...  
 29\_128 D ... We've more or less decided  
 29\_221 D ... Makes more sense, doesn't it. Made a decision...

In the other decision examined from this Consultation, on the problem of anal warts, a glance at Figure 5.18 shows that Enactment occurs directly after Bearings, with no Proposal of Options. Again, the out-of-order sequencing has potential for precluding shared decision-making, and if the discussion were about starting or changing antivirals it would almost certainly signify a highly paternalistic style of decision-making, or some kind of major problem. For the reasons discussed above,

however, the wart decision is *not* inappropriately non-participative. The schematic representation of this decision episode in Figure 5.18 can be seen as an extreme version of another fairly common pattern among the consultations examined in this corpus, which we might describe as the “coda” pattern. In these decision-making episodes, the process of deciding unfolds almost until it is marked by both sides as complete – i.e., enunciated and/or enacted – and then there is a coda, initiated by the patient, that redirects attention to an earlier phase and results in a reconsideration of the decision.

### 5.5.3 Some key findings on phasal sequencing and shared decision-making

The observed patterns in HIV decision-making in Sydney in the late 1990s show a number of similarities with other recent studies of shared decision-making (e.g., Elwyn et al. 2001), but a number of other patterns were found in this present study that have not been highlighted in the literature.

#### Bearings phase: knowledge and values calibration

Unlike Elwyn et al.’s consultations, considerable time is given in the consultations in the present study to exploring patient ideas and concerns about treatment options. This can take place early in the consultations, but it seems it is always possible for the consultation to “go back”, either to revisit information discussed earlier or, more commonly, to elaborate quite substantially on it, or to address patient queries about the applicability or theoretical plausibility of technical or strategic arguments.

#### Exploring the patient’s preferred role in decision-making

Significantly, I have found very little explicit reference to decision-making styles, or to the patient’s role in decision-making or preferences in decision-making (only 2 instances in 74 consultations). Where explicit attention is drawn to the patient’s role, it tends to consist either of the doctor declaring that the patient needed to own the decision, or of the patient declaring some level of frustration with the burden of responsibility, and it tends to be done with some levity. In no case does the discussion of the difficulty of responsibility appear as a cue for handing over



responsibility. In one consultation (Consultation 59) the doctor treats the issue of patient ownership of decisions as a protection for the doctor against patient dissatisfaction, although in a humorous manner. Note that this exchange takes place *after* a complex treatment decision has been reached:

59_719	P	God, imagine trying to make these decisions if you didn't even have the half a brain I've got! It'd be very difficult, wouldn't it?
59_720	D	Well, people often manage to instead um .. get told what to do.
59_721	P	I think that's great, at least you can complain about something going wrong, you know. ((laughs))
59_722	D	It's all your fault - you told me?
59_723	P	Yeah
59_724	D	I'm not stupid! I'm not going to get you to do that! Crikey moses!

Elwyn et al. (2001) offer by way of explanation of this phenomenon the analysis that public discourse, including medical interaction, works by “muddling through” in the face of numerous and various resource and other constraints, rather than by careful implementation of policies such as steps in shared decision-making (citing Lindblom 1959). Elwyn et al.’s findings that practitioners “explore” issues by “presenting practical options and teasing out the resulting issues” (Elwyn 2001: 219) resonates with the observation in this study that the preferred method seems to be for doctors to present a treatment choice, even as a contingent choice, and see how it goes conversationally. The conversational strategy seems not unlike the pharmacological treatment strategy itself, which is often a serial trial-and-error approach, and which is often stated as “let’s try xyz and see how you go on that, and if it doesn’t work, fine, we’ll try abc”.

But the metaphor of “muddling through” suggests that practitioners are trying to behave a certain way and not managing to do so. It would be more appropriate to view such professional practices as (not necessarily conscious) flexible discursive strategies which in fact fit the design of shared decision-making in the context of HIV medicine better than an approach in which the options are pre-determined and laid out before the interactive discussion begins, and in which dialogic style is a topic in its own right. Compared with the HIV consultations examined here, treatment consultations between women with breast cancer and their oncologists, including discussion of clinical trial participation, are more likely to be set out in the latter

way, i.e., in a way which separates the listing of options and evaluation of options from the doctor's recommendation of a particular option (see Brown et al. in press).

A slightly different take on Elwyn et al's explanation would be to invoke the work of conversation and discourse analysis and argue that patient autonomy, like doctor-patient asymmetry (Maynard 1991, ten Have 1991, Drew and Heritage 1992) in decision-making, is an interactional achievement in the sense that it may be possible to enact preferences for decision-making style without eliciting or declaring them – as it is in many other conversational practices, for example when one interactant expresses a grave tone and others “automatically” follow suit, or when one person begins to “take charge” in an emergency and others “automatically” follow. The “automatic” response emerges from an interaction of the participants' respective habitus with the meanings exchanged in the situation, i.e., when there is strong codal sharing.

We could argue that since the parties in my study have well-established professional relationships we would expect them to have discussed preferences for decision-making styles at an earlier point in the relationship. However, this seems unlikely, because the Tenor of the majority of the relationships observed here is at odds with an approach that elicits decision-style preferences up front as a separate task of professional ‘work’. The display of reciprocal agentive status, and extensive codal sharing, seem likely to come with an implicit expectation on the part of doctors that patients will want to be active in treatment decisions. Note too that there does not seem to be any upfront negotiation of the format of information that patients might prefer, including preferences for risk format or visual/verbal mode. There is however evidence that doctors are attentive to patients' use of rhetorical strategies or tropes (e.g., viral metaphors including “Star Trek” metaphors and the metaphor of “making virus babies”), and it is likely that they adapt their coding of information to suit (their sense of) the patient's style.

### Enunciation of decisions

This phase is often invisible, minimally realised, realised simultaneously with an earlier phase, and can occur sequentially before “logically” prior moves, such as describing and evaluating the alternatives.

### Recursive/ iterative nature of the phases

Unlike most published models of shared decision-making that invoke specific stages, the decision-making observed here unfolds as a series of semantic elements which tend to be grouped with other semantic elements to form phases of the context of situation, but which can be 'revisited', or 'reclustered'. Even the phases that appear to be the least open to revisiting are, empirically, open to such treatment. The moves Declaration and Enunciation (which best correspond to Charles et al.'s "final choice") are often revisited in this way. The analysis here is similar to the 'banding' analysis provided by Elwyn et al. (2001), but there are a number of crucial differences, as follows.

1. The phases in shared decision-making about HAART, based on the data examined here, are not distinct from each other. They can be interpreted as a kind of semantic drift, such that the same message may have a different status depending on where it is placed sequentially in the interaction. When the various semantic elements are repackaged, it is often important to acknowledge changes in their contextual status. Thus the status of a move may be a function of the interaction of sequential placement and temporally stable semantic factors.
2. Contextual elements may cluster into one pattern of phases or another. For example, the likely side effects of a particular treatment may be described as part of the Proposal phase, as a kind of mapping out of alternatives and potential experiences; or the same kinds of issues may be found as part of the Enactment phase, after a decision has been made about which treatment to have. A third alternative is that the side effects of a treatment are explained and described as part of a subsequent consultation in which the drugs decided on previously are now being evaluated. In this case the mode of presentation is report, and the phase this helps to realize is the Bearings phase.
3. Stages do not take a fixed order, but cannot be undertaken in just *any* sequence without deleterious semantic and contextual effects. For instance, for doctors to

collapse Declaration of preference and Enunciation arguably propels a consultation towards the paternalistic model. If that instance is to retain any potential for shared decision-making, some kind of counter-movement will need to be made. In order to display this we can plot the relation between Field, Tenor and Mode settings and Generic Structure Potential, building a dynamic orientation into both our synoptic (Field, Tenor and Mode) and dynamic (GSP) modelling.

4. Contra Elwyn et al. (2001), phase-shifts in HIV treatment decision-making are not consistently the professional’s responsibility. Whether this has any negative effects is unclear. In practice, episodes that ultimately instantiate shared decision-making often rely on patient-initiated phase shifts, particularly in the revisiting of phases.

Effects of fuzzy phase boundaries

The functional and transitional boundaries between consultation phases may be incremental, and also negotiable. In the following example from Consultation 8, this can be seen in the patient’s move at turn 248, where the boundaries between Eliciting a recommendation and Declaring a recommendation become very fuzzy. This of course has consequences for the portrayal of the patient as a semiotic agent, and for the analysis of such a portrayal.

ENACT:	8_243	D	If you're uncertain about it, you've got bad diarrhoea or whatever, just stop them, that's fine.
	8_245	P	Yeah, yeah.
	8_245	D	A day or two off the tablets ..
	8_246	P	Yeah
	8_247	D	won't make any difference.
DECLARE? ELICIT?	8_248	P	Given that I in the past I've had a problem with haemorrhoids et cetera and s- s- sometimes it's been precipitated by a diarrhoea type thing um I s'pose I should use um .
	8_249	D	Rectinol?
	8_250	P	Yeah, Rectinol as a sort of a .. a safety guard.
	8_251	D	Yep, I can give you a script for that.

Such fuzziness is best interpreted as a feature of linguistic and other semiotic systems (Halliday and Matthiessen 1999) which interactants may exploit for various rhetorical purposes. Producing interaction-directing moves which lie on such a fuzzy boundary between Declaring a recommendation and Eliciting a recommendation allows patients to push the agentive roles of treatment decision-making towards equality without claiming full equality.

#### Directiveness in shared decision-making

Research on counselling in such settings as family planning (Candlin and Lucas 1986), HIV testing (Peräkylä 1995, Silverman 1997) and medical genetics (Sarangi and Clarke 2002) have shown that despite an explicit professional commitment to non-directiveness counsellors are often heard as providing clinical recommendations or advice. In HIV medicine there does not seem to be an explicit policy of eschewing advice. There does seem to be a policy of avoiding responding in terms of what the doctor would do personally (cf. Sarangi 1998), but HIV practitioners appear to be ready to present their professional recommendation and mount persuasive arguments as to why it might be better than the patient's preference. Instead of a problem with doctors covertly implying a preference that may or may not be correctly interpreted by patients (cf. Charles et al. 1999a, Brown et al. in press), the problems in this area for HIV medicine seem to be (i) that doctors' recommendations may be heard as comparative evaluations of treatment options when they are not, or are only minimally so; and (ii) that only patients with strong rhetorical skills may be in a position to enter into persuasive debate.

To summarise the findings of this section, the meaning potential of typical-ideal shared decision-making can be analysed to a large extent in terms of my proposed model of the sequencing of phases of in the context of HIV treatment decision-making. Further descriptive power is available by attending to the way semantic features cluster to mark shifts in phase, e.g., through the concept rhetorical units, which have been used informally here. The model is, of course, far from perfect, and only one of a range of perspectives required. In particular, more clarification is required on the ways in which agentive roles are construed, and the ways in which

doctors and patients respond to differences in their view of the context as it is unfolding. These issues will be discussed in chapter 6.

## **5.6 Implications of modelling medical decision-making as multidimensional**

Before closing this chapter, it remains to recapitulate the advantages that the approach outlined above provides, along with some of its limitations and challenges. I have argued that a multidimensional approach captures ways in which informed choice is similar to paternal medicine, and shows that representing these two decision-making styles as two extreme poles with shared decision-making in between is in some ways misleading. In particular, and most importantly, this continuum model is misleading about what kind of context SDM is and therefore it is misleading about how we might achieve SDM, or avoid it, or evaluate its effects. A multidimensional approach like the one explored here allows decision-making styles to be more carefully compared with each other, and embeds their comparison within a theory of contextual variation more generally. Thus the different ways of conducting medical interactions and decisions about treatment are considered not as isolated phenomena but as part of the repertoire of the “forms of life” of a culture. However, three main challenges for contextual modelling remain, largely stemming from the need to adequately encompass the effects of dialogic mode.

### **Divergent participant views of the context**

Firstly, there is a need to account for the different views of the context which an individual patient and an individual doctor may be trying to impose on each other. It may be argued that there are always two versions (or more in multi-party talk) of any map of the contextual configuration and of the contextual phasing. This perspectival character must be acknowledged, but the danger of writing two separate accounts is that we fail to acknowledge that interaction itself is always jointly achieved, including in medicine (Maynard 1991, ten Have 1991).

### Mobilising divergence to change the 'style' in which a decision is made

Secondly, there is the need to account for a kind of dynamic potential for the contextual configuration of any instance of decision-making to change, over and above the dynamic movement that occurs as the unfolding of phases. A decision-making episode may progress from being paternalistic to being shared (cf. Charles et al. 1997), at the same time as the episode progresses through some kind of temporal phasing, whichever 'style' it becomes. Although this is a problem, it is a very general one<sup>1</sup>. As any text/context unfolds over time, the choices from the network that have gone before influence which choices may follow – that is, what has been said, meant, and done constrains, but does not determine, what speakers can say, mean, and do next (Lemke 1991). This issue can be dealt with informally in a number of ways. The solution used here is to envisage the contextual configurations of decision-making episodes as a series of snapshots. The aim of the snapshots is to show how the contextual parameters are related to each other syntagmatically (what can follow or evolve into what) but to keep this within a paradigmatic perspective (showing how each parameter takes its value from its domain of contrast). It would certainly be possible to map such dynamic negotiation of context by showing a series of the "snapshots" of Field, Tenor and Mode shown here, but it has not been possible for reasons of space to present such a time series here, and it may be too cumbersome for most research.

### Complex contexts

Thirdly, as Cicourel (1992) points out, there is always the challenge of identifying which context or which aspects of context are relevant to the description and

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<sup>1</sup> There is a vast literature on the need for linguistics to take a dynamic approach to verbal interaction, which is beyond the scope of this chapter to entertain in any detail (see Sacks et al. 1974) (Sacks and Schegloff 1979 for general arguments). For arguments that pertain particularly to the modelling of context see Martin (1985), Hasan (1995) and Ventola (1987). In my view, a dialectic between the so-called synoptic and so-called dynamic approaches is necessary (cf Hasan 1999; Markova 1990a, ten Have 2001), although such a dialectic might of course take many forms and would not necessarily resolve disparate views into consensus. For SFL, in my view, some of the problem comes from doctrine that probabilities of certain choices and combinations occurring are inside the linguistic system itself. Reconsidering the implications of the observations that led to such a doctrine may release some of the pressure against allowing a single network to represent more than one register, context, depth of context ( $\alpha$ ,  $\beta$  and so on). It would be consistent with recent directions in the philosophy of probability and philosophy of statistics (Price 1981).

explanation of interaction – and the challenge of supporting one’s reasoning about this. In a similar vein, Hasan suggests (1999) that the difficulty is not in identifying multiple contexts or aspects of context but in theorising the relation between the relevant contexts in play in any particular stretch of interaction, principally whether they are complex (comprehensively relevant to the principal activity) or parallel (and co-occur by chance). For the present study, we have noted that *decision-making about treatment* is in a sense always a second-order ( $\beta$ ) context which is aligned to the first-order ( $\alpha$ ) context, HIV treatment, a context which in terms of enactment largely takes place off-stage, but which is recontextualised – to a greater or lesser extent – within the process of making decisions and reviewing treatment. A key challenge is that it is not only the medicalised aspects of the patient’s life outside the clinic (e.g., dosing) that count as relevant here; it is important from analytical and practice perspectives to be open to relations between contexts that patients construe as related, even when these may seem unrelated by practitioners or analysts. E.g., if a patient asks “Can I have sex while taking 3TC?”, the context of sex must be considered part of the complex context of treatment decision-making<sup>1</sup>.

## 5.7 Summary of this chapter

Despite their difficulties, the context network and GSP schema used in the analyses above provide a consistent contrastive matrix for describing and comparing different instances of treatment making, and characterising these in terms of variation in style of decision-making. The analyses highlight a number of features that distinguish shared decision-making from other varieties, most crucially:

- a) phasally varying and complementary agentive roles
- b) reflection-based action
- c) the recognition, negotiation and alignment of multiple goals as three key parameters
- d) the amplification of the patient’s voice

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<sup>1</sup> The contexts of HIV treatment, adherence and sexual activity have since become a recognised set of interrelated contexts, mainly around concerns that people become complacent about safe sex when achieving ‘viral suppression’ from treatment, which risks transmission and reinfection (Davis et al. 2002).



- e) the discreteness of the moves Declaration and Enunciation
- f) the differentiation of the doctor's and patient's voices in the phases of Declaration and Enunciation.

Chapter 6 explores in more detail the linguistic and interactive realizations of these key features, with particular reference to agency and alignment.