Communication Patterns in Consultations Between Patients with Atrial Fibrillation and Health Professionals

Eleni Siouta

School of Health Sciences, Jönköping University

DISSEPTION SERIES NO. 35, 2012

JÖNKÖPING 2012
Till Michael
Abstract

Background
Patients’ preferences, needs and desires are important when discussing treatment. In consultations between patients with atrial fibrillation (AF) and health professionals, knowledge, understanding and insight about communication patterns are of vital importance for strengthening patient involvement in decision-making about their care and treatment.

Aim
The general aim of this thesis was to describe communication patterns in consultations between patients with AF and health professionals.

Specific aims
(1) To describe (i) the topics patients with AF and their nurses and physicians discuss; (ii) the use of discursive space in consultations between these participants; and (iii) the frequencies with which patients and nurses/physicians introduce the identified topics.
(2) To describe the types of patient resistance to accepting treatment with warfarin and how cardiologists respond to such resistance.

Methods
An inductive design was used. In study I, the sample consisted of 23 consultations between patients with AF (13 women and 10 men) and health professionals (5 women and 5 men) who were employed in six different cardiologic outpatient clinics. Content analysis was used to obtain a description of topics discussed. The patterns of dominance for the various topics and participant were explored from the framework of an analysis of dominance (I). In study II, the sample consisted of 11 consultations between patients with AF (7 women and 4 men) and cardiologists (2 women and 3 men). Conversation analysis was used to describe interactions concerning resistance to treatment with warfarin.

Findings
Study I. Four topics were introduced by both nurses and physicians during the consultations. These were “pathophysiology”, “treatment”, “diagnostic procedures”, and “activity”. In the nurse–patient consultations an additional topic, “routines related to the physician’s responsibilities”, emerged. With respect to the number of words and turns, the distribution of the discourse
space was almost equal between nurses and patients, and unequal between physicians and patients. The patients were the dominant initiators of the topic “activity”, which refers to adaptation of activities in daily life in relation to AF.

**Study II.** There were four types of patient resistance to accepting treatment with warfarin. These included “Giving reasons for their resistance”, “Suggesting other treatment options”, “Stating treatment preferences” and “Questioning or challenging the cardiologist’s treatment recommendations”. The cardiologists’ responses to the patients’ resistance included “Repeating the treatment recommendation”, “Negotiation with the patient”, “Providing additional information about the recommended treatment” and “Extending their explanation of the purpose of the treatment”.

**Conclusions**
The medical-driven agenda dominated over the patient-driven agenda in consultations between health care professionals and patients with AF. During conversations in consultations with nurses, the patients initiated discussion of living with AF and were more talkative than they were with physicians. An awareness of types of patient resistance to treatment would enable cardiologists to consider patients’ experience-based views about their treatment; this should increase patient participation in treatment decisions.

**Keywords**
Atrial fibrillation, communication, consultation, dominance, patient participation, resistance interaction, shared decision-making, warfarin.
Original articles

This thesis is based on the following studies, which are referred to by their Roman numerals in the text:

Study I

Study II

These studies have been reprinted with the kind permission of the respective journals.
# Contents

**Introduction** .......................................................................................................................... 9

**Background** ............................................................................................................................... 11  
**Patients with atrial fibrillation** .................................................................................................. 11  
Pathophysiology, prevalence and incidence .................................................................................. 11  
Symptoms ...................................................................................................................................... 11  
Treatment ....................................................................................................................................... 12  
**Patient participation** ................................................................................................................. 13  
The concept of patient participation .............................................................................................. 13  
Patient participation in general health care settings ....................................................................... 13  
Patient participation in nursing settings ....................................................................................... 14  
Patient participation in medical settings ....................................................................................... 15  
**Decision-making** ....................................................................................................................... 16  
The concept of decision-making .................................................................................................... 16  
**Decision-making models** .......................................................................................................... 17  
The paternalistic model ................................................................................................................... 17  
The shared decision-making model ............................................................................................... 17  
The informed decision-making model ............................................................................................ 18  
**Communication** ....................................................................................................................... 19  
The concept of communication ....................................................................................................... 19  
Communication as institutional talk ............................................................................................. 20  
Monologic and dialogic views of communication ......................................................................... 21  
Studies on the contexts of consultations ....................................................................................... 22  
**Theoretical underpinnings** ........................................................................................................ 25  
**Aim of the thesis** ....................................................................................................................... 27  
Study I ........................................................................................................................................... 27  
Study II .......................................................................................................................................... 27
Material and methods .............................................................. 29
Design and setting ...................................................................... 29

Description of methods ............................................................ 30
  Qualitative content analysis (Study I) ........................................ 30
  Dominance patterns in interactions (Study I) ............................ 31
  Conversation analysis (Study II) .............................................. 31
  Participants (Studies I and II) .................................................. 32
  Data collection (Studies I and II) ............................................. 33

Data analysis ........................................................................... 37
  Qualitative content analysis (Study I) ........................................ 37
  Analysis of dominance (Study I) ............................................. 37
  Conversation analysis (Study II) ............................................. 38

Ethical considerations ............................................................. 40

Results ..................................................................................... 43

Study I ..................................................................................... 43
  Topics in consultations with nurses ......................................... 43
  Topics in consultations with physicians ................................. 44
  Use of the discourse space in relation to topics discussed during consultations with nurses ................................. 45
  Use of the discourse space in relation to topics discussed during consultations with physicians ................................. 46
  Distribution of initiating statements according to the topics discussed in consultations with nurses ......................... 46
  Distribution of initiating statements according to the topics discussed in consultations with physicians ......................... 46

Study II ...................................................................................... 48
  Patient resistance to cardiologists’ recommendations regarding warfarin treatment ............................................ 48
  Cardiologists responses to patient resistance .......................... 49

Discussion ............................................................................... 51
  Study I .................................................................................. 51
  Study II ................................................................................. 53
General discussion ............................................................................................ 58
Methodological considerations ......................................................................... 59
Comprehensive understanding ......................................................................... 61
Conclusions ........................................................................................................ 64
Clinical implications ........................................................................................ 65
Study I .................................................................................................................. 65
Study II ................................................................................................................ 65
Future studies ...................................................................................................... 67
Svensk sammanfattning ..................................................................................... 69
  Bakgrund .......................................................................................................... 69
  Studie I .............................................................................................................. 70
  Studie II ............................................................................................................ 72
Acknowledgements ............................................................................................ 74
References ............................................................................................................ 77
Appendix: Extracts used in Study II ................................................................. 91
Introduction

Atrial fibrillation (AF) is a common cardiac dysrhythmia [1], the prevalence of which is estimated to be 1.5–2% of the general population in the developed world [2, 3]. Having AF can negatively affect physical, mental and social aspects of patients’ daily lives [4]. Patient preferences, needs and desires, are important when discussing treatment [5] and there is growing agreement that patients should be more involved in their own treatment decisions [6]. Both nationally and internationally, patients’ positions regarding sharing of information and knowledge according to their individual needs have become stronger. The Swedish National Board of Health and Welfare and national guidelines for cardiology [7] highlight patient participation in decision-making about treatment as an important issue. Ethical guidelines also emphasize the right of patients to be fully informed and to participate in treatment decision-making by sharing information, opinions and decision-making itself [8]. Factors affecting the ways patients communicate with health care providers can have important implications for patient satisfaction and participation; attention to them results in better health outcomes and quality of care [9].

Institutional discourses primarily involve asymmetries in which patients are subordinated, or subordinate themselves, to experts [10]. Such asymmetry is related to patterns of dominance; for example, regarding knowledge or the relative positions of the participants [11, 12]. Even when there is institutional asymmetry between the parties in a consultation, such consultations are still meetings between two equal human beings [8]. There is a trend toward change in patients’ and providers’ attitudes and needs in health care. Nowadays, because patients are generally better educated and often free to choose their health care, their position in health care is stronger [13]. The advantages of patient participation in decision-making are not only political and economic, but also medical; patients who have participated in decision-making are more likely to follow the agreed treatment plans and take their medications as prescribed [14].

The phrase “…a meeting where the patient’s world is confronted with the institution’s world” conveys the difference between the participants in consultations [15]. Professionals often control these conversations and are acceded power because they have the required expertise [16]. In order to make
proper assessments, professionals need insight about patients’ personal experiences [17]. Fossum considers that patient-centered conversations are the most effective way to communicate in consultations [18]. There are strong recommendations for patient involvement in health care, including in treatment decisions [19]. Engaging people in their health care is a key component of developing a health care system of the highest possible quality; one that is safe, effective, person centered, timely, efficient and equitable [7].

One of commonest reasons for patients being dissatisfied with health services is not being properly informed about their illness(es) and the options for treatment [20]. Supporting people to be active participants in their consultations may have important implications for patient satisfaction, the extent to which they comply with treatment, relationships between patients and professionals and long-term health outcomes [21]. Fully involving patients in their care and in decisions about their care is one component of this.

Many patients want greater involvement in decision-making about their treatment [20]. In recognition of this, this thesis focuses on communication patterns in face-to-face interactions between patients with AF and health professionals and considers the implications of aspects of these communication processes on patient participation and decision-making about treatment. There is evidence from patient groups with conditions other than AF that variations in communication between patients and professionals can help or hinder participation in decision-making [22, 23]. Research on the processes of communication in consultations between patients with AF and health professionals can provide valuable knowledge; for example, about the aspects of communication that affect patient participation in decision-making about treatment.
Background

Patients with atrial fibrillation

Pathophysiology, prevalence and incidence

Atrial fibrillation is a common cardiac dysrhythmia associated with increased morbidity and mortality [24]. The heart rate is irregular and varies from rapid to slow with narrow QRS-complexes [25]. Between 2.3–10 million individuals in the USA and 12 million in the European Union have this arrhythmia, (i.e., it affects 1–2% of these populations). This prevalence will probably increase in the developed world because the average age of patients with this condition is steadily rising, now averaging between 75 and 85 years [3]. The risk is higher in women than in men [26, 27]. AF is classified as paroxysmal (i.e., episodes that usually last less than 24 hours, but can go on for up to 7 days, and terminate spontaneously), persistent (i.e., episodes that last more than 7 days and terminate only with pharmacological or electrical interventions), and permanent (i.e., cardioversion has failed or never been attempted)[3]. The rate of recurrence is 10% in the first year after the initial diagnosis and 5% per annum thereafter. The presence of co-morbidities and increasing age significantly accelerate both progression of AF and the development of complications. Approximately every fifth stroke is due to AF. Cryptogenic strokes [28] are probably caused by undiagnosed AF. Paroxysmal AF carries the same stroke risk as permanent or persistent AF [3]. AF may manifest initially as an ischemic stroke or transient ischemic attack. It is reasonable to assume that most patients experience asymptomatic, often self-terminating, episodes of arrhythmia before AF is diagnosed and may long remain undiagnosed. Many patients with AF are never referred to hospitals and do not receive care [29].

Symptoms

Breathlessness, palpitations, syncope, dizziness and chest discomfort are common symptoms of AF [3]. High levels of anxiety are often associated with more severe symptoms, such as increased psychological stress and lower physical quality of life [4]. One third of AF patients have greater than average depression and anxiety. Symptoms of depression are the strongest independent
predictor of future quality of life in these patients [4]. They often describe themselves as active, healthy and having been involved in family, work and leisure activities before becoming ill [30]. Patients with AF have significantly inferior well-being [4]. AF results in noticeable limitations on daily life caused by reduced physical capacity and fear of provoking an episode of this dysrhythmia [31]. Relationships with partners are affected by cardiac disease [32]. Cognitive dysfunction, including vascular dementia, may be associated with AF. Symptomatic embolic events may contribute to cognitive dysfunction in AF patients in the absence of overt strokes [3].

_Treatment_

Treatment of AF focuses on reducing symptoms and preventing complications. Medication, cardioversion and ablation techniques are used to treat episodes of AF and maintain sinus rhythm; these therapies often improve symptoms. However, symptom relief may require additional rhythm control therapy by cardioversion, ablation or antiarrhythmic drug therapy [3].

Because of the stroke risk, antithrombotic therapy is an important part of the pharmacological management of patients with AF [3]. Several randomized controlled trials have shown that treatment with warfarin significantly reduces the risk of stroke [33]. Negative consequences of taking warfarin include the need for regular blood testing, changing food habits and limiting alcohol intake, the cost of the drug if it is not covered by insurance [34], and decrease in quality of life because of the requirement for frequent blood tests, limitations in aspects of lifestyle (for example physical activity) and alcohol intake [34, 35]. Even though side effects are possible, antithrombotic therapy for patients with AF should be considered to reduce their risk of complications from blood clots [3]. However, health care staff should strive to create circumstances that lead to well informed patients who participate actively in their treatment decisions [36].
Patient participation

The concept of patient participation

The meaning of the term participation has been explored from the patient’s perspective; it connotes being confident, maintaining a sense of control and recognition of one’s own responsibility as a patient [37]. Dimensions of patient participation include sharing of information, communicating feelings about symptoms and compliance with nurses and physicians orders [38]. Sahlsten defined participation as performing clinical or daily living skills. Furthermore, patient participation in care can be defined as a dynamic process that changes over time and can be facilitated by professionals seeking to understand the person, emotional work and partnership [39]. Terms associated with the concept of patient participation are “patient involvement”, “collaboration”, “partnership” and “influence”.

Patient participation means being involved in the decision-making process [40] or expressing views on different treatments [41]. Patient involvement ranges from simply answering health professionals’ questions to actively participating in discussions and decision-making. Patient participation, especially in relation to decision-making, is sometimes described as a hierarchy with different degree of participation. Partnership, with its high degree of involvement or collaboration, is on the top of this hierarchy [42]. The process of partnership underpins participation by identifying the values and beliefs on which decisions are based [39].

Concordance is a particular kind of patient participation in consultations. It stresses the importance of incorporating the patient’s own experiences, opinions, values, preferences and beliefs in the evolving process of the consultation and medical decision-making [43]. Goffman has a wider perspective, viewing participation as a social activity in any given moment of social interaction [44].

Patient participation in general health care settings

The recent emphasis on patient participation in general health care settings promotes moving away from a paternalistic form of care towards one of partnership between health professionals and patients [45]. Patient participation
should not be limited to sharing in clinical decision-making, but rather involve general involvement of patients in everyday aspects during their hospital stay [46]. The International Classification of Functioning, Disability and Health describes participation as a person’s engagement in her or his life situation. This definition suggests that participation is a key component of decision-making and includes capacity both from the perspectives of individuals and the society [47].

Research on patient participation also investigates individuals preferences regarding both participating and reserving the right not to participate in, for example, shared decision-making [48]. Patients’ preferences for participation in decision-making are not uniform. They range from passive to more active roles and vary according to the individual’s age and social status [49]. Both external and internal factors are important. Patients’ physical ability, willingness and ability to make rational decisions are examples of relevant internal factors [50]. Others internal factors are attitude towards self-care, cultural background, desire to be a “good” patient, level of medical knowledge, and previous hospital experience [40]. Still more internal factors are age, marital status, and time since diagnosis [38]. Patients experience not understanding and not being accountable as not participating at all [6]. One external factor that affects a patient’s desire to participate is how professionals provide information [38]. Professionals who ignore patients’ wishes and their extent of knowledge increase non-participation in health care [51]. Some patients exceed their preferred level of participation [52]. Others are passive, maybe because of fear or perceived lack of knowledge [53]. When a patient prefers a passive role, health professionals should respect this preference [54].

Patient participation in nursing settings

Patient participation is an important factor in nursing care and medical treatment. Patient participation in nursing settings exists once nurse and patient establish a relationship [39]. Nurses and patients need to discuss patient changes in preferences during different phases of a disease and patients’ degrees of participation [37]. Instruments for measuring the degree of patient participation have been tested and constructed [55]. Factors that restrict patient participation include limited communication between nurses and patients, task-oriented nursing, a lack of the knowledge and critical-thinking skills necessary for deeper reflection, which come only with time and experience [56]. Other factors that restrict patient participation are when nurses treat patients in such a way that they feel neglected and experience themselves as helpless objects of a nurse’s actions [57]. Patients who do not have an equal relationship with nurses,
or receive insufficient information and respect from nurses, participate less than patients who do [37]. In addition, environmental factors such as lack of privacy, an impersonal atmosphere and time constraints limit opportunities to invite patient to talk about their experiences and to have conversations with them [58].

Patient participation has been explored in different contexts, such as discharge planning, and has focused on decision-making about care [59]. Researchers have also explored patients’ perceptions and barriers to participation in nursing care. Patients express a need to be listened to regarding knowledge of their own bodies and to be treated as valuable coworkers [57, 60]. Nurse theorists have also explored patient participation. Orem uses the term “participation” when exploring the self-care deficit theory [61] and sees participation as fundamental to the patient–nurse relationship and built on achieving a balance between patient self-care and self-care needs. The nurse’s role is both to act when the individual cannot do so and sometimes not to act. Orem states that patients know their needs, that patients’ decisions are always trustworthy, and that participation presupposes partnerships between patients and nurses. From nurses’ perspectives, participation is more about giving patients individually tailored information [37].

**Patient participation in medical settings**

Patient participation in medical settings depends on the interplay between personal, physician, and contextual factors and is situation-specific [62]. Street showed that female physicians are more likely to use supportive talk than are males, and that physicians generally use less supportive talk with nonwhite than with white patients. More actively participatory patients receive more facilitative communication from physicians, are more educated, and more likely to be white than of another ethnicity. The strongest predictors of patient participation are situation-specific, namely the clinical setting and the physician’s communicative style [62].

Researchers have studied patient participation in the consultation process, particularly regarding medical treatment decisions [63, 64]. The main focus has been on how patients participate explicitly by asking questions or requesting information during consultations [65]. Peräkylä et al. have suggested the following important key components of patient participation in medical settings. By providing the reason for the visit and proposing explanations for aspects of their illness, the patient influences development of the consultation’s agenda. Patients’ share in the medical reasoning process and how well health
professionals provide them with information on diagnosis, prognosis and treatment options are important key components. Patients’ opportunities for expressions of emotion, how professionals respond to these displays, and patients’ influences in decision-making are also important key components of health care encounters [66].

The American College of Cardiology Foundation Clinical Quality Committee started to develop a patient-centered approach to cardiovascular care in 2009. They have published a review of the current state of patient-centered care (PCC) in cardiovascular medicine. The term PCC describes an approach to care that empowers patients to become active participants in their own health care. The concept of PCC has developed to incorporate the factors of patient preferences, differing lifestyles, special population needs, and introducing improved communication tools into a new model of care [18, 67].

Decision-making

The concept of decision-making

Decision-making is defined as a communicative process in the relationship between health professionals and patients and is affected by the elements of trust, role expectations, information exchange, arguments and collaboration [68]. That incorporation of patients’ values and preferences, together with clinical evidence concerning treatment, promotes their involvement in the decision-making process has also been highlighted [69].

Patients must actively communicate their preferences, concerns, opinions, and questions in order to contribute to a collaboration [70]. Health professionals could encourage patient involvement by more frequently using partnership-building and supportive communication [71]. Achieving a shared decision with a patient is more difficult when that patient’s preferences conflict with the strongest clinical evidence [72]. Becoming aware of, and understanding, the other’s position is not enough. There is also a need for dialogue to find common ground, identify and resolve differences, and negotiate or compromise to reach a collaborative, agreed-upon decision [73]. The deliberation stage of decision-making refers to the process of expressing and discussing treatment preferences [21].
There are reportedly no differences between patients’ decision-making when it comes to medical treatment in nursing or medical setting [38]. However, examples of activities involved in nurses’ decision-making processes include observations of signs that convey information about the patient’s situation, confirmation of information gathered and implementation of action strategies [59]. Nurses make decisions based on delegated responsibility within the medical knowledge domain. This responsibility is based on established guidelines and directives from, for example, physicians [59].

**Decision-making models**

Researchers have proposed three different models of decision-making: the paternalistic, the shared and the informed decision-making model. These decision-making models vary in the roles that health professionals and patients play in the final selection of treatment [74]. The models of decision are good tools for raising awareness about communication in health care encounters [75].

*The paternalistic model*

In the paternalistic model, which is the most common model, health professionals choose the treatment after evaluating information about the patient’s disease [76]. The health professionals alone weigh the benefits and risks of each treatment option and the probabilities of various outcomes, and dominate the deliberation process while the patients listen passively [77]. The health professionals dominate agenda setting, identification of goals and decision-making. The patients’ voices are underprovided and their medical conditions are defined in biomedical terms [78]. Elderly persons prefer the paternalistic model [79]. Status differences between health professionals and patients, such as those relating to education, income and sex, also contribute to power differentials in health care encounters [77]. The obligation of health professionals to act in the patient’s best interest is based on the assumption that patient values and preferences are the same as those of health professionals [78].

*The shared decision-making model*

The model of shared decision-making (SDM) is a middle ground approach to decision-making [80]. Health professionals and patients share their areas of expertise, for example, scientific knowledge and personal preferences and
experience, respectively. Negotiating and committing to a collaborative agreement regarding health care decisions also occurs in this model [81]. The term SDM has been used to describe many aspects of patient involvement in their health care, including access to personal health records, personal health budgets, care planning and decision aids [20]. Decision aids based on the SMD are designed to help patients make informed choices among diagnostic or treatment options by delivering evidence-based information on options and outcomes [82].

Shared decision-making is defined as a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and patients’ informed preferences. It involves provision of evidence-based information about options, outcomes and uncertainties, together with decision support counseling and a system for recording and implementing patients’ informed preferences [20]. SDM also includes components like establishing patient’s views about treatment options and making sure that patients have an adequate understanding of the information provided [77]. Other examples of components of SDM are talking about the degree of involvement in decision-making that patients want [83].

Shared decision-making does not work in all circumstances [84]. Not all patients feel comfortable about having a choice: patients with less education, poorer prognoses or higher levels of anxiety tend to have less obvious preferences for involvement [85, 86].

The informed decision-making model

In the informed model, health professionals have no role in the decision-making process beyond information transfer [77]. For example, patients need to receive all relevant information about the evidence for the benefits and risks of various treatments. Their primary source of information about medical/scientific aspects of their disease and treatment options is health professionals. Patients alone engage in the deliberation process and decision-making [77]. In informed decision-making, patients make the decisions after receiving information about benefits, risks and alternative treatment options [87].

Patients must not only have the necessary information, but also be able to process that information in a way that truly reflects their preferences [88]. Reasoned choices that are in agreement with an individual’s beliefs can be made
by rational individuals using relevant information about the advantages and disadvantages of all possible courses of action [89].

The informed decision-making model and informed consent are closely related because the patient has the final decision-making authority in both models. The differences are that in the informed decision-making model health professionals present all available treatment options and then patients decide which option to choose, whereas the process is different with informed consent [90]. Informed consent protects patients’ rights to voluntary consent to, or refusal of, any medical treatment, procedure, or intervention, and includes providing them with information regarding the risks, benefits, and alternatives for care [42]. Informed consent is a form of legal authorization [90]. Patient competence, understanding of the information and freedom from manipulation by physicians are required for their authorization to be valid [91].

Communication

The concept of communication

According to Pearson, communication is the process of using messages to generate meaning [92]. Communication is not a linear process that involves only the speaker and the listener, nor is it merely transformation of thoughts, ideas and emotions into words, symbols or pictures, as Shannon and Weaver assumed [93]. Communication is a complex process in which thoughts are formed through talking, and are thus socially produced [94]. This definition emphasizes the ways by which participants create meaning and the role of language in the whole process of communication. Both parties must have a mutual understanding of the message (the encoding) for the receiver to succeed in understanding (decoding) it. The culture of individuals influences their processing of perceptions and interpretation of reality and the ways in which they create meaning. Verbal or nonverbal codes are systems suitable for creating messages. Nonverbal behavior is a powerful medium for conveying meaning during communication, especially when there is a contradiction between verbal and non-verbal messages [94].

Interaction, a vital part of communication, is defined as behaviors and actions in the communication situation [95]. Examples of communicative interactional patterns are sequences, turn taking, feedback, repairs, rhythm and spatial relations that influence the communication. Understanding is not about a
shared code of symbols, decoding or encoding; rather, it is more about building up a mutual understanding in sequences [92].

Psychological, environmental and cognitive factors impact on communication [94] and are influenced by both collective activity and individual factors [96]. Purposes/functions, roles, artifacts and environments are examples of collective factors [97]. Examples of individual factors are biological, psychological and social aspects of the participants, both patients and health professionals. Their beliefs, attitudes, skills, experience, emotional and behavioral factors influence communication [96].

Majors for communication include face-to-face, television, web and phone. Contexts of communication can be intrapersonal, interpersonal, public, mass (non-interactive) or computer-mediated (interactive) [92]. Communication is a multidisciplinary research field with contributions from anthropology, psychology, sociology and linguistics.

**Communication as institutional talk**

Communication during consultations can be described as institutional interactions or institutional talk between health professionals and patients and sometimes between relatives and patients. Agar identified three goals of institutional talk when viewed from the perspective of institutional representatives, namely diagnosis, directives and reporting. Institutional talk has to address specific tasks, requires a particular structure, has clear roles for participants and takes place in special rooms [98]. Communication in institutional talk is influenced by its purpose, activity structure, typical procedures, and health professionals’, patients’ and relatives’ roles, rights and obligations within the interactions [99].

Compared with daily talk, asymmetry in interaction, skills, interests and perspectives characterizes institutional talk. It has rules for the drawing of conclusions and for what and for whom it is relevant. Professionals are the ones who have the right to ask personal questions, not the other way around [10]. Patients’ diagnoses are based on the ways the institution thinks about the problem [98]. Even though institutions may use a conversational, informal style, at a deeper level the institutional rules and procedures remain central [100, 101].

In institutional talk, the power differential in relationships between two persons, which can be defined by who controls the other's behavior or
thoughts, affects the degree of asymmetry [10, 97]. When one of the participants has the power to control the interactions, there is asymmetrical communication between health professionals and patients [97]. Independent of variations in power between health professionals and patients, health professionals must take responsibility for minimizing strain on the health professional–patient relationship, while benefiting the patient in the interaction [102]. There is power, there is resistance and resistance cannot be understood as non-power but as a counterforce, the one who is powerless from one perspective processes power from another perspective [18, 103]. Patients need to be viewed as active participants rather than passive recipients in their own health care [104].

Monologic and dialogic views of communication

There is a distinction between monologic and dialogic views of communication and language [105-107]. Monologism and dialogism are seen as opposite and complementary perspectives [94] (Table 1). Monologism is a dominant discourse of understanding of language in which words and expressions are understood as product-oriented, fixed and finished meanings and messages. Meanings are decontextualized and exist independently of subjects’ experiences. In monologism, the reality is a given and registered objectively, and the speaker alone decides to use certain words and defines the meaning of what is said [108]. In the monologic model of language, speakers transfer messages to passive receivers.

According to the dialogic view of language and communication, meanings and messages are co-constructed and made concrete by the involved participants as they switch between being speakers and listeners [107, 109]. The content of what they are saying cannot be separated from their interactions and the relationships in which they are involved, is seen as a part of a communicative project and is contextualized. All experiences are conditioned perspectives, seen from the subject's position. The dialogic model of language interprets interactions between participants as social actions. A dialogic approach to interpreting allows investigation of various communicative activities in social interactions and is process-oriented [106]. Reality is co-constructed and subjectively experienced.
Table 1. Different approaches to communication [94].

<table>
<thead>
<tr>
<th>Monologism</th>
<th>Dialogism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product-oriented</td>
<td>Process-oriented</td>
</tr>
<tr>
<td>Finished messages</td>
<td>Co-designed messages</td>
</tr>
<tr>
<td>Transfer model</td>
<td>Dialogue</td>
</tr>
<tr>
<td>Focus: talk intention</td>
<td>Focus: communicative project</td>
</tr>
<tr>
<td>Passive receivers</td>
<td>Contributing listeners</td>
</tr>
<tr>
<td>Language: code/system/structure</td>
<td>Language: discourse/practice</td>
</tr>
<tr>
<td>(abstract)</td>
<td>(concrete)</td>
</tr>
<tr>
<td>Homogeneous use of language</td>
<td>Heterogeneous use of language</td>
</tr>
<tr>
<td>Decontextualized</td>
<td>Contextualized</td>
</tr>
<tr>
<td>Designed</td>
<td>Authentic examples</td>
</tr>
<tr>
<td>Meanings exist independently of</td>
<td>All experiences are conditioned</td>
</tr>
<tr>
<td>subject's experience</td>
<td>perspectives, seen from the</td>
</tr>
<tr>
<td></td>
<td>subject’s position</td>
</tr>
<tr>
<td>Reality as a given, objectively</td>
<td>Reality as (co-)constructed,</td>
</tr>
<tr>
<td>registered</td>
<td>subjectively experienced</td>
</tr>
<tr>
<td>Social, mental/cognitive realism</td>
<td>Social constructivism</td>
</tr>
</tbody>
</table>

Studies on the contexts of consultations

Researchers have studied communication in medical consultations for many years [102]. These studies initially focused on physicians’ consultations, but have recently addressed nurses’ consultations as well. It is not possible to explain or understand communication by looking at the actions of only one of the parties involved. One early study [110] found that the more information patients obtained from their physicians, the more restrained the patients were in asking questions. Receiving large amounts of information restrained patients from talking about their most important concerns. Byrne and Long divided medical visits into distinct medical procedures, namely history taking, physical examination, diagnosis and treatment, and examined the communication structure for each phase [111]. Beck et al. (2002) reviewed primary-care-based studies from 1975 to 2000 in order to identify the verbal and nonverbal behaviors used by physicians during medical encounters. Verbal behaviors positively associated with good health outcomes included empathy, support, patient-centered questioning, explanations, both dominant and passive physician styles, humor, psychosocial talk, friendliness, politeness, orienting the patient during examination, summarization and clarification. Nonverbal behaviors positively associated with good outcomes included head nodding,
direct body orientation, uncrossed legs and arms, arm symmetry and less mutual gaze [112]. Later studies [113] focused more on behavior during consultations; for example, the differences between short, moderate and long consultations in general practice settings have been studied. By using a system to code the communicative behavior of both health professionals and patients, researchers have devised an interaction analysis system [114]. One study focused on the patient–physician discourse and dominance in palliative cancer care [115]. These researchers found that patients and physicians shared the discursive space unequally. Another study [116] about communication style during telemedicine consultations showed that physicians were verbally dominant. Differences between nurses’ and physicians’ communication have also been studied [117]. Patients’ contributions determined nurse’s communication in consultations, whereas physicians’ communication gave an overarching direction to the consultation as a whole. While nurses’ explanations began from the viewpoint of patients’ responsibility and behavior, physicians’ explanations began from the viewpoint of biomedical intervention. Their consultations provided different opportunities for patients’ involvement [117].

From a cardiological perspective, there have been few research studies on consultations and communication. Gordon et al. (2005) studied the communication behavior of physicians and patients and found that physicians dominated interaction and communication following coronary angiography [118]. Another study that focused on dominance in a cardiovascular setting examined the relationships between sex, trait dominance and cardiovascular reactivity during dyadic interactions [119]. Dominance was positively associated with blood pressure reactivity among men, but not among women. Interacting with a highly dominant partner was associated with increased blood pressure reactivity only among men with strong trait dominance. No studies have focused specifically on communication between patients with AF and their nurses and physicians. Neither have any published studies examined resistance interactions between patients with AF and cardiologists in consultations regarding treatment with warfarin.
Theoretical underpinnings

Patients and health professionals represent different perspectives; this can complicate their understanding of each other. Mishler’s concept of institutional talk asserts that physicians often speak with a medical voice and from a biomedical perspective [15]. One consequence of this is that abstract rules that serve to decontextualize patients’ personal and social contexts provide the meaning of procedures during these consultations. On the other hand, patients use their own life–world voice and knowledge of their own life situation, reactions and experiences [15]. It is important to consider the dominance of professionals’ bio-medical voices and patients’ predispositions to place their illness experiences into their life–worlds (the patient’s everyday life) when studying asymmetries in health professionals’ and patients’ communication. It is of interest to understand how patients manage to make their voices heard by talking about their life–world situations. Mishler showed how health professionals shift the focus of conversation away from the patient’s life–world voice back to the voice of medicine [15]. An institutional way of seeing the world that includes a specific way of classifying patients and their concerns informs health professionals. In order to achieve medical tasks in consultation, matters involving patients’ life–worlds need not be restrained by moving the discourse to bio-medical matters. Health professionals can communicate competently in both worlds; they can speak in either the voice of the life–world or that of medicine, whereas patients can speak in only one of these voices. Health professionals therefore have the responsibility to translate patient’s life–world perspectives into medical terms and medical perspectives of problems into patients’ terms [15].

Goffman offered an institutional perspective on aspects of face-to-face interactions and comments that are important when studying communication in consultations [120]. He proposed language rules for the social conventions that have evolved to manage the risks of face-to-face interactions. Much of the work of decision-making and information giving occurs face-to-face, and is therefore exposed to face-to-face effects. Face-to-face interactions require a lot of work and attention if no one is to lose face. In relation to consultations between health professionals and patients with AF, this means showing respect, attention and interest while carefully avoiding issues that may cause embarrassment or offence. Patients sometimes disguise their resistance by
expressing it covertly in their interactions with health professionals, rather than creating open conflicts. Goffman (2002) describes social life as a kind of multistage drama in which the participants perform different roles in different social areas, depending on their particular roles in them and the nature of the situations. The participants involved can take positions as speakers, recipients, side-participants and observers [121]. Relationships with the people with whom we communicate are of great importance and how we communicate with each other always depends on the people around us [120]. When we interpret what happens in interactions, we join different perspectives by basing our understanding on that of similar situations that we have experienced previously. For example, consultations between nurses and patients may take the form of formal interviews or everyday conversations that are less formal. For example, patients’ relationships with nurses or physicians are important in determining how patients communicate with them. Goffman also discusses patients’ roles as “non persons”, persons with peripheral roles in relation to experts [44]. Those who are in positions of authority are often the ones who dominate interactions [44]. Because of the asymmetry in the authority of the participants, health professionals are in a powerful position in relation to patients with AF when they communicate during consultations.
Aim of the thesis

The overall aim was to describe communication patterns between patients with AF and nurses/physicians in consultations. The Licentiate thesis includes two studies, the specific aims of which were:

Study I

To describe (i) the topics participants talk about; (ii) the use of discursive space in consultations between patients with AF and their nurses and physicians; and (iii) the frequencies with which patients and nurses/physicians introduce the identified topics.

Study II

To describe the types of resistance when patients resist treatment with warfarin, and how cardiologists respond to such resistance.
Material and methods

Design and setting

This thesis is based on empirical data from two studies (Studies I and II), which were epistemologically based on cross-sectional designs with a qualitative inductive approach. The data for the studies that comprise part of this thesis derive from video-recorded consultations between patients with AF and nurses/physicians in 2009 in a number of outpatient cardiology clinics, including six hospitals: one university and five county hospitals located in different regions of the southern parts of Sweden. Cardiology-related activity varied greatly between these centers, ranging as they did from a university hospitals with a large catchment area to small county hospitals. I have presented an overview of the research design, data resources and data analysis in each paper below (Table 2).

The Swedish National Board of Health and Welfare has developed guidelines for the care of patients with AF [7]. There is, however, no statistical information about how many Swedish hospitals have such AF clinics; an unofficial estimate of the number of outpatient nurse-led AF-clinics in Sweden is 20–25. There are no official documents describing the agenda for nurse-led AF clinics. Thus, the respective roles and duties of nurses and cardiologists vary from clinic to clinic. One description of the functioning of a clinic in southern Sweden is as follows. Planned visits to the nurse-led clinic take place three months after the patients’ diagnoses. Nurses perform and document electrocardiographic monitoring and document the effects of cardioversion. In that clinic, nurses are responsible for controlling patients’ dosages of beta-blockers. When patients need counseling and support on a level that is not within nurses’ authority, nurses are responsible for referring them to the cardiologists (Personal communication, 23 October 2012).
Table 2. Design, data resources and data analysis, Studies I and II.

<table>
<thead>
<tr>
<th>Paper</th>
<th>Design</th>
<th>Data resources</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Inductive</td>
<td>Videotaped consultations (n=23) with patients with AF and nurses/physicians</td>
<td>Manifest Content analysis and Dominance analysis</td>
</tr>
<tr>
<td>II</td>
<td>Inductive</td>
<td>Videotaped consultations (n=11) with patients with AF and physicians</td>
<td>Conversation Analysis</td>
</tr>
</tbody>
</table>

Description of methods

Qualitative content analysis (Study I)

Content analysis is a research technique for making replicable and valid inferences from texts concerning the contexts of their use [122]. Researchers can use this method with either qualitative or quantitative way and in an inductive or deductive way. Nursing studies commonly use qualitative content analysis [123]. Important concepts related to qualitative content analysis include manifest and latent content, unit of analysis, meaning unit, condensation, abstraction, code, category, and theme. When using qualitative content analysis, selecting the unit of analysis is a basic part of the procedure. Another basic task is deciding whether to focus the analysis on manifest (i.e., visible, obvious components) or latent content (i.e., the underlying meaning of the text) [123]. Both manifest and latent content deal with interpretation; however, the interpretations vary in depth and level of abstraction. Creating categories or themes is characteristic of qualitative content analysis. A category is a group of content that shares a commonality [122]; a category answers the question “What?” [122] and can be identified as a line throughout the codes. A theme
answers the question “How?” and can be seen as an expression of the latent content of the text since all data have multiple meanings [122].

Dominance patterns in interactions (Study I)

In order to accurately describe dominance of behavior, it is important to understand the power of dialogue [11]. Linell defines power as a potential for exercising influence over other peoples decisions, actions and thoughts. Who has the dominant role in a dialogue can be variable and depend on many factors; power and dominance are not synonymous [124]. Linell think of power in terms of underlying structure regulating interpersonal relations, whereas dominance has to do with how the participants allocate the available space in the dialogue, its disposal in quantitative terms. To dominate the dialogue is to dominate most of the territory, a domain or “the floor” [124].

Asymmetric dialogues take place when interactions are dominated by one participant [12]. Domination is a quantitatively oriented concept; Linell and Gustafsson distinguish four types of dominance. One of these types is quantitative dominance, in which the number of words spoken by each of the participants determines which of them is the dominant interlocutor, the one who speaks the most. In this type of dominance, average turn length also indicates who is dominant because holding on to a turn restricts the other speaker's right to start talking and forces him or her to remain a listener. The number of turns of each participant is an indicator of quantitative dominance. Which participant chooses the topics characterizes another type of dominance. The participant who dominates the choice of topics tries to focus the significant content and to make it socially shared in discourse. Another type of dominance is strategic dominance in which the dominant interlocutor is the one who initiates the strategically most important contributions. Finally, there is interactive dominance, which involves the distribution of initiatives and responses. By asking questions and taking initiatives that direct the other participant to respond in certain ways, the dominant participant controls communicative actions [12].

Conversation analysis (Study II)

Conversation analysis (CA) is a method used in ethnomethodology [125]. The ethnomethodological view is that participants in any social situation establish the social action in interactions [126]. The principles of CA concern how interactions are structurally organized and how the participants orient to the situated context of their interactions [125]. The resultant detailed analysis allows
a deeper and more insightful understanding of how people communicate in consultations between patients and nurses/physicians [127]. In CA, sequence organization is the basic way of organizing conversations. Sequences are at least two adjacent utterances that are produced interactively [128] and consist of at least two adjacent turns. Each adjacent pair of utterances has first and second pair parts. Second pair parts are projected and made relevant by first pair parts and second pair part proposals are interpretations of first pair parts [128].

Previous CA studies of interactional resistance distinguish two main categories of resistance, passive and active. Passive resistance includes silent gaps, nodding the head separately and producing minimal non-marked acknowledgements such as “mm hm” [129]. In contrast, in active resistance participants implicitly or explicitly ask questions or challenge physicians’ treatment recommendations, either with counter-proposals or by expressing preferences for alternative treatments [130].

Acceptance of invitations is preferred, whereas their rejection is dispreferred. Preference organization refers to the ways in which a certain array of second pair parts becomes relevant and is oriented to as expected after a given first pair part; a question makes an answer relevant, whereas a proposal makes its acceptance or rejection relevant. Characteristically, preferred responsive turns are produced immediately, whereas dispreferred responses are often produced with hesitations and delays [131].

Participants (Studies I and II)
An overview of the participants in studies I and II is presented in Table 3. We used strategic selection [132] to ensure a broad sample with maximal variation, thus enabling description of different ways of communication and interaction. The participating professionals were nurses and physicians in outpatient clinics with experience in cardiology. Variations in sex, age and clinical experience of cardiology guided selection of participating nurses and physicians in the various hospitals. Participating patients had AF and we selected them based on sex, age, education, type of AF, time since diagnosis, type of planned visit (i.e., early re-consultation or routine follow-up), treatment regime and ability to communicate in Swedish. Three accompanying spouses were present during their partners’ consultations. Data regarding patient’s characteristics in all consultations (n = 23) are presented in Table 4.
Table 3. Number of participants (patients and professionals) in Studies I and II.

<table>
<thead>
<tr>
<th>Study</th>
<th>Number of consultations</th>
<th>Number of patients</th>
<th>Number of professionals</th>
<th>Number of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>23</td>
<td>23</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 women (4 nurses/2 physicians)</td>
<td>(1 University and 5 county hospitals)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 men (1 nurse/3 physicians)</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>11</td>
<td>11</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 female physicians</td>
<td>(1 University and 4 county hospitals)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 male physicians</td>
<td></td>
</tr>
</tbody>
</table>

In study I, the sample consisted of 12 consultations between patients with AF and nurses and 11 consultations between patients with AF and physicians (Table 4).

In study II, the sample consisted of 11 consultations between patients with AF and physicians (the same as described above, see Table 4) but no consultations with nurses. We included all consultations in which there were conversations about warfarin. The characteristics of the consultations and participating patients (n = 11) and physicians are presented in Table 5. We used the term “cardiologists” for physicians in study II.

Data collection (Studies I and II)

The author (ES) issued invitations and held responsibility for data generation for this thesis (Studies I and II). Before the study, ES introduced information about it, including the means of data collection and its purpose, to potential professional participants and made several phone calls to each clinic to motivate and instruct these professionals. These phone calls included time for questions and discussions. It was also possible for potential participants to
phone the researchers when needed. These strategies were used to motivate participation in the study. Nurses and cardiologists chose to be involved on a volunteer basis. One hospital declined because the professionals did not want to be videotaped. The participating professionals were regular staff members who were on duty as normal at the time of data collection. The professionals gave written consent for videotaping.

The professionals then sent invitations to participate in the study by letter to their patients; these invitations included information about the aim and method, which involved videotaping, and described the themes of the project. The professionals repeated this information orally during the consultations. They informed each patient about the purpose of the study and how the researchers would use the video-recordings. Each participant was given the researcher’s contact information in case they had any inquiries concerning the study or their participation in it. All patients agreed to participate in the study and gave their written consent. The professionals informed the patients that they had the right to cancel their consent without specifying their reasons for doing so.

The video recordings started before and ended after the actual visits. In all consultations, the researcher switched the video camera, which was already set up in the corner of the consultation room, on and off. The researcher was not present in the consultation room but talked with the participants before and after the consultations. The lengths of the consultations varied from approximately 20 to 90 minutes (the unusually long 90 minute consultation occurred because of complications with the patient’s pacemaker).
Table 4. Characteristics of patients (*n* = 23) who participated in nurse/physician consultations (Study I).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total sample</th>
<th>Nurse consultations</th>
<th>Physician consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=23</td>
<td>n=11</td>
<td>n=12</td>
</tr>
<tr>
<td>Sex, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male/Female</td>
<td>10 (43)/13 (57)</td>
<td>6 (55)/5 (45)</td>
<td>4 (33)/8 (67)</td>
</tr>
<tr>
<td>Age, Mean years (range)</td>
<td>72.6 (37-90)</td>
<td>70.7 (37-79)</td>
<td>74.4 (44-90)</td>
</tr>
<tr>
<td>Education, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nine-year compulsory school</td>
<td>7 (31)</td>
<td>4 (36)</td>
<td>3 (25)</td>
</tr>
<tr>
<td>Upper secondary school</td>
<td>7 (31)</td>
<td>4 (36)</td>
<td>3 (25)</td>
</tr>
<tr>
<td>University</td>
<td>9 (39)</td>
<td>3 (27)</td>
<td>6 (50)</td>
</tr>
<tr>
<td>Time since diagnosis of AF, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>8 (35)</td>
<td>6 (55)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>5 (22)</td>
<td>3 (27)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>2 to 5 years</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (8)</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>9 (39)</td>
<td>2 (18)</td>
<td>7 (58)</td>
</tr>
<tr>
<td>Type of AF, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paroxysmal</td>
<td>17 (74)</td>
<td>9 (82)</td>
<td>8 (67)</td>
</tr>
<tr>
<td>Persistent</td>
<td>3 (13)</td>
<td>1 (9)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Permanent</td>
<td>3 (13)</td>
<td>1 (9)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Treatment, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>16 (4)</td>
<td>4 (36)</td>
<td>12 (100)</td>
</tr>
<tr>
<td>Cardioversion</td>
<td>9 (36)</td>
<td>6 (55)</td>
<td>3 (25)</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>3 (13)</td>
<td>2 (18)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Comorbidities, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>12 (52)</td>
<td>4 (36)</td>
<td>8 (67)</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>2 (9)</td>
<td>1 (9)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Stroke</td>
<td>1 (4)</td>
<td>1 (9)</td>
<td>0</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>3 (13)</td>
<td>2 (18)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Transient ischemic attack</td>
<td>1 (4)</td>
<td>1 (9)</td>
<td>0</td>
</tr>
<tr>
<td>Hypothyreosis</td>
<td>2 (9)</td>
<td>1 (9)</td>
<td>1 (8)</td>
</tr>
</tbody>
</table>
Table 5. Characteristics of consultations and participating patients (n=11) and physicians (designated as cardiologists) in Study II.

<table>
<thead>
<tr>
<th>Consultation number</th>
<th>Sex and age (years)</th>
<th>Disease characteristics</th>
<th>Comorbidity time since diagnosis (years)</th>
<th>Marital status</th>
<th>Education</th>
<th>Warfarin treatment</th>
<th>Gender and clinical experience in cardiology (years)</th>
<th>Types of hospitals</th>
<th>Type of consultation</th>
<th>Total consultation length</th>
<th>Occurances of resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>Female 80-90</td>
<td>Paroxysmal HT</td>
<td>0.5 yrs</td>
<td>Widow</td>
<td>Nine year compulsory school</td>
<td>Initiation of warfarin</td>
<td>Male, 19 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>22.13 min</td>
<td>2</td>
</tr>
<tr>
<td>C2</td>
<td>Female 70-80</td>
<td>Paroxysmal_</td>
<td>5 yrs</td>
<td>Married</td>
<td>University</td>
<td>Initiation of warfarin</td>
<td>Male, 19 yrs exp</td>
<td>University</td>
<td>Revisit</td>
<td>25.45 min</td>
<td>2</td>
</tr>
<tr>
<td>C3</td>
<td>Male 70-80</td>
<td>Paroxysmal HT</td>
<td>5 yrs</td>
<td>Widower</td>
<td>Upper secondary school</td>
<td>On going</td>
<td>Female, 20 yrs exp</td>
<td>University</td>
<td>Revisit</td>
<td>36.00 min</td>
<td>1</td>
</tr>
<tr>
<td>C4</td>
<td>Female 80-90</td>
<td>Paroxysmal HT</td>
<td>5 yrs</td>
<td>Widow</td>
<td>Upper secondary school</td>
<td>On going</td>
<td>Female, 20 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>31.31 min</td>
<td>0</td>
</tr>
<tr>
<td>C5</td>
<td>Male 80-90</td>
<td>Paroxysmal HT</td>
<td>5 yrs</td>
<td>Married</td>
<td>University</td>
<td>On going</td>
<td>Male, 30 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>09.50 min</td>
<td>2</td>
</tr>
<tr>
<td>C6</td>
<td>Female 60-70</td>
<td>Paroxysmal HT</td>
<td>5 yrs</td>
<td>Widow</td>
<td>Nine year compulsory school</td>
<td>Initiation of warfarin</td>
<td>Male, 5 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>20.42 min</td>
<td>1</td>
</tr>
<tr>
<td>C7</td>
<td>Female 70-80</td>
<td>Paroxysmal HT/IHD</td>
<td>3 yrs</td>
<td>Single</td>
<td>University</td>
<td>On going</td>
<td>Male, 30 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>10.39 min</td>
<td>3</td>
</tr>
<tr>
<td>C8</td>
<td>Male 60-70</td>
<td>Permanent HT</td>
<td>6 yrs</td>
<td>Married</td>
<td>Upper secondary school</td>
<td>On going</td>
<td>Female, 5 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>38.12 min</td>
<td>2</td>
</tr>
<tr>
<td>C9</td>
<td>Female 80-90</td>
<td>Persistent HT</td>
<td>1 yrs</td>
<td>Widow</td>
<td>Nine year compulsory school</td>
<td>On going</td>
<td>Female, 5 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>28.21 min</td>
<td>2</td>
</tr>
<tr>
<td>C10</td>
<td>Female 70-80</td>
<td>Paroxysmal_</td>
<td>5 yrs</td>
<td>Widow</td>
<td>University</td>
<td>On going</td>
<td>Female, 5 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>29.45 min</td>
<td>1</td>
</tr>
<tr>
<td>C11</td>
<td>Male 40-50</td>
<td>Persistent HT/DM</td>
<td>2 yrs</td>
<td>Married</td>
<td>University</td>
<td>On going</td>
<td>Female, 5 yrs exp</td>
<td>County</td>
<td>Revisit</td>
<td>33.23 min</td>
<td>4</td>
</tr>
</tbody>
</table>

Abbreviations: DM, diabetes mellitus; exp, experience; HT, hypertension; IHD, ischemic heart disease.
Data analysis

Qualitative content analysis (Study I)

To achieve a description of topics discussed during the consultations, the researchers analyzed transcripts of all consultations using qualitative content analysis [122]. A systematic description of the manifest content of the transcribed videotaped consultations to identify the topics discussed during the consultations between patients with AF and nurses/physicians was used. First, video recordings were transcribed, checked and compared once again with the original video recordings. Before performing the analysis, words that we had heard inaccurately during the initial transcription and/or that compromised patient confidentiality were corrected or deleted. The analysis focused on verbal activity and captured verbal utterances. For the purposes of this study, we did not analyze the non-verbal communication that accompanied the verbal utterances.

The researchers reread the transcribed consultations texts several times to identify the manifest topics [122]. We made observational notes in the margins while reading the transcripts of each consultation. The analysis continued, which involved rereading the texts and condensing it into meaning units. Considering the context, the meaning units were condensed and coded into a description close to the text, the manifest content. The condensed text was then read and coded into subtopics, continually noting emergent subtopics. A process of reflection and discussion resulted in agreement on a set of sub-topics and identification of the final topics. Further analysis of the interpretations of the videotaped consultations revealed nothing that contradicted the identified topics. The validation process was concluded by selecting extracts from each topic that corresponded to the topic description. Checks were made to ensure consistency between the topics and the extracts selected to illustrate them. Finally, consensus between the researchers concerning the topics and the selection of extracts belonging to them was achieved.

Analysis of dominance (Study I)

The patterns of dominance for each topic and participant were explored from the framework of an analysis that explores dominance in a quantitative manner [12]. In this type of analysis, researchers count all the words of each participant for each topic identified in the consultations. According to quantitative dominance theory, the dominant participant is the one who talks most in terms
of both the number of words and turns compared to the other participant [12].
The term “word” means an independent orthographic unit in the written
account of the consultation [133]. Sounds like “eh” and “oh” were not counted
as words, but all interrupted, incomplete words were counted. Sounds like
backup “hms” were counted as words only if the participant had formulated a
backup with emphasis such as “of course”; we did not count these as short
backups [12]. The analysis displayed the total amount of talk for each topic
identified by content analysis within the written reproduction of the
consultations and involved counting all the words that each participant uttered
during each topic during the consultations. Because transition between topics
often occurred within the utterances before introduction of the new topic, we
included ten words in the utterances immediately before and after the topic in
question when calculating the discourse space [134]. The words and turns of
the three accompanying spouses were included in the patients’ discursive
spaces.

The second analysis concerned the total number of turns, namely the number
of statements by each participant about each topic [124]. We use the concepts
“turns” and “utterances” synonymously, they refer to the substance of what
one speaker utters during the period of time that he or she directs the speech
[124]. All turns for each participant for each topic in the consultations were
counted.

In this analysis, we also assessed dominance in terms of who initiated each
topic. One way to initiate a topic is with a requesting initiative, that is, a
question. Another way is by a claiming initiative, that is, to say something
without requesting a response. A third way is by a submissive initiative, that is,
contributing a content that is not expected by the other party; this is a more
careful way to introduce new content into a conversation [12]. The distribution
of initiators within each topic was calculated.

Conversation analysis (Study II)

Conversation analysis was used to identify and describe how patients resisted
treatment with warfarin and how cardiologists responded to patients’ resistance.
In view of the close links between active and passive resistance [129]
indications of active resistance were focused on because these can be clearly
identified. We counted each sequence of active resistance as an identified
indication of active resistance [130].
In this analysis, interactional variations in sequences that dealt with expressions of active resistance about warfarin were identified. We related the analysis to preference organization in conversations (i.e., preferred and dispreferred responses). A dispreferred action was a marked and unexpected response. Dispreferred responses characteristically occur: (1) after a noteworthy delay; (2) with an explanation of why the preferred next action cannot be performed. A proposal rejection is an example of a dispreferred next action; (3) with usage of appreciations (invitations, suggestions); and (4) with apologies if considered appropriate [135].

Each instance of resistance was counted as one identified frequency of resistance. In one of the eleven consultations, no instances of resistance were identified. In all, 20 instances of resistance were identified in the other consultations (i.e., 1–4 instances per consultation, Table 5). We transcribed all identified instances of resistance in each sequence in greater detail to examine certain aspects of the conversations (i.e., overlapping talk and silences) using a simplified form of transcription originally developed by Gail Jefferson [136] (Table 6).
Table 6. Transcription symbols used in this article (according to Jefferson, 2004).

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0.6)</td>
<td>Pause timed in tenths of a second</td>
</tr>
<tr>
<td>(.)</td>
<td>A pause, which is noticeable, but too short to measure</td>
</tr>
<tr>
<td>=</td>
<td>No discernible interval between adjacent utterances</td>
</tr>
<tr>
<td>::</td>
<td>Elongated utterances - the longer the elongation, the more colons are added to the utterance</td>
</tr>
<tr>
<td>Underlined</td>
<td>Louder stretches of talk are underlined</td>
</tr>
<tr>
<td>&gt;right&lt;</td>
<td>Faster stretches of talk</td>
</tr>
<tr>
<td>.</td>
<td>A stopping fall in tone, not necessarily at the end of a sentence</td>
</tr>
<tr>
<td>,</td>
<td>Continuing intonation, not necessarily between the clause of sentences</td>
</tr>
<tr>
<td>[ ]</td>
<td>Overlapping utterances are marked by a parallel square bracket</td>
</tr>
<tr>
<td>(huh.)</td>
<td>A laugh</td>
</tr>
<tr>
<td>(word)</td>
<td>A single set of parentheses with word (s) indicates doubt of the transcriptionist</td>
</tr>
<tr>
<td>(((word)</td>
<td>Double parentheses with word (s) indicates characterization by the transcriptionist of some event</td>
</tr>
</tbody>
</table>

During analysis, the main analytical CA question asked about any action produced by conversational participants was: “Why that now?” [137]. In answering this question the conversation analyst formulates what the action does in relation to the preceding action in the conversation and what it projects about the next action [137].

Ethical considerations

The regional Medical Ethics Committee at Linköping’s University Sweden gave permission to carry out these studies (Dnr. M8-09). We considered the ethical dimensions according to the ethical guidelines for studies involving human subjects. It is important to protect the confidentiality, wellbeing, privacy, dignity and self-determination of each individual [138]. We also considered the ethical dimensions in relation to ethical principles associated with video-taping of consultations [139, 140]. The first principal is autonomy. The informed consent process allows patients to weigh up the risks and benefits of a procedure and determine whether they want to participate [141]. All participants participated voluntarily and were told that they could withdraw from the study at any time.
without giving any explanation. Confidentiality was assured by written acceptance of the patients’ voluntary, informed consent. Beneficence is the second principal. Patients wished to receive information about the project because they believed this was for the greatest good. Nonmaleficence is the third principal; we should not harm the participants. In clinical research, this is addressed by disclosing the risks associated with being a participant in a research project and explaining that care and treatment did not depend on participation in the study. We kept the videotapes in a safe. The final principal is justice. The principal of justice addresses respect for people’s rights and for morally acceptable laws [139]. It is important that participants experience wellbeing, privacy and dignity. It is also important to ensure the anonymity of participating patients and health professionals [142]. One of the strategies we used to achieve this was to protect all identities by not using names in the transcriptions, in accordance with Swedish Research Council guidelines. We removed all names of participants, places and other details when reporting research results for publication. We have published some extracts from consultations between patients and professionals (Study II), but only after ensuring that we had protected the anonymity of the participants in those extracts. Our intention was to make it difficult to identify participating individuals. The code of ethics regarding evaluation and research includes avoiding conflicts of interest and dual relationships with participants [143]. Our aim was to adopt an ethical pattern of behavior with regard to participants’ wellbeing, privacy and dignity; no ethical problems occurred. One example of an ethical dilemma is that participants may experience pressure to communicate in a way that promotes participation. The researcher has to be clear about how and why to use the data, always keeping in mind that the well-being of the individuals involved is more important than anything else. We provided such protection throughout these studies, not only during the data collection phase, but also during data processing, analysis and publication.
Results

Study I

Topics in consultations with nurses
Five topics emerged in consultations with nurses: (1) pathophysiology (2) treatment (3) diagnostic procedures (4) activity (5) routines related to physicians’ responsibilities.

The topics, subtopics and distribution of space between the topics in consultations with nurses are presented in Figure 1.

Figure 1. The topics (in bolded text), the subtopics (in unbolded text under each topic) and the distribution of space between the topics in consultations with nurses.
Topics in consultations with physicians

Four topics emerged during content analysis of the consultations with physicians: (1) pathophysiology (2) treatment (3) diagnostic procedures (4) activity. Figure 2 shows the topics, subtopics and distribution of space between the topics in consultations with physicians.

**Figure 2.** The topics (in bolded text), the subtopics (in unbolded text under each topic) and the distribution of space between the topics in consultations with physicians.
Use of the discourse space in relation to topics discussed during consultations with nurses

Table 7 shows the use of the discourse space for each topic in the consultations (i.e., the proportion of words and turns spoken by patients and nurses). Overall, distribution of the discursive space (27,581 words) was almost equal between patients and nurses; however, there were differences in four of the five topics discussed (Table 7). The patients used 58% of the words (1,568/2,716 words) in the topic “activity” and 56% (4,756/8,473) in “pathophysiology”. The nurses used 61% of the words (4,669/7,703 words) in “diagnostic procedures” and 72% of the words (397/548) in “routines related to physicians’ responsibilities”.

Table 7. The proportion of words and turns (n, %) in relation to each topic in consultations with nurses and physicians.

<table>
<thead>
<tr>
<th>Topics in Nurse consultations</th>
<th>Topics in Physician consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients</td>
</tr>
<tr>
<td>1. Pathophysiology</td>
<td></td>
</tr>
<tr>
<td>Words n (%)</td>
<td>4756 (56)</td>
</tr>
<tr>
<td>Turns n (%)</td>
<td>489 (50)</td>
</tr>
<tr>
<td>2. Treatment</td>
<td></td>
</tr>
<tr>
<td>Words n (%)</td>
<td>3778 (46)</td>
</tr>
<tr>
<td>Turns n (%)</td>
<td>475 (50)</td>
</tr>
<tr>
<td>3. Diagnostic procedures</td>
<td></td>
</tr>
<tr>
<td>Words n (%)</td>
<td>3034 (39)</td>
</tr>
<tr>
<td>Turns n (%)</td>
<td>463 (51)</td>
</tr>
<tr>
<td>4. Activity</td>
<td></td>
</tr>
<tr>
<td>Words n (%)</td>
<td>1568 (58)</td>
</tr>
<tr>
<td>Turns n (%)</td>
<td>156 (49)</td>
</tr>
<tr>
<td>5. Routines related to the physician's responsibilities</td>
<td></td>
</tr>
<tr>
<td>Words n (%)</td>
<td>151 (28)</td>
</tr>
<tr>
<td>Turns n (%)</td>
<td>25 (54)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Words n (%)</td>
<td>13287 (48)</td>
</tr>
<tr>
<td>Turns n (%)</td>
<td>1608 (50)</td>
</tr>
</tbody>
</table>
Use of the discourse space in relation to topics discussed during consultations with physicians

Table 7 shows the use of the discourse space for each topic (i.e., the proportion of words and turns spoken by patients and physicians) during consultations. Physicians dominated the discursive space, using 70% of it (32,737 of the total 46,989 words) and used the highest number of words in all topics in comparison with the patients (Table 7). The physicians used 78% of the words (8,620/11,065 words) in the topic “diagnostic procedures” and 72% (15,870/22,191) in “treatment”. The topic with the closest to equal distribution of words was “pathophysiology”, in which patients using 48% of the words (3,510/7,779).

Distribution of initiating statements according to the topics discussed in consultations with nurses

In total, nurses initiated topics more frequently (105/178) than did patients. Nurses were the dominating initiators of four of the five topics discussed, whereas patients were the dominating initiators of the topic “activity” (Table 8).

Distribution of initiating statements according to the topics discussed in consultations with physicians

In total, physicians initiated topics more frequently (130/226) than did patients, dominating initiation of two of the four topics discussed. Patients were the dominating initiators of the topic “activity”, whereas physicians and patients initiated the topic “pathophysiology” almost equally (Table 8).

Table 8 shows the distribution of initiation according to who introduced each specific topic during consultations with nurses and physicians.
Table 8. Topics and initiator of topics (n, %) in consultations between patients and nurses/physicians

<table>
<thead>
<tr>
<th>Patients-Nurses</th>
<th>Initiator</th>
<th>Total</th>
<th>Patients-Physicians</th>
<th>Initiator</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Pathophysiology</strong></td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (%)</td>
<td>P 23 (46)</td>
<td>N 27 (54)</td>
<td>50 (28)</td>
<td>P 28 (53)</td>
<td>P 25 (47)</td>
</tr>
<tr>
<td><strong>2. Treatment</strong></td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (%)</td>
<td>P 24 (43)</td>
<td>N 32 (57)</td>
<td>56 (31)</td>
<td>P 37 (39)</td>
<td>P 59 (61)</td>
</tr>
<tr>
<td><strong>3. Diagnostic procedures</strong></td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (%)</td>
<td>P 14 (27)</td>
<td>N 37 (73)</td>
<td>51 (29)</td>
<td>P 9 (20)</td>
<td>P 36 (60)</td>
</tr>
<tr>
<td><strong>4. Activity</strong></td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (%)</td>
<td>P 11 (73)</td>
<td>N 4 (27)</td>
<td>15 (8)</td>
<td>P 22 (69)</td>
<td>P 10 (31)</td>
</tr>
<tr>
<td><strong>5. Routines related to the physician’s responsibilities</strong></td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (%)</td>
<td>P 1 (17)</td>
<td>N 5 (83)</td>
<td>6 (4)</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>P 73 (41)</td>
<td>N 105 (59)</td>
<td>178</td>
<td>P 96 (42)</td>
<td>P 130 (58)</td>
</tr>
</tbody>
</table>
Study II

Below is a description of the types of resistance patients expressed to warfarin and the cardiologists’ responses to that resistance. Table 9 presents an overview of the types of patient resistance identified in the consultations and the cardiologists’ responses, which we did not subdivide according to specific type of resistance. Appendix 1 presents extracts from interactions between patients (P) and cardiologists (C).

Table 9. The types of patient resistance and the cardiologists responses to them.

<table>
<thead>
<tr>
<th>Patient’s resistance to treatment</th>
<th>Cardiologist’s response to resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving reasons for their resistance</td>
<td>Repeating the treatment recommendation</td>
</tr>
<tr>
<td>Suggesting other treatment options</td>
<td>Negotiation with the patient</td>
</tr>
<tr>
<td>Stating treatment preferences</td>
<td>Providing additional information about the proposed treatment</td>
</tr>
<tr>
<td>Questioning or challenging the cardiologist’s treatment recommendations</td>
<td>Extending the explanation about the purpose of taking the medication</td>
</tr>
</tbody>
</table>

Patient resistance to cardiologists’ recommendations regarding warfarin treatment

The main outcome of Study II was the identification of the following four variations in patients’ resistance. The patients gave reasons for their resistance. Patients expressed their resistance as a fear that the treatment would cause cerebral hemorrhages. The patients’ lack of certainty prompted their active resistance to the physicians’ recommendations. They were unsure about what the treatment
might mean and withheld their acceptance as a way of gaining a better understanding of the risks. The patients suggested other treatment options by proposing alternatives to warfarin. The patients expressed treatment preferences and started to discuss implementing their own preferences. The patients stated treatment preferences by asking the cardiologists if they had to go to another city for blood tests and suggesting that they could have them at the local primary health care center. The patients challenged the cardiologists by using disparaging terms regarding treatment with warfarin. For example, patients issued challenges by asking questions such as “What happens now?” and “The central question is, am I sitting here planning to eat fox poison?”

Cardiologists responses to patient resistance

Another outcome of this study was the identification of the following four variations in cardiologists’ responses to patients’ resistance. The cardiologists repeated the treatment recommendations by explicitly articulating the risk factors and their intentions to prevent occurrence of more serious illnesses, such as strokes caused by a new episode of AF. They also described the risk of having asymptomatic AF and expanded further on the risks by repeating their treatment recommendations again. Physicians continued discussion of treatment recommendations until the patients accepted them. The cardiologists negotiated with the patients by recommending that they continue the treatment, stating that warfarin treatment confers good protection against strokes, and suggesting that the patients would need fewer blood tests than previously. Physicians also discussed the possibility of the patients having the tests near their homes. When the cardiologists failed to convince the patients to accept warfarin treatment, they altered their recommendations to obtain the required acceptance through negotiation. The cardiologists provided additional information about the recommended treatment by explicitly articulating how their recommendations would address the patients’ recognized medical diagnosis by preventing occurrence of more serious illnesses, such as strokes. The cardiologists extended their explanations of the reasons for taking the treatment by telling the patients about AF in relation to high blood pressure. After this explanation, the cardiologists recommended warfarin treatment as an alternative to on-going aspirin (acetylsalicylic acid) treatment. The cardiologists stated that the recommended treatment would prevent stroke. By explaining their recommendations, the cardiologists gave the patients another opportunity to accept them. The cardiologists then emphasized the shared responsibility of the proposed treatment.
Discussion

Study I

The main findings of study I were that both nurses and physicians addressed four topics during their consultations. These were “pathophysiology”, “treatment” “diagnostic procedures”, and “activity”. In the nurse–patient consultations an additional topic emerged, namely “routines related to physicians’ responsibilities”. With respect to the number of words and turns, the distribution of the discourse space was almost equal between nurses and patients and unequal between physicians and patients. The patients were the dominating initiators of the topic “activity”, which refers to adaptation of activities in daily life in relation to AF.

The topics that emerged in the consultations show that patients and health professionals seem to follow an implied agenda and that a medical-driven agenda strongly directed communication in the studied consultations. The dominance of the health professionals could be attributable to the help of the guidelines for AF and the fact that the most common issues discussed concerned patients’ treatment and diagnostic procedures.

Looking at how health professionals are involved in consultations can make asymmetries visible. According to Goffman, the participants in consultations often take up positions as speakers, recipients, side-participants or observers [44]. Those who are in positions of authority and organize the consultations are often the ones who dominate in them. Thus, professionals are in a powerful position in relation to patients when they communicate. One way that professionals can neutralize their power is by trying to understand their clients’ (patients’) frames as distinct from the institutional frame [98]. In this study, both nurses and physicians gave patients the opportunity to discuss their own topics by asking them if they had any questions, but returned to the medical-driven agenda, thus limiting the patients’ opportunities to talk about their everyday life situations. During medical consultations, health professionals tend to speak more than their patients and to prevent them from explaining their perspectives by using closed-ended questions and interrupting [15]. Mishler has shown how health professionals shift the focus of conversation from patients’ voices concerning their life–worlds back to the voice of medicine. Health
professionals can achieve medical tasks during consultations without avoiding matters concerning patients’ life–worlds. They should be communicatively competent in both worlds and not need to restrict the discourse to bio–medical matters. Health professionals can speak in either the voice of the life–world or the voice of medicine, whereas patients cannot [15].

There was unequal distribution of the discursive space between patients and physicians, the latter using 70% of the discursive space (32,737/46,989 words), whereas patients used 30% of the discursive space (14,252/46,989 words). Physicians used more words in all topics than did patients. This domination is in line with previous findings about institutional conversations [115, 144]. In medical consultations, physicians tend to speak more than their patients and also to prevent them from telling their own stories by using closed-ended questions and interruptions [15]. Roter and Hall have shown that less verbal dominance by professionals and greater patient input into the medical dialogue is associated with better patient recall of information, compliance with treatment, satisfaction with care, and health outcomes [145]. One consequence of the dominance of physicians is that patients find it difficult to communicate about their own experiences [146]. Thus, patients have a peripheral role in relation to professionals [120]. There is therefore a need to help patients with AF to express themselves within the framework of the medical agenda. Health professionals can increase patient involvement by asking questions about how AF affects their personal lives, private relationships and work situations.

Patients seemed to be more active and talkative and to take active roles more frequently during consultations with nurses than during those with physicians. The distribution of the discursive space was almost equal between patients and nurses, the latter using 52% of the discursive space (14,294/27,581 words), whereas the patients used 48% of it (13,287/27,581 words). The way we communicate with one another always depends on the people around us [120]. For example, the nature of a relationship between a patient and nurse can be a determinant of the way the patient communicates with the nurse. Communication is based on reaching similar understandings of experienced situations [120]. For example, consultations between nurses and patients may take the form of formal interviews or relatively informal everyday conversations. If patients feel as though they are participating in consultations, they feel safer and will more readily talk about their feelings and concerns with nurses [57]. Personal understandings can develop through talking about the things that are closest to patients’ hearts. Taking a two-sided perspective of the dialogue can facilitate patient participation. Nurses’ intentions in their dialogues should be to elicit patients’ potentials by asking open and reflective questions.
Despite their different resources and the asymmetry of knowledge and relationships in institutional talk, nurses and patients can reach common understandings and complementarity during consultations through such interactions [147].

Although health professionals introduced the majority of topics, patients introduced the topic “activity” in consultations with both physicians and nurses. It seems that patients in these situations want to relate to topics connected to their everyday life knowledge. Patients told the health professionals facts about their previous life situations and disclosed their concerns about everyday activities. They also stated concerns about their changed life situations and management of such changes. Patients with AF do adapt to current limitations caused by their illness. However, this adaptation leads to additional concerns and long-term emotional effects, for example, feelings of decreased energy and hopelessness [31]. Patients want to share such changes with their health professionals. The findings of another study in which patients were most satisfied by conversations that encouraged them to talk about psychosocial issues highlights this point [148]. From the professional’s point of view, it seems that the goal of consultations is to get information in order to decide on appropriate treatment. Mishler says that health professionals do have a responsibility to get all necessary information from their patients and to translate that into a medical perspective [15]. An important challenge for health professionals is to enable hearing of patients’ preferences and voices. In order to increase patient involvement, it is important to include questions about private relationships, work situations, and the impact of their illnesses on patients’ personal lives. Such meeting and dialogue between patients and health professionals is essential for good health care.

Study II

The main outcome of study II was the identification of four variations in patients’ expressions of resistance. These included “Giving reasons for their resistance”, “Suggesting other treatment options”, “Stating treatment preferences” and “Questioning or challenging the cardiologist’s treatment recommendations”. We also identified four variations of cardiologist’s responses to patient’s resistance. These included “Repeating the treatment recommendation”, “Negotiation with the patient”, “Providing additional information about the recommended treatment” and “Extending the explanation about the purpose of taking the treatment”. Our findings are in line
with a Finnish primary care study on upper respiratory tract infections [43]. These researchers found that patients resisted diagnoses by asking for additional or alternative information about the diagnosis presented by the physician. The patient’s influence in decision-making includes different components of communication, namely initiation (i.e., requesting or proposing a treatment) and responsive actions (i.e., expressing a certain standpoint toward the physician’s proposals) [130].

Patients expressed their resistance as a fear that the treatment could cause cerebral hemorrhage. They actively resisted the physicians’ recommendations due to uncertainty. Because they were unsure about what the treatment might mean, they withheld acceptance as a means of gaining a better understanding of its risks. Cardiologists may not recognize resistance as an attempt at concealing treatment preferences or patients’ concerns. The patients in study II also suggested other treatment options by proposing alternatives to warfarin. Health professionals and patients should deliberate together about whatever healthcare options are important to the patient while simultaneously seeking to reach decisions that reflect both research evidence about the effects of different options and the patients’ preferences [149]. It is important for health professionals to invite and encourage good communication during consultations while verifying that patients do have a good understanding and are motivated to comply with their treatment [149]. Exploring the patient’s perspective also creates an opportunity to discuss the effects a treatment may have in more detail. Patient participation in decision-making has not only political or economical advantages, but also medical advantages [43]. Patients who have participated in decision-making better follow agreed treatment plans and comply with medication regimes [14]. Focusing on clarity in communication situations usually achieves efficient use of time and reduces resistance. On the other hand, interactional behavior, such as cardiologists pushing the overall visit forward, can reduce patient participation. Supporting people to be active participants in their care may have important positive implications for patient satisfaction, the extent of compliance with treatment, relationships between patients and professionals and long-term health outcomes [21]. Fully involving patients in their care and in decisions about their care is one component of this [21]. In addition, cardiologists have a responsibility to facilitate effective communication by understanding patients’ resistance and acknowledging the patients’ perspectives. Some patients do not know about their treatment in detail and leave treatment decisions to their cardiologists [150]. Therefore, physicians should invite patients to participate and negotiate a treatment regime that is in parallel with patients’ preferences [151]. How can cardiologists determine what is relevant or not in particular
situations regarding specific problems in consultations? Pendleton emphasizes the importance of participants’ different backgrounds in communication [96] and states that values, beliefs and attitudes, skills and experience, and emotional and behavioral factors influence consultations. Cardiologists who place emphasis on patient autonomy can gain understanding of their patients’ perspectives by encouraging them to formulate their thoughts about warfarin treatment.

Patients also expressed treatment preferences and started discussions of recommendations that suited their treatment preferences. One patient stated her treatment preference by asking the cardiologist if she had to go to another city for her tests, suggesting that she could have her blood tests at the local primary health care center. Rather than blindly pursuing patients’ acceptance, cardiologists can see patients’ expressions of resistance as opportunities to discuss treatment preferences. Resistance can be considered as a source of knowledge about patients’ current situations and what motivates them [152]. Patients’ treatment preferences and beliefs are important factors; cardiologists can ask patients how they wish to be involved in decision-making [153]. Some patients questioned or challenged their cardiologist’s treatment recommendations. Patients sometimes disguise their resistance and use covert forms of resistance in their interactions with health professionals rather than creating open conflicts [120, 154]. Resistance expressed as dispreferred accounts tends to break down social solidarity between participants. Goffman explained that “face-to-face” interactions between participants require a lot of work and attention if no one is to “lose face” [120]. Resistance can be considered an expression of patients’ anxiety or fear. According to a dialogic view of language and communication, meanings and messages are co-constructed by participants as they switch roles between those of speakers and listeners [94]. The content of what participants say cannot be separated from their interactions and the relationships in which they are involved [107, 109].

Study II also examined how cardiologists respond to patients’ resistance. Cardiologists provided additional information about the recommended treatment by explicitly articulating how their recommendation would address the patients’ recognized medical diagnosis by preventing occurrence of more serious illnesses such as strokes. Cardiologists extended their explanations of the purpose of the medication to convince the patients to accept it. Miller called this a correction reflex; it is often an expression of care [152]. The cardiologists repeated the treatment recommendation by explicitly articulating the risk factors and explaining how to prevent new episodes of AF from resulting in illnesses that are more serious such as strokes. Cardiologists continued
discussion of treatment recommendation until their patients accepted them. Information exchange may involve one-way or two-way communication. In the paternalistic model, the exchange is largely one-way, the direction being from physician to patient. At a minimum, physicians must provide patients with relevant information about treatment options. This model depicts patients as passive recipients of whatever type of information physicians choose to impart. Cardiologists may ask their patients about specific issues such as side effects that could affect their reactions to the treatment selected by the cardiologist. The paternalistic model assumes that physicians know best and will make the best treatment decisions for patients [77]. Information exchange between participants and adequate perception and understanding are essential for successful communication processes. It is important that information exchanges between cardiologists and patients with AF are effective. Ways to acknowledge information provided and verify it are asking questions and using feedback. Research suggests that some older people prefer a more paternalistic or directive style of interaction with clinicians [155]. One US study [156] found that about half of older people prefer passive roles in health care decision-making. Men are more likely to be involved in some health care decisions than are women [157]. In contrast, a survey of elderly people in Sweden found that sex did not influence the extent to which people want involvement in decision-making [158]. Young people are more likely to want to participate in decision-making than are older people [159].

Exchanging information is a process that enables patients and cardiologists to get to know each other and determines how well they can work together. Through the process of information exchange, patients have the opportunity to weigh the extent to which their cardiologist’s attitudes and behavior match their own expectations of how the cardiologist should interact with them. Building trust is one part of this process [160]. Physicians could more effectively facilitate patient involvement by using partnership-building and supportive communication more frequently [62]. There were no instances of patients not accepting recommended treatment and no cardiologists changed their treatment proposals. The cardiologists based their treatment decisions on clinical findings and guidelines for the management of AF emphasize the importance of warfarin therapy for prevention of strokes. Patients’ resistance did not alter cardiologists’ recommendations about warfarin. In contrast to our findings, others have shown that social interaction between medical practitioners, patients and hospital doctors determines treatment decisions about warfarin rather than those decisions being influenced by applying evidence from published guidelines [161]. Cardiologists are more likely to involve patients in decisions about severe disease [162]. Researchers emphasize that health practitioners
should, whenever possible, offer patients choices about their treatment decisions [149, 163]. Patients have a right [19] and wish to share decisions with their providers [164]. In our study, cardiologists negotiated with patients by recommending that they continue with the treatment, stating that warfarin treatment confers good protection against strokes, and telling patients that they would need fewer blood tests than previously. Another possibility that was discussed was that patients could have their tests closer to their homes. When the cardiologists were unsuccessful in convincing patients to accept warfarin treatment, they altered their recommendations to obtain the required acceptance through negotiation.

Patients have improved health outcomes and feel more satisfied when they participate in medical decision-making [165]. Edwards and Elwyn reflect on models of paternalistic decision-making, SDM and informed decision-making. They propose that the SDM model is the best available and least time-consuming model of clinical communication for patients with AF [166, 167]. It seems that patients who participate in SDM are less concerned about the possible consequences of anticoagulation medication than patients who do not [166]. Health practitioners do not routinely implement SDM in their clinical practice in Sweden. They should modify management of AF to incorporate patients’ preferences about treatment decisions, particularly with regard to the possible consequences of anticoagulation treatment [168]. Cardiologists can use patients’ resistance to encourage them to formulate their thoughts regarding treatment, thus engaging them in a collaborative process in which there is a shared responsibility for treatment goals. However, this does not always occur. Patients’ personal characteristics, the nature of their illness(es) and their level of trust in their physicians are some factors that affect their willingness to participate [45]. For example, a study in Switzerland found that two-thirds of people preferred to leave decision-making to their doctors. Those who preferred SDM were likely to be younger, better educated and in more discomfort than those who did not [162]. In England, investigators found that 40% of people wanted to be involved in decisions about heart care. They found no differences in terms of age, sex or ethnicity [162].

Dialogues between patients and health professionals create space for development, learning, understanding, confirmation, change and liberation [107]. They can be interpreted as a distribution of responsibility whereby patients not only receive information, but can also discuss and process their specific issues. Thus, communication in consultations can be perceived as complementary rather than asymmetric [147]. Points of meeting in consultations are central to people and provide opportunities for patients to
become involved. Good communication is an essential ingredient for participation in decision-making [169].

General discussion

Can communication and what actually happens in conversations increase patients’ opportunities for involvement and participation? Can professionals learn to interact in ways that increase patient involvement? There is evidence that that insufficient information between patients and professionals can help or hinder decision-making [23]. Carr and Jacox have shown that, compared with patients with low levels of participation, patients who have participated well in consultation talk with professionals have less chest pain, fewer problems with breathing and comply more closely with medical decisions [170]. Communication matters in many clinical situations. For example, a study of patients with breast cancer showed that those who participated as much as they wanted to were more satisfied with the decision-making process and had lower depression scores three months later than patients who did not [171]. Researchers have designed decision aids to help patients make informed choices among treatment options. These aids deliver evidence-based information on options and outcomes and provide information about how health professionals perceive communication and input into decisions [82]. Rather than assuming problems with knowledge, skills, attitudes, or motivation, one explanation for why health professionals do not implement and adhere to findings of research on clinical behavior change recognizes that all people, health care professionals included, are prone to developing efficient and automatically activated habits [172]. Patients’ attitudes and values are likely to interact with the attitudes and behaviors of professionals to influence shared decision-making [173]. That cardiologists view their patients as active participants in treatment decisions and ask them to share potential concerns about treatment may be of vital importance in strengthening patient involvement in treatment decision-making processes. Establishing preferences is important if the aim is to make health care more sensitive to the needs and expectations of each individual patient [149]. Patients have preferences in the form of beliefs and values and it is the responsibility of health professionals to elicit them and take them seriously. Patients may not consciously know what they prefer. Their preferences may be based on a lack of understanding, or misunderstandings, about their health states or possible interventions [174]. Patients may need to find ways of checking their preferences, identifying which are longer standing or more profound (or which represent their most deeply
held values). Health professionals should help patients to construct, check and prioritize their preferences in domains that are important for decision-making [76]. Engaging people in their health and care is a key component of developing a health care system of the highest possible quality; one that is safe, effective, person centered, timely, efficient and equitable [7]. Fully involving patients in their care and in decisions about their care is one component of developing such a health care system [149]. Both the characteristics and attitudes of the parties involved and the culture and infrastructure within which they are operating shape interactions between patients and health professionals [121]. Recognizing this, this thesis has focused on communication strategies that facilitate the participation of patients in decision-making. Such strategies include patient-driven agendas in which patients with AF introduce the majority of the topics in consultations with nurses and physicians. Another strategy is to ensure that both the topics discussed and the discursive space support patients involvement as active partners with professionals in clarifying acceptable treatment options. In addition, cardiologists can use patient resistance to stimulate their patients to formulate their thoughts regarding treatment and to engage the patient in a collaborative process in which there is a shared responsibility for treatment goals. By taking the view that individual patients can act as co-workers in different ways and acknowledging both the uniqueness of each person and of existing power structures, health professionals can bridge possible gaps.

Methodological considerations

Our first concern was the characteristics of our samples. We considered the characteristics of our samples, data collection, and data analysis when designing the studies. According to published data analysis methods, our sample size was appropriate for our studies [143]. The samples come from both large and small hospitals. We collected all data in both studies in ordinary clinical practice settings. All patients who participated in studies I and II were receiving health care and required professional interventions. One strength of our studies is that we included patients with a variety of forms of AF, both men and women, from different sized hospitals. The participating nurses and physicians were experienced in cardiology and aware of the purpose of the studies. Thus, we can assume that they were motivated to communicate well, which constitutes an unavoidable selection bias. We did encounter some difficulties when
choosing the professionals. One hospital declined to participate because the professionals did not want to be videotaped. A more varied group of professionals may have been preferable. It would have been interesting to include some relatively inexperienced cardiologists. In both studies, the participating professionals were the normal staff for the settings at the time of data collection. The fact that the regular staff participated may have influenced the data negatively as well as positively. Before the study, we introduced information about it to the professionals by making several phone calls to each clinic with the aim of motivating and instructing the professionals. In an attempt to ensure dependable findings in the qualitative studies, we used different methods. In qualitative research, the quality or excellence of an inquiry can be assessed by the following criteria for trustworthiness: credibility, transferability, dependability and confirmability [143]. The credibility criterion refers to confidence in the truth of the data. To enhance credibility, we had conversations with the patients and health professionals both before and after the consultations. We videotaped the consultations and made verbatim transcriptions of them and the coauthors took part in the analysis process. Dependability of qualitative data refers to data stability over time and over conditions [143]. We have described the assumptions that are central in this research context and presented the methods used in a way that the reader can understand. The coauthors assessed the data and arrived at conclusions separately [143].

Our second concern was the videotaping. The use of videotaping during the consultations may have influenced the participants’ behavior. Because the participants may have behaved and communicated in an atypical manner, the videotaping may have compromised the internal validity of the study. However, the literature states that people tend to resume their natural behaviors fairly quickly [175]. Videotaping is considered a valid and reliable method that causes limited disturbance to the consultation process [176]. However, the fact that video recording is occurring is obvious. Its advantage is that it allows researchers to review the material whenever they want to [175]. In these studies, we used data that we had transcribed from the spoken form as well as assessing both verbal and nonverbal communications. The videotapes allowed assessment of many aspects of the consultations. Nevertheless, these studies enabled us to highlight specific dimensions of interactions between patients and health professionals, thereby contributing to further understanding of communication in clinical consultations.

Our third concern was the methods. In study I, we assessed each speaker’s contribution to the conversation by counting the number of words they spoke
to evaluate dominance quantitatively. However, because in these studies we did not attempt to analyze dominance in terms of interactional structure; we risked losing the finely detailed evaluation that is possible with frameworks that are more complex. Itakura suggests that quantitative data regarding conversational dominance in institutional talk needs to be interpreted qualitatively by paying attention to the speakers’ conversational styles, goals and strategies, and the social and cultural aspects of the mutual construction of meanings [177].

Content analysis does not allow evaluation of the sequence of the topics. This means that it fails to provide information about interactional sequences in conversations in which some topics are discussed and others are not. In the sense of content of a conversation, a topic is a part of the conversation that is remembered and that characterizes the conversation [94]. Linell says that topics are difficult to define clearly, that is, different topics often cannot be adequately separated from each other by defining them only in terms of their sets of referents [106]. The challenge is to find a unit that is both relevant to the participants in an interactional sense and able to be defined strictly enough to be useful as a research tool [106]. Confirmability refers to the objectivity or neutrality of the data and the analysis [143]. To enhance confirmability, all authors discussed the analysis of the data until they reached consensus. In addition, to strengthen confirmability, we have presented descriptions of the research process and included some of the original data in the form of quotations from study I and extracts from study II. Inclusion of these extracts from the consultations in the Appendix also facilitates transferability. Although the videotapes of the consultations (studies I and II) made it possible to analyze many aspects of the interactions, we analyzed only the spoken, verbal and nonverbal levels of the communications recorded. We used CA in study II. Mishler has criticized CA on the basis that analytic studies of conversations normalize the voice of medicine while suppressing the voice of the life–world, and thus result in loss of much of what constitutes the illness experience from the patient’s point of view. The methods we used in both studies did not allow us to investigate the individual participants’ own perspectives. We also failed to take the perspective of gender into account. The critical discourse theory perspective allows more focus on power positions (Fairclough, 2001).

**Comprehensive understanding**

Our findings concerning topics discussed in consultations, patterns of dominance, the ways patients express resistance to treatment with warfarin and
how cardiologists respond to that resistance may help in devising clinical strategies directed at incorporating patients’ perspective into clinical consultations. This thesis discusses the interplay between incorporation of patients’ voices and perspectives into consultations (or failure to do so) and patient involvement in decision-making about treatment. In both nurse-led and physician-led consultations with patients with AF, the medical-driven agenda dominated the patient-driven one. It seems that patients dominate only when they are initiated topics connected to their everyday life knowledge. Patients informed health professionals about their previous life situations and disclosed their worries about everyday activities, including expressing concerns about their changed life situations and management of such changes. The topic that patients most often initiated was “activity”, which relates to living with AF. In contrast, nurses and physicians initiated the topics “treatment”, “diagnostic procedures” and “pathophysiology”, which reflected the medical approach laid down in the national guidelines for AF. Implementation of improved strategies for facilitating patients to discuss their illness experience in relation to all topics discussed in consultations is desirable. For example, health care professionals could take the role of active listener for a greater proportion of these conversations. This could decrease the domination of health professionals (for example, it could mean that they initiated fewer topics) and use of a medical-driven agenda and increase patients’ participation and their opportunity to initiate different topics of their own choosing. Thus, both the types of topics discussed and the proportion of the discursive space occupied by patients would support their involvement as active partners with professionals in clarifying acceptable treatment options. The medical-driven agenda identified in our study could well have reduced the possibility of patients participating in decisions about their treatment and care.

When resisting treatment recommendations, patients resort to experience-based views on their treatment. Identifying and understanding patients’ methods of resisting treatment may help to facilitate shared decision-making about that treatment. Cardiologists could use patient resistance to encourage their patients to formulate their thoughts regarding treatment and to engage them in a collaborative process in which there is a shared responsibility for treatment goals. Patients are active participants in treatment decisions when they express resistance to warfarin (or any recommended treatment). In order to strengthen patients’ involvement in their care and in decision-making about treatment, it is vitally important that physicians include them when making treatment decisions.
It is important to understand the factors that influence the way patients communicate with health professionals. Increased communication of patients’ perceptions of their illness experience might decrease their anxiety and stress. Patient participation in treatment decisions has become increasingly important with the recognition that a greater degree of active patient participation results in better health outcomes and quality of care. Engaging people in their health and care is a key component of developing a health care system of the highest possible quality: safe, effective, person-centered, timely, efficient and reasonable. Recognizing this, this thesis suggests that cardiologists encourage their patients to be active participants in treatment decisions by asking them to share potential concerns about treatment. An awareness of patients’ resistance to treatment would enable cardiologists to address patients’ experience-based views on treatment and their individual concerns. These clinical strategies to increase patient participation in treatment decisions would enhance subsequent compliance with treatment. Including patients in the making of treatment decisions confirms their active participation.
Conclusions

- We identified four topics in the consultations we assessed. These were “pathophysiology”, “treatment”, “diagnostic procedures”, and “activity”. In the nurse–patient consultations an additional topic, “routines related to the physician’s responsibilities”, emerged (I).

- With respect to the number of words and turns, the distribution of the discourse space was almost equal between nurses and patients, but unequal between physicians and patients (I).

- Patients tended to engage more (be more talkative) and to take active roles more often during consultations with nurses than during those with physicians (I).

- Health professionals initiated topics more frequently than did patients. Patients were the dominant initiators of the topic “activity”, which refers to adaptation of activities in daily life in relation to their AF (I).

- Patients exhibited four types of resistance to accepting treatment with warfarin. These included “Giving reasons for their resistance”, “Suggesting other treatment options”, “Stating treatment preferences” and “Questioning or challenging the cardiologist’s treatment recommendation” (II).

- Cardiologists’ responses to the patients’ resistance included “Repeating the treatment recommendation”, “Negotiation with the patient”, “Providing additional information about the recommended treatment” and “Extending the explanation about the purpose of taking the treatment” (II).
Clinical implications

Study I

In nurse-led as well as physician-led consultations with patients with AF, a medical-driven agenda dominated over a patient-driven one. It is possible to improve patients’ expression of their perceptions of their illness experiences in relation to all topics discussed in clinical consultations. It is important that health care professionals take the role of active listeners for a greater proportion of the conversation during consultations. This might decrease the domination of health professionals (for example, they would initiate fewer topics during consultations) and use of a medical-driven agenda while increasing patients’ participation and their opportunity to initiate topics of their own choosing. Increased communication regarding patients’ perceptions about their illness experiences might decrease their anxiety and stress. One reason for that might be that when the patients present their problems and symptoms to their health professionals, they often provide their own explanations of illness and thus give the health professionals insight into their situations. In this way, communication in the consultation is complementary rather than asymmetric.

Study II

Our findings concerning interactions about resistance to recommended treatment support the potential for cardiologists to view resistance as an expression of patients’ anxiety or fear. It is important to view patients’ resistance as a resource, a source of information. When health professionals take this view, patients can give subjective accounts of their concerns. It is important that cardiologists remain in the position of information receiver, not vice versa, when patients exhibit resistance. Cardiologists could use motivational interviewing techniques to develop a dialogue and initiate thoughts about changes in patients’ ideas and treatment preferences. Our findings support the potential for cardiologists to adapt to each individual patient’s perceptions and utilize their patient’s perspectives to increase their understanding and recognition of the various ways of expressing resistance. Cardiologists should tell patients that their recommendations are preliminary, pending the collection of more information, including identification of the basis of patients’ resistance. Resistance represents direct feedback that there is dissonance between patient and health professional and serves as a signal to alter communication strategies. Our findings have potential for application in nursing and medical training.
Future studies

Our findings (I-II) illuminate the need to conduct more research on communication patterns in consultations, with a focus on patient participation in decision-making. These studies suggest that further investigation of communication aspects of participation in decision-making in consultations could include:

- Investigating patients’ and health professionals’ impressions about communication and participation in treatment decisions in consultations by subsequently interviewing them with a focus on their own experience.

- Investigating how information exchange in consultations affects patient participation by further qualitative analysis of the interactions in consultations.

- Investigating how nurses and physicians encourage patients to express their preferences and thereby facilitating incorporation of patients’ perspectives into decision-making. One way to do this is by examining how nurses and physicians present information during consultations with patients with AF.

- Investigating the components of SDM by using the Swedish version of the OPTION (observing patient involvement) rating scale when assessing consultations between patient with AF and cardiologists (http://www.optioninstrument.com/translations.php).

- Investigating how many Swedish hospitals have nurse-led AF clinics and whether those clinics have structured follow up routines based on medical guidelines that impose constraints or provide opportunities for more effective sharing of decision-making with patients.
Svensk sammanfattning

Bakgrund


överenskomna behandlingsplanen och att ta de ordinerade läkemedlen. Att studera kommunikationen mellan patienter och vårdpersonal kan användas för att t.ex. utveckla aspekter av patienternas delaktighet och beslutsfattandet som rör behandlingen.

Skillnaden mellan parterna under konsultationen har beskrivits som ett möte mellan skilda världar där patientens värld konfronteras med institutionens värld. Vårdpersonalen styr ofta samtalen och förväntas ha övertaget när det gäller den nödvändiga expertisen. För att kunna göra en korrekt bedömning bör vårdpersonalen ha en insikt i patientens egna erfarenheter. En policy mot ökat patientengagemang och patientcentrerad kommunikation ger patienten bättre möjlighet att vara delaktig i konsultationsprocessen inklusive behandlingsbeslut.

**Studie I**

**Titel:** Innehåll och fördelning av det diskursiva utrymmet vid konsultationer mellan patienter med förmaksflimmer (FF) och professionella

**Bakgrund:** Ur ett kommunikativt perspektiv äger konsultationsmötet mellan patienter med FF och vårdpersonal rum inom ramarna för en institutionell diskurs. Diskursen definierar vad som kan sägas och tänkas om en företeelse, vem som kan prata om den samt när och med vilken auktoritet. Det finns få studier om kommunikation inom kardiologiområdet och dessa fokuserar främst på patienter inom kardiologin i allmänhet. Läkares och patienters beteende vid kommunikation har studerats, interventioner har gjorts med syfte att stödja den gemensamma beslutsfattande processen. Studier som fokuserar på dominans inom kardiologin har undersökt relationer för kön, dominans i relation till kardiovaskulära reaktiviteten som bedöms vid dyadiska sociala interaktioner. Kunskap, förståelse och insikt är mycket viktigt för att stärka patientens engagemang i behandlingens beslutsfattande process. Andra patientgrupper, som tar aktiv del i det kliniska beslutsfattandet vid vårdkonsultationer, har associerats med kön, ålder, utbildningsnivå, levnadsförhållanden och anställning.

**Syfte:** Att beskriva (i) de ämnen som deltagarna talar om, (ii) användningen av diskursivt utrymme vid konsultationer mellan patienter med FF samt deras sjuksköterskor och läkare inklusive (iii) frekvensen för de olika sätt som patienter, sjuksköterskor och läkare introducerar ämnenna.
Metod: Data samlades in från 23 videofilmade konsultationer med patienter med FF (11 med läkare och 12 med sjuksköterskor). För att kunna beskriva de ämnen som diskuterades analyserades utskrifterna med hjälp av innehållsanalys. De dominerande mönstren för respektive ämne och deltagare undersöktes genom ett analysramverk som behandlar dominans.


Slutsats: Den medicinskt drivna dagordningen dominerar över den patientdrivna dagordningen vid konsultationer mellan vårdpersonal och patienter med FF. Patienterna tog initiativet i samtalen när det talades om att leva med FF och var mer talföra under samtalen vid konsultationer med sjuksköterskor.

Studie II

Titel: Motstånd i interaktionen mellan patienter med förmaksflimmer (FF) och kardiologer vid konsultation om behandling med warfarin: Värdet av gemensamt beslutsfattande


Mål och syfte: Att identifiera på vilket sätt patienter motsätter sig behandling med warfarin och hur kardiologer bemöter patienternas motstånd. Avhandlingens co-konstruktiva perspektiv analyserar konsultationerna genom att understryka de kliniska kommunikationsstrategierna för både patienter och kardiologer.

Metod: Elva videoinspelade konsultationer på fyra olika sjukhus valdes ut för analys. Interaktionen mellan patienter med förmaksflimmer och kardiologer rörande behandling med warfarin analyserades med hjälp av konversationsanalys (CA).

Resultat: Bland patienterna förekom fyra olika typer av motstånd mot att acceptera behandling med warfarin. De inkluderar “Patienten ger skäl för sitt motstånd mot behandlingen,” “Patienten föreslår ett annat behandlingsalternativ,” ”Patienten anger en behandlingspreferens” samt ”Ifrågasättande av eller invändningar mot kardiologens behandlingsrekommande”. Kardiologens bemötande av patientens motstånd inkluderar ”Upprepan av behandlingsrekommanden,” ”Förhandling med patienten,” ”Att ge ytterligare information om den rekommenderade behandlingen” och ”En mer utförlig förklaring av syftet med behandlingen”.

Slutsats: Genom att uppvisa motstånd mot behandlingen tros patienten uttrycka sin önskan att vara delaktig i behandlingsbesluten och genom att vara medveten om patientens motstånd mot behandlingen kan kardiologen bemöta patientens personliga oro och erfarenhetsbaserade syn på behandlingen som en del av de kliniska strategierna för att öka den medicinska behandlingens fokus på personen.
Acknowledgements

First of all, I want to thank all patients, nurses and physicians that have participated in the videotaped consultations. The present thesis would not have been possible without these valuable consultations.

I would like to thank gratefully the Order of Saint John (Johanniterorden) in Stockholm, Sweden, Vinnvård, FORSS and Futurum, the Academy of Health and Sciences, Jönköping County Council, Sweden for their financial support. Thank you to Bridging the Gaps II and professor Jan Mårtensson. Thanks also to the Faculty of Health school in Jönköping.

I especially express my gratitude to the following persons:

My main supervisor, associate professor Anders Broström, who with great patient and friendly way led me through the process of writing despite my incomplete manuscripts.

My supervisor, Care Controller and Senior Lecturer, Berith Hedberg, who gave me the opportunity to undertake this research project.

Professor Elisabet Cedersund, senior lecturer Pia Bülow, associate professor Gunilla Jansson, associate professor Henrik Rahm and senior lecturer Gunlög Sundberg for valuable comments.

All my colleagues at the research school Health and Welfare Jönköping, present and past, for a lot of interesting conversations.

During this journey of the thesis I have met people that have in some way or another inspired, helped and supported me. Thank you all for being there for me when I needed what you provided for me, whether it was some critical reflection, providing insights into the analysis or reading of the manuscripts and revising the English. My warmest thanks to Per Reinholdsson, Anna Booberg, Karl Hedman, David Brodin, Vasilis Fourlakidis, David Finer, Lars Andersson, Ann-Magret Wedin Ohlsson, Gunilla Brushammar, Maria Engström, Ann Blomgren, Astrid Fager, Håkan Montelius, Thommy Andersson and Paula Lernstål-Da Silva.
Finally, those who reminded me that there are other things in life besides working on the thesis, my family, specially my son Michael, my “daughter” Fredrika and all my friends.

Jönköping December 2012,

Eleni Siouta
References


[94] Norrby C. Samtalsanalys: så gör vi när vi pratar med varandra. [Conversational analysis: this is how we do when we talk to each other]. Lund: Studentlitteratur, 1996.


Appendix: Extracts used in Study II

Patients’ resistance to treatment

Giving reasons for patients’ resistance

The extract is derived from consultation number 7.

<table>
<thead>
<tr>
<th>Line</th>
<th>Speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>C: so, when using (.) warfarin: ((lays the pen on the table)) the idea is that there is less risk for stroke:: that is the thing which does it.</td>
</tr>
<tr>
<td>02</td>
<td>P: yes</td>
</tr>
<tr>
<td>03</td>
<td>C: and you can keep it there with the help of the tests, so it is a really good medication</td>
</tr>
<tr>
<td>04</td>
<td>P: don’t I need to be afraid about a cerebral haemorrhage as it has been in the newspapers that it is so dangerous?</td>
</tr>
<tr>
<td>05</td>
<td>C: yes, but well, then you forget that there is the risk of having a stroke if you don’t take {warfarin}</td>
</tr>
<tr>
<td>06</td>
<td>P: yes</td>
</tr>
<tr>
<td>07</td>
<td>C: =and it is much higher than having a cerebral haemorrhage when you take warfarin</td>
</tr>
<tr>
<td>08</td>
<td>P:</td>
</tr>
<tr>
<td>09</td>
<td>C: := a small risk of bleeding</td>
</tr>
</tbody>
</table>

91
Suggestion of another treatment option by the patient

The extract is derived from consultation number .7.

01 C: there is
02 P: yes
03 C: a small risk of bleeding
04 P: there is a new medicine available
05 C: yes, but it is not out on the market yet
06 P: no:
07 C: this new medicine is currently being researched
08 P: Yes
09 C: unfortunately, it is unlikely that everyone will switch to the new medicine
10 P: no:
11 C: for those it is as usual that it sounds so extremely good later when you start to know about it more and more then it has also
12 P: ((nods)) side effects=
13 C: =side effects
14 P: yes
15 C: it is likely to be a couple of years before the new medicine will be available
16 P: yes
**Stating of treatment preference**

The extract is derived from consultation number 6.

| 01 | C: it is something that we could think about where I could          |
| 02 | write a referral to the care centre (.) or to                    |
| 03 | the medical clinic in (name of the city) where they can          |
| 04 | give you warfarin                                               |
| 05 | P: hmm, hmm (0.2)                                               |
| 06 | but, but (.) then I **must** go to (name of the hospital) once  |
| 07 | a week [then = ((the patient placed her/his hand on the         |
| 08 | table))]                                                       |
| 09 | C: [No, no=                                                       |
| 10 | P: =you know that (.) blood tests can be performed at            |
| 11 | the care centre                                                 |
| 12 | C: = without that, you take the tests in (name of the city)      |
| 13 | but it is (name of the other city) that calls you later          |
| 14 | and says what your | warfarin dose will be                                          |
| 15 | P: [yes, yes                                                     |

**Questioning or challenging the cardiologist’s treatment recommendation**

The extract is derived from consultation number 11.

| 01 | P. I have been removed from the cardioversion [list             |
| 02 | C: [yes, exactly =                                               |
| 03 | =because you know I talked with [first name] that               |
| 04 | you::would be released from the cardioversion list(.) yes       |
| 05 | exactly                                                         |
| 06 | P: so what happens now it is the big question that is why       |
| 07 | I am sitting here [ why I take fox poison then (huh.)          |
| 08 | C: [exactly                                                     |
| 09 | the fox poison,[you were thinking about the rat’s poison?       |
| 10 | P: [or rat poison, yes                                          |
Cardiologists responses to the patients’ resistance

Repeating the treatment recommendation

The extract is derived from consultation number 8.

01 C: exactly, warfarin and so (.) then you get to look a little
02 at which risk factors you have. Why you take
03 warfarin (.) really you can take it depending on which risk
04 you have for having blood clots[
05 P:        [yes:
06 C: if you have had a fibrillation one time (.) then it is a lot
07 that speaks for that you maybe at some time [get it
08 again
09 P:          [hm hm
10 C: and you don’t always feel the fibrillation episodes
11 there are studies that are done where you
12 done where you see that most of the fibrillation episodes
13 they are asymptomatic as we say you don’t feel them
14 P: ((nods))
15 C: you don’t notice them . just those where fibrillations
16 that come and go and then you (.) however know an
17 increase risk for blood clots, to have an atrial fibrillation
18 at all is an increased risk for blood clots because it
19 little turbulent in the vessel that doesn’t flow in the same
20 way that it does when it beats regularly
21 P:yes
Negotiation with the patient

The extract is derived from consultation number 11.

01 C: so, warfarin is extremely much better at protection
02 but at the same time it is so that you somehow do not
03 have you take it just in order to protect yourself against
04 blood clots and do not think to have a cardioversion or on
05 the way to do some other form of measure then it is
06 then you need then it is enough of course to check
07 sometime during the month
08 P: [hm
09 C: many times you can of course check that you have
10 left tests at the lab you happen to be at and then it is
11 possible electronically
12 P: [hm
13 C: because you shouldn’t need to come just here if it is
14 not a bad time so to speak or to the care Centre, or
15 wherever you may be

Providing additional information about the recommended treatment

The extract is derived from consultation nr 11.

01 C: there is namely a scale that is called CHADS2 score
02 P: hm
03 C: and then you check on this how many and then you
04 can have a number of points for each of this type of
05 letter for the letters stand for different risk factors
06 P: hm
07 C: and if you then get one or primarily two or more
08 points on this then you usually say that warfarin is
09 appropriate to go with it like in the future because
10 you know of course that warfarin protects maybe
11 seventeen percent against stroke while of course
12 trombyl that can be the alternative goes up to=
13 P:=(nods) I took that before
14 C: and it protects maybe thirty percent
15 P: hm
Extending the explanation about the purpose of taking the treatment

The extract 8 is derived from consultation number 6.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>C: if you look at the notes from the heart clinic (name of the city) then you have the diagnosis</td>
</tr>
<tr>
<td>02</td>
<td>atrial fibrillation and high blood pressure</td>
</tr>
<tr>
<td>03</td>
<td>P: yes yes</td>
</tr>
<tr>
<td>04</td>
<td>C: and when you have it then you can say that it can be good to treat instead of trombyl so you can also treat with warfarin against blood clots so that you don’t get clots from your atrial fibrillation for it is actually that which is the most serious eh eh it is of course that which is the greatest risk with atrial fibrillation</td>
</tr>
<tr>
<td>05</td>
<td>P: ((nods))</td>
</tr>
<tr>
<td>06</td>
<td>C: it is this stroke risk you</td>
</tr>
<tr>
<td>07</td>
<td>P: yes yes yes yes</td>
</tr>
<tr>
<td>08</td>
<td>C: so that eventually it would thus benefit you to have warfarin if you don’t have anything against it then you can you can be given that instead of trombyl</td>
</tr>
<tr>
<td>09</td>
<td>P: yes</td>
</tr>
</tbody>
</table>