How and when do patients request life-expectancy estimates? Evidence from hospice medical consultations and insights for practice

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How and when do patients request life-expectancy estimates? Evidence from hospice medical consultations and insights for practice

Marco Pino*, Ruth Parry

Department of Social Sciences, Loughborough University, Brockington Building, Margaret Keay Rd, Loughborough, Leicestershire, LE11 3TU, UK

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ABSTRACT

Objective: To break new ground by directly examining how patients seek life-expectancy estimates, and how doctors support them in doing so.

Methods: Conversation analytic examination of 10 recorded UK hospice consultations involving 3 palliative specialists.

Results: Life-expectancy estimate episodes frequently begin after a doctor has given a patient an opportunity to shape the consultation agenda. Rather than posing direct questions, patients cautiously display their interest in receiving an estimate using statements. These often contain preparatory information about: what they already know about their prognosis, their perspective on it, and readiness to hear more. When patients do not provide this information, doctors invite it before giving an estimate. Patients’ companions also contribute to this preparatory work.

Conclusion: Doctors, patients, and companions collaboratively work to prepare a conversational environment wherein emotional states and uncertainties have been addressed prior to delivery of the actual estimate. This helps manage both possible emotional distress, and prognostic uncertainty entailed in seeking and delivering estimates.

Practice implications: Clinicians should be mindful that rather than overtly requesting estimates, patients may seek them more cautiously. Before delivering estimates, doctors can support patients to articulate their existing understanding and perspective regarding prognosis, and their readiness to hear more.

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1. Introduction

Palliative medicine specializes in providing care for people who have life-limiting illnesses [1]. Discussing future illness progression with patients is part of palliative care doctors’ professional remit [1–3]. These discussions can enable patients to make plans for their future and to communicate their preferences for end-of-life care. Discussions about the future comprise several aspects of illness progression, including information about patients’ likely life-expectancy [4]; they can be initiated by doctors or patients [5–8]. Patients differ in terms of how much they want to know about their prognosis [9–13].

Life-expectancy talk presents dilemmas sometimes captured through the metaphors “elephant in the room” [14] and “dancing around death” [15]. Doctors have a duty to inform patients of how their condition might impact their future. However, doctors may be reluctant to do so for fear of destroying patients’ hope [4,16]; or for fear that a prognostic estimate (for which doctors may be liable) turns out to be incorrect. Whilst patients are entitled to ask about prognosis, they may be reluctant to. They may dread a gloomy prognosis; they may also be uncertain about their doctors’ ability and willingness to estimate their life expectancy. These dilemmas have been debated; some commentators support the idea that doctors should always be honest with patients, others argue that all-embracing honesty is not always possible and should be subject to situated decisions [4].

In this paper, using recordings of real-life consultations, we directly examine how patients and doctors navigate the dilemmas of life-expectancy talk in their face-to-face interactions. We focus on cases where patients request life-expectancy estimates (hereon, estimates), that is, seek information on how long they are likely to live (or how long it might be before they die). We examine patients’ estimate requests and doctors’ initial responses. We show how doctors, patients and their companions (when present) cooperate in preparing conversational environments that facilitate the delivery of estimates [17]; that is, environments wherein patients’ emotional states and uncertainties have been addressed prior to delivering an estimate.

* Corresponding author.
E-mail addresses: M.Pino@lboro.ac.uk (M. Pino), R.Parry@lboro.ac.uk (R. Parry).

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1.1. Conversation analysis and the study of end-of-life talk

A handful of studies have explored life-expectancy talk by examining recordings of doctor-patient interactions [15,18–21]. These have employed qualitative methods or coding approaches for analysing doctors’ and patients’ language in discussions of prognosis. In these, utterances are typically reported stripped of context; i.e., omitting preceding and responsive turns [22]. Therefore, those studies can only offer limited insights.

By contrast, the conversation analytic approach allows us to examine what people do through spoken language and other communicative resources, including the non-verbal [23]. It involves detailed examination of how people design their talk (e.g., what words they use, and how they vocally deliver them), and yields empirically grounded claims about the functions and consequences of talk and non-verbal conduct. This allows us to provide rich, detailed and novel evidence about life-expectancy requests.

Some prior conversation analytic studies have examined how end-of-life talk emerges in interactions between healthcare professionals and patients. This research has focused on how professionals initiate or promote (or sometimes do not promote) end-of-life talk [5,8,24–30]. Relevant to our focus, one study examined how a child undergoing chemotherapy asked questions about future treatment, and highlighted that doctors gave the child as little information as possible, whilst avoiding appearing blatantly evasive [31]; arguably, this constitutes one way to navigate the dilemmas mentioned above. By contrast, the doctors in our study do not evade patients’ requests for information; rather, they address them by communicating estimates. In this paper, we focus on how doctors, patients and their companions (when present) work together to prepare conversational environments for the delivery of estimates.

1.2. Requests

The communicative actions we examine are requests whereby patients seek prognostic information; we pay attention to the way patients position and design them. Prior research has shown people word requests in different ways depending on whether they anticipate that granting them might be easy or difficult, and on whether they present themselves as having weak or strong entitlement to make those requests [32–34]. For example, people use the interrogative form Can you when they anticipate few difficulties (called ‘contingencies’ in conversation analytic terms) in granting their request and to portray themselves as entitled to the requested service. They use the declarative form I wonder if to convey they anticipate more difficulties and to portray themselves as less entitled [32].

The patients in our study use interrogative (sometimes) and declaratives formats (more frequently) to request estimates (in Section 3.2.1 we examine the meaning of these terms). With declaratives, patients display low entitlement and convey they anticipate possible difficulties in granting the request. Patients can also make available, through the design of their requests, what they already know about their prognosis, their perspective on it, and their readiness to receive additional prognostic information. We will show that, by doing so, patients contribute to preparing conversational environments that facilitate the delivery of estimates.

2. Methods

Patients with a terminal diagnosis having an inpatient, outpatient, or day therapy consultation with one of the senior medical doctors in one English hospice were invited to participate if they had capacity to consent, could speak and understand English, and were judged by the care team not to be in acute distress. All were attending to review difficult symptoms or for help with planning future care (for further details on our procedures, [35]).

We recorded 37 consultations (33 video, 4 audio) with 37 patients (16 of these were accompanied by family or friends; we refer to these as companions) and 5 doctors. Everyone recorded gave written consent for retention and analysis of the recording, and for transcript publishing. We have removed identifying information – person and place names – from the transcripts, and pseudonymised names.

We used the conversation-analysis approach to transcribe and analyse [23,36]. We identified consultations wherein a patient requests an estimate. We examined the sequential placement and design of patients’ estimate requests, as well as doctors’ initial responses (however, we do not in this paper examine doctors’ estimate deliveries and their reception).

3. Results

Of our thirty-seven recordings, ten included patient estimate requests. Table 1 gives characteristics of the ten consultations. We now examine: [1] when patients make estimate requests, [2] how they make them, and [3] what doctors and patients’ companions do following patients’ requests.

3.1. When do patients request estimates?

In the majority of cases (7/10), patients request estimates after the doctor provides an opportunity to influence the consultation agenda; specifically, after the doctor:

- **Offers an opportunity to request information.** In Extract 2, the patient requests an estimate (lines 8–17, examined in Section 3.2) after the doctor offers her an opportunity to request information with “Anything you’d like to ask me?” (line 6). In Extract 3, the patient requests an estimate (lines 7–41) after the doctor offers him an opportunity to introduce agenda items (lines 1–8).
- **Asks about concerns that are end-of-life related (two cases not shown in this paper).**
- **Mentions future appointments and conversations plus topics, questions and concerns these might entail.** Patients can treat these as opportunities to request estimates here and now.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Characteristics of the ten consultations where patients request estimates.</th>
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<tr>
<td>Patient diagnosis</td>
<td>7 cancer, 1 motor neurone disease, 1 sensorimotor neuropathy, 1 chronic obstructive pulmonary disease (COPD)</td>
</tr>
<tr>
<td>Patient gender</td>
<td>5 Male; 5 Female</td>
</tr>
<tr>
<td>Presence of companions (partner, relative or friend)</td>
<td>7 consultations: each with 1 companion present</td>
</tr>
<tr>
<td>Doctor’s role and gender</td>
<td>3 consultations: no companion</td>
</tr>
<tr>
<td>Presence of family friends;</td>
<td>3 experienced palliative medicine consultants; 2 female (Drs B and F), 1 male (Dr D)</td>
</tr>
<tr>
<td>Length of the consultations</td>
<td>17–75 min (total 475; mean 47.5)</td>
</tr>
<tr>
<td>Type of appointment</td>
<td>8 outpatient, 2 inpatient</td>
</tr>
<tr>
<td>First or follow up hospice appointment?</td>
<td>5 first appointments; 5 follow-up appointments</td>
</tr>
</tbody>
</table>
Extract 4, the patient requests an estimate (lines 12–20) after the doctor offers a next appointment and suggests the patient may have things she wants to “talk through” then (lines 1–7). In Extract 5, the doctor mentions other healthcare professionals (“Vent team”) and suggests that the patient have a conversation with them about “the future” (the patient’s condition affects her breathing and she may need tracheotomy in the future; lines 1–34). The patient confirms (line 35) and requests an estimate (lines 37–41).

The remaining three cases are different in that the patient requests an estimate after talk about scan results, prognosis (see Extract 1), or place of death.

Although we only have ten cases, it is notable that in seven of them patients request estimates after doctors give them an opportunity to influence the agenda of the consultation.

3.2. How do patients request estimates?

3.2.1. The format of requests

In this section, we examine how patients request estimates; in doing so, we show and discuss transcribed episodes from our collection. Patients sometimes use interrogative formats. ‘Interrogative’ refers to grammatical formats commonly used for questions, such as question words (e.g. what, how, when) and subject-auxiliary inversion (e.g., “do you”) [37]. To help our report’s accessibility to non conversation analyst readers, we refer to interrogative request formats as ‘question formats’ or ‘question-formatted requests’. Patients use question formats in the three cases (see Section 3.1, above) where their estimate requests come at locations other than doctor-provided opportunities to influence the consultation agenda. Instead, in these three, patients make estimate requests within ongoing discussions about their condition or future care. Extract 1 exemplifies this.

Extract 1 (VERDIS_DOCTORS35 13,56 VT345 EL35.1 MP)
The patient and her husband have been complaining about a hospital doctor, saying he questioned whether the patient was actually ill (they are bringing this topic to a close at lines 1–9). The extract starts 11 minutes into the consultation.

01 Hus: You- you’ve had your rant.
02 Pat: Ye[ah. I ↑ have. ]
03 Hus: [Heh heh heh h.]
04 (0.9)
05 Pat: I have.
06 (.)
07 Pat: And I ↑ haven’t.[
08 (1.0)
09 Pat: Because now (1.3) I ↑ am ill.
10 (0.3)
11 Doc: ↑ Hmm.
12 Pat: Um (.) am ↑ I ill.
13 Hus: Hm, hm.
14 (0.2)
15 Doc: ↑ Okay.
16 (.)
17 Pat: <How ↑ I ill am [?] (staccato)>
18 Hus: [Heh heh.]
19 Doc: Okay.[
20 (0.4)
21 Doc: Okay. .hhh So (.) I ↑ think (0.8) I don’t (remember) (.)
22 I don’t know what you remember (.) what I said last time?
23 (.)
24 Pat: ↑ Hmm [hm]?
25 Doc: [Okay. .hh I think what is (.) ↑difficult to know? (0.3)
26 ↑ is is: (.) how things are going
27 Pat: ↑ Going to go.
28 Doc: to go.
29 (.)
30 Pat: ↑ Hmm.[
31 Doc: ←Okay, (.) .hh (0.2) I: think (0.4) u:m
32 ↑thl ↑ when (.) when you have (0.5)
33 Hus: the (n, you get more of those now.)
34 and the[h]n, you get more of those now.]
35 Doc: [Yeah? (.) So you’ve had a couple more
36 of the[me].
37 Hus: [Ye[ah.]
38 Pat: ↑ #An’ I’ve had# (.) yeah? Another
39 ↑ tw[o].
40 Doc: [Do you think (.) you’ve got ↑ back to where you we↑:re?
41 (0.2)
42 Pat: No?
43 Doc: ↑ No.[
44 Pat: ↑ No. ‘No. ‘No. ‘No.[
45 (0.2)
46 Doc: [M] ↑ Okay,[
47 Doc: .hhh (.)
48 Pat: I-
49 Doc: Uh-[huh
50 Pat: ↑ and I ↑ know I ain’t.

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In Extract 1, after some talk about prognosis (lines 17–117) – itself originated by a patient request for information (line 17) – the patient summarises a previous conversation in which this doctor had asked her (the patient) about what she thought her life-expectancy was (lines 118–122). The patient says she had estimated her own life-expectancy as “two to three years”. With the subsequent question-formatted request “How did you look at it?” (line 122), wherein ‘it’ clearly refers to her life-expectancy, the patient implies the doctor had not in that earlier conversation expressed an opinion on what the patient’s life expectancy was, thereby pushing it for now. As discussed above, requests via question formats convey a relatively strong sense of entitlement and limited anticipation of difficulties in granting the request [32]; they create a strong expectation that the doctor will provide an estimate, as she does, from line 124.

However, in the majority (7/10) of our cases when patients request estimates, they use declarative grammatical formats (i.e., grammatical formats commonly used in statements or assertions), and they do so after doctors have given them an opportunity to influence the agenda of the consultation. Hereon, we refer to these as ‘statement formats’ or ‘statement-formatted requests’. These comprise expressions of concern about life-expectancy (e.g. in a case not shown: ‘I’m just a bit concerned about the way it’s going downhill’) and, more frequently, expressions of lack of knowledge about it (Extract 2: “I don’t know when it’s coming”, line 15; Extract 3, lines 7–32; Extract 4, lines 12–15; Extract 5, lines 37–41).

Doctors treat these statements by patients as requests for estimates in that they go on to provide estimates; although, as we will show, they do so only after some preparatory work. Doctors provide estimates in Extract 2 (lines 56–57), Extract 3 (lines 169–170), and Extract 4 (lines 169–171). In Extract 5, although the doctor treats the patient’s statement as a request for an estimate she does not actually go on to provide it; because, as she observes, of the patient’s ambivalence (lines 155–161; examined in Section 3.3).

Why do we find patients using statement formats rather than question formats? First, because of when it is that they make their requests: when a statement format follows a doctor-provided
opportunity to influence the consultation agenda it is then hearable as an information request. Consider Extract 2, which is annotated to indicate recurrent features that we found built into estimate request and delivery sequences (see Section 3.2.2).

With “Anything you’d like to ask me?” (line 6), the doctor offers the patient an opportunity to request information. The patient then covers ground we found to be recurrently covered within these sequences. The patient reports having already addressed the same request to other doctors (line 8), and conveys that she anticipates the doctor may not be able to estimate her life expectancy (lines 9–10). Using an idiomatic expression (“the grim reaper”), she conveys that she feels she is dying (lines 12–13) and, crucially, that she does not know when this is going to happen (line 15). The patient’s statement that she lacks this information is hearable as conveying a request for that information. This is partly because it comes after the doctor has given her an opportunity to request information. After a gap of silence (line 16) the patient expands, expressing her desire that death comes sooner rather than later (line 17). After more silence, the doctor asks about the estimate the patient has previously received (line 19). The doctor later builds on the patient’s answer to produce an estimate (lines 56–57; examined further below).
Thus, the doctor treats the patient’s statement (lines 8–19) as an estimate request. Besides the role played by their sequential location, the hearability of patient statements as requests is provided by statements’ assertions of lack of knowledge on matters about which doctors can be seen as experts. Research in other interactional contexts indicates that when someone makes a statement about matters on which the recipient is knowledgeable, the recipient regularly takes these as requests for information [38–40]. Again, Extract 2 exemplifies this. Although she conveys she anticipates the doctor may not be able to provide an estimate (lines 9–10), the fact the patient raises life expectancy at this point conveys her understanding that this is information the doctor might be able to provide. She also conveys this by reporting having asked other doctors about her life expectancy (line 8).

A further question is: what may motivate patients to use statement-formats, rather than question formats, to request estimates? We propose that in doing so, patients display cautiousness. Rather than overtly asking for an estimate, statements leave requests available for doctors to infer and act upon [39,41]. Patients can thereby avoid being heard as exerting pressure on doctors to provide information they might not be able or willing to provide. Compared to question formats, statement formats convey less entitlement and more anticipation of the possible difficulties involved in estimating [32]. This is evident in various features that patients build into their statement-formatted requests, to which we now turn.

### 3.2.2. Design features of statement-formatted requests

One general feature of patients’ statement-formatted requests is their elaborated nature; this provides evidence of patients’ cautiousness. For example, in Extract 2, the statement-formatted request extends through lines 8–17. The elaborated nature of the statement-formatted request is the outcome of joint work, to which the doctor contributes in two ways. First, she allows silences to emerge at points (lines 14, 16 and 18) where she could start to respond, giving the patient additional space to elaborate her statement. Second, she asks some preliminary questions before delivering an estimate, resulting in further elaborations by the patient (lines 19 and 35; see Section 3.3). These two features (allowing silences, asking preliminary questions) recur in our cases.

Patients’ cautiousness is also conveyed through certain elements which are recurrent within their estimate requests. Table 2 summarises these elements, which we examine by reference to Extracts 2 and 3.

| Table 2 | Recurrent elements within patients’ estimate requests. |
|-----------------|-----------------|-----------------|
| **Element** | **Example** | **Present in** |
| Anticipation of inability | “I know you can’t say how much time I’ve got left” (Extract 2, lines 9–10). | Extract 2: ll. 9–10 Extract 3: ll. 27–28 Extract 5: l. 39 |
| Prior conversations | “Each time I’ve asked I’ll have for the last three years been told about a year” (Extract 3, lines 20–23). | Extract 2: l. 8 Extract 3: l. 20 Extract 4: ll. 12–15 |
| Reasons for request | “And to me this is incredibly important because . . .” (Extract 3, lines 11–12). | Extract 2: ll. 12–17 Extract 3: ll. 11–18 |
| Readiness claim | “I wanna know” (Extract 3, line 32); “I’m open to that” (Extract 3, line 41). Most often, these are produced following doctor preliminary questions (see Section 3.3); e.g., following a doctor question: “I don’t mind because I know I’m gonna die” (Extract 2, lines 37–38). | Extract 3: ll. 31–41 |
| Previous estimate | “The doctor said he probably thought I’d got a month or so” (Extract 2, lines 21–23). Sometimes produced following a doctor preliminary question (see Section 3.3); e.g., “on Sunday the doctor said he probably thought I’d got a month or so” (Extract 2, lines 21–23). | Extract 1: l. 121 Extract 3, ll. 22–23 |

Legend: l./ll. = line number(s)
Extract 3 (VERDIS_DOCTOR518 20,06 VT706 EL18.0 MP)

Outpatient consultation. First appointment. Patient’s diagnosis: cancer
Pat = male patient. Doc = doctor D. Patient’s wife is present but does not speak during this episode. Audio recording only.

The extract starts 20 minutes into the consultation.

01 Doc: In terms of things (.) that you’d like
02 to get out of the meeting today?
03 Pat: Yeah.
04 Doc: .(0.3) have you anything im-p—or what—
05 >what in particular would be useful< (.)
06 to:
07 Pat: [U:]r I [uh I: keep] asking=
08 Doc: [to talk through?]
09 Pat: =how long I’m likely to live.
10 Doc: [Okay,]
11 Pat: (And to me this is incredibly important) [reason for request]
12 be[cause] ] um: (0.2) you know? (.)
13 Doc: [Of course,]
14 Pat: it’s the: (.) it’s going to be the end
15 and I’ve got a few things I want to do?
16 Doc: Yes?
17 Pat: =Amid: (e)obviously whether I can do them or not,
18 depends how ~it I am?
19 Doc: (Yeah,]
20 Pat: Yeah t– I – I’ve ~
21 Doc: Yeah.]
22 Pat: I’ll have for the last three years been told (0.3)
23 about a year?
24 (0.2)
25 Pat: skl Amid (.]
26 Doc: [Okay?]
27 Pat: [um (.)] now (it) maybe: they don’t ~know. And fair enough?
28 Pat: You know, if you don’t know say (.) “don’t ~know.”
29 You know? Um: .[h]h
30 Pat: Yeah. [Yeah,]
31 Pat: [Maybe it’s (.) don’t be squishy because=um: (.)
32 I– I’ll– I wanna ~know.
33 Doc: Yeah?
34 Pat: [You know? U:::[:h]
35 Doc: [Yeah,
36 Pat: =it’s um (0.9) “it’s” (0.3) you know? If you say
37 to me “Oh (.). I don’t think in your condition
38 you’re going (.) you’re gonna see Christmas”,
39 well you say so you know. I’m: I’m (.]
40 Doc: Sure.
41 Pat: I’m open to that.
42 (0.2)
43 Doc: Oka[y?]
44 Pat: [U:m
45 Doc: <So you want to think about how long it might be? Yeah?
46 Doc: .[hhh Good? Ah what else: for today,
47 (0.3)
48-66 ([Twenty second omitted: the patient says he has nothing else for today])
48 Doc: [uhm (0.3) (I mean it’s–) (0.2) well let’s talk about
49 “m:::m” how long you might have then?
50 Doc: [So I guess um .[h]h
51 Pat: [Mm.
52 Doc: if we’d met before you started your steroids,
53 Pat: [Mm.
54 Doc: and before you looked quite chirpy, (0.4) .[h]h
55 Pat: [Mm.
56 Doc: I might be thinking a different (.]
57 Pat: [Mm.]
58 Doc: =answer [from seeing you today.
59 Pat: [Sure.
60 (0.6)
estimate (lines 21–23: “a month or so”), and a claim of readiness to know (lines 37–38). Extract 3, provides further examples of these features.

In Extract 3, following the doctor’s offer regarding the consultation’s agenda (lines 1–8), the patient mentions having previously asked about his life expectancy (lines 7–9); that is, he uses a statement format to convey an estimate request. He gives a reason for wanting an estimate (lines 11–18), mentions prior conversations with other doctors (line 20) and reports a previously received estimate (“about a year”, lines 22–23). Subsequently, he acknowledges doctors’ possible inability to make estimates (line 27), and expresses his readiness to know (lines 31–41, especially “I’m open to that”). The patient strongly conveys his interest in receiving an estimate without formally requesting one.

3.2.3. Consequences of the recurrent elements within requests

Through the elements examined above, patients establish their life expectancy as a delicate matter — a topic requiring special, interactionally cautious treatment, which should not be raised abruptly but, rather, worked up to [24,42–44]. Importantly, through these elements patients help prepare a suitable conversational environment where doctors can deliver estimates.

By anticipating doctors’ (possible) inability to make estimates, patients display sensitivity to the burdensome and complex nature of their requests [45]. They articulate the possible difficulties in fulfilling estimate requests [32]. This is consistent with prior research which has found that statement formats can work to anticipate possible difficulties with fulfilling a request [32].

By reporting previously-received estimates, patients provide resources upon which doctors can build their own estimates. Thus, we see doctors formulating their estimate as agreeing with a prior one (e.g., Extract 2, lines 56–57: “I think what he said is probably about right”) or as modifying it. This preparatory element also enables doctors to frame estimates as information not entirely new to patients, possibly preventing or minimising the risk of engendering distress [17,46,47].

By mentioning having asked before about life expectancy, patients display motivation to receive an estimate. They further convey their readiness by giving reasons for their request. Finally, they sometimes express their readiness explicitly (e.g., Extract 3, lines 31–41). In doing so, they imply emotional preparedness and license doctors to provide an estimate.

In sum, patients anticipate the difficulties possibly involved in providing estimates; volunteer information about what they already know about their prognosis; and manifest their readiness to learn more. Patients thereby facilitate doctors’ work [5,17]. At the same time, patients place an expectation on doctors to deliver an estimate, for example by giving reasons for their interest in receiving one. Furthermore, patients sometimes complain about other doctors not having been explicit about prognosis in the past (e.g., Extract 3, lines 20–32), which encourages their current doctor to be more forthcoming [48].

In sum, patients deploy mundane, everyday features of language (grammatical form and topical content) to highly nuance their requests: minimising the imposition of seeking an estimate, whilst also conveying the importance for them of receiving it.

3.3. After patients’ requests: doctors’ and companions’ facilitative actions

As shown, elements of patients’ estimate requests help create conversational environments suitable for delivering estimates. By ‘suitable’ we mean environments where patients have shared what they already know about the prognosis and their readiness to know more. However, on occasion, patients

<table>
<thead>
<tr>
<th>Table 3</th>
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<tbody>
<tr>
<td><strong>Doctors’ communicative actions that help prepare a communicative context suitable for the delivery of estimates.</strong></td>
</tr>
<tr>
<td><strong>Action</strong></td>
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<tr>
<td>Asking the patient’s knowledge on their life expectancy</td>
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<tr>
<td>Inviting the patient’s perspective on (e.g., how they feel about) life expectancy</td>
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<tr>
<td>Checking the patient’s readiness to know more about their life expectancy</td>
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Pat = female patient. Hus = patient’s husband. Doc = doctor B.

The extract starts 57 minutes into the consultation.


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Right. .hhhh So what do you know.

M: Well th— .hh (0.5) o— only that’s it’s a slow growing cancer,

D: Mm hm? (0.2)

M: .hhhh uh one of the— the the guy that I’ve forgotten

H: his name? no I haven’t. (. ) Putnam.

M: Putnam yeah.

D: [Mister Putnam]

M: [Mister Putnam, who(1)

took it [out.

H: [(He probably) took it out yeah?

M: Yeah.

D: (0.5)

M:仙actually said (0.3) “You do realise

this is going to kill you don’t you.”

(26 seconds omitted: talk about the surgeon)

M: .hhhhh Well I mean we [only know that it’s (. ) =

M: [Mm.

M: = so far that it’s (. ) I’ve got

a bit on my lying and I’ve— and I’ve got a bit

that’s—

H: [(Your (. ) [bone.)

M: [that’s compressing me: (0.3)

D: Yeah.

M: [spine.

M: “Yeah.” .hhhh So I haven’t got any up to date (. ) scans,

M: No:.

D: beyond what you already know,

M: Yes. Yeah. =

D: = um (. ) but I think that if Dr Brock was saying

M: “Look, it’s six months to a <year>,”

M: Yeah.

D: (.hhh) then I’d be inclined

M: to say it’s (. ) if that’s what you’re

M: wanting to know,

M: Yeah. =

M: “Is that what you want to know?”

M: We’ll yes.

D: (0.2)

M: (I would) yes.

M: Mm.

M: (0.4)

M: “(Hummm?)”

M: (.hhh) HEHH HEHH heh Don’t you

M: [think I :shou:

M: [(It’s) [(It’s tough?]

D: No. Not a[t all. I’m [just checking =

M: [No.] [No.

M: = that that it actually is what you’re =

M: [(Yeah)

D: = wanting [to know.

M: [Mm.

M: Then I’d be (. ) inclined [to say =

M: [Yeah.

M: = Look .hh we know it’s spread to your lungs,

M: Mm:.

M: we know it’s spread to your bone =

M: Mm.

M: .hhhh um: (. )

M: (No cos I’ve not the un) It’s not the bone.

D: (0.2)

M: It’s not [at the moment].

M: No.
do not, or only partially, share this within their initial requests. We have already touched above on our finding that when doctors start to respond to patients’ requests they do not immediately provide an estimate; specifically, they postpone its provision by first asking patients about what they know, and how they feel about their prognosis. Doctors thereby invite information that patients might have not included in the formulation of their estimate requests. We summarise the communicative actions doctors use in Table 3 and examine them in more detail below.

In Extract 2, the patient’s initial request does not specify what information she received from the doctors she has mentioned (line 8). Before delivering an estimate, the doctor asks two questions. First, she seeks the patient’s knowledge of her life-expectancy: “what did the other doctor say” (line 19); the patient reports the other doctor’s estimate (lines 21–22), with which this doctor will later agree (lines 56–57). Second, she asks how the patient felt about that prognosis (line 35); the patient goes on to display acceptance and readiness (lines 37–38), licensing the doctor to produce the estimate. The patient and the doctor thus cooperate, working together in preparing a conversational environment that is favourable to delivering an estimate: an environment where the patient has expressed readiness to know and provided information that the doctor can build upon to formulate the estimate.

When patients’ requests lack most of the facilitative elements examined above, this places doctors in the position of being asked for estimates without an indication of what patients already know and how they might react [17]. We found that recurrently in this circumstance, doctors invite this information before fulfilling the estimate request. To illustrate, let us consider Extract 4.

In Extract 4, the patient’s request (lines 12–13) contains only one of the recurrent elements we examined in Section 3.2.2; a reference to prior conversations with doctors, but neither the content of those or how the patient reacted to them. The patient’s husband and the doctor display an orientation to the absence of other facilitative elements. First, the husband corrects the patient’s claim that no-one has informed her of her prognosis, by reporting what a doctor had told them (lines 22–27). Following the patient’s objection (line 28), her husband makes a statement about doctors’ inability to make precise estimates (line 29) and reports the estimate they have previously received (lines 30–31). As in other cases, e.g. Extract 2, the doctor later uses this estimate as a basis to formulate her own estimate (lines 127–128). Second, and similarly to Extract 2, the doctor enquires about the patient’s prior knowledge (“So what do you know”, line 70). She also checks her readiness to know (lines 47–49, 53–56, 131–132 and 134) before delivering an estimate.

Doctors’ questions sometimes result in establishing that the patient may not be ready to receive an estimate, and to withholding it on this basis; this happens in Extract 5.

In Extract 5, the patient requests an estimate through a statement format (lines 37–40), which conveys recognition of uncertainty and anticipation that the doctor may be unable to respond but does not clarify what the patient already knows and how she feels about it. The doctor fishes for this information by referring to the patient’s use of an online forum for people with her diagnosis (lines 44–46); in conversation analytic terms, she uses a ‘my-side’ telling [39,40]. The patient responds that she does not use the forum anymore because she found it depressing.
The doctor takes this as suggesting the patient might not be in the right state of mind to receive an estimate (lines 98–105). This leads towards the patient articulating her ambivalence (lines 104–113) and, ultimately, to the doctor’s proposal that they discuss the prognosis in a future appointment (data not shown).

These analyses evidence a noticeable orientation by all participants (patients, doctors and relatives) to the delicacy and difficulty of requesting and delivering estimates. Patients recurrently design their requests in ways that establish they recognise the difficulty of prognosticating, reveal what they already know about their prognosis and how they feel about it, and convey readiness to know more. Doctors and patients’ co-present companions can and do participate in promoting articulation of this information before an estimate is delivered. In this way, they cooperate in creating favourable conversational environments for estimate delivery.

4. Discussion and conclusion

4.1. Discussion

Life-expectancy talk presents patients, their families and doctors with dilemmas. Doctors can be caught in a dilemma between their duty to inform patients of their likely life expectancy and a need to protect them from the emotional harm that can result from hearing such information. Patients can be uncertain about how much they can and should ask and how much and how accurately doctors can estimate. The patients most frequently requested estimates after doctors gave them an opportunity to influence the agenda of the consultations; this suggests – albeit indirectly – that patients might wait for such opportunities to appear in consultations, rather than initiate an estimate request in their absence. We also found that patients design their requests in ways that help them and their doctors navigate the dilemmas of life-expectancy talk. In summary, patients most frequently display an interest in receiving an estimate rather than formally requesting one. They also volunteer information about their current knowledge and their readiness to know more. In doing so, they license their doctors to communicate an estimate. Furthermore, doctors and patients’ companions regularly co-participate in preparing the conversational environment for estimate delivery.

4.2. Conclusion

Seeking and delivering life-expectancy estimates are well understood to be sensitive, difficult tasks. This is the first study to analyse in detail how these tasks are attempted and accomplished in (recorded) real-life consultations involving experienced practitioners and patients who are, arguably, also often experienced in these kinds of conversations. The detailed empirical analysis enables explanation of why people use the particular practices they do – including why patients make requests through statement formats – and why doctors do not provide estimates immediately subsequent to these requests.

The doctors, patients and companions in our recordings cooperate in preparing conversational environments for the delivery of estimates. Patients recurrently share what they already know about their life expectancy, their perspective on it, and their readiness to know more. When they do not do so, co-present companions sometimes produce that information. Doctors also invite that information before delivering estimates. Patients, their companions and doctors thereby display a shared orientation to certain constraints associated with the delivery of estimates. Whilst they treat life-expectancy as information that patients can legitimately request, they nevertheless treat estimates as information that should not be delivered point blank but, rather, communicated in a prepared conversational environment – an environment where patients’ prior knowledge, emotional state, and their readiness to receive an estimate have been ascertained.

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4.3. Clinical implications

Implications from this study are necessarily limited by its empirical basis—a small number of life-expectancy conversations recorded in one hospice setting. However, our own findings build upon and reflect what has been found in other contexts about how people make and respond to requests, and manage difficult, delicate communicative tasks. Thus, we cautiously suggest that:

- One place where patients can and do request life-expectancy estimates is after doctors give them an opportunity to influence the consultation agenda. Practitioners may wish to purposefully give patients such opportunities.
- Practitioners should be alert to the ways in which patients communicate their interest in receiving estimates: not always through question formats but also more cautiously through statement formats.
- Practitioners can deploy certain communicative practices to help prepare conversational environments that are favourable to the delivery of estimates; these are exemplified in Table 3.

Conflict of interest

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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Data statement

The primary data for the study consists of a corpus of audio/video recorded medical consultations. The authors’ study protocol does not allow them to share the data beyond the research team in order to protect the participants’ confidentiality.

Ethical approval was obtained from NRES Committee West Midlands—Coventry & Warwickshire, UK (ref 14/WM/0128).

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Appendix A.

Transcription conventions [36,49].

<table>
<thead>
<tr>
<th>Doc, Pat, Hus</th>
<th>Participant (Doctor, Patient, Husband).</th>
</tr>
</thead>
<tbody>
<tr>
<td>?.</td>
<td>Punctuation captures intonation, not grammar: Comma is for slightly upward intonation; question mark for upward intonation; and period for falling intonation.</td>
</tr>
<tr>
<td>[ ]</td>
<td>Left-side brackets indicate where overlapping talk begins.</td>
</tr>
<tr>
<td>(0.8)</td>
<td>Right-side brackets indicate where overlapping talk ends.</td>
</tr>
<tr>
<td>(.)</td>
<td>Numbers in parentheses indicate silences in tenths of a second. A period inside parentheses is a silence less than two-tenths of a second.</td>
</tr>
<tr>
<td>wo:rd</td>
<td>Colons indicate a lengthening of the sound just preceding them, proportional to the number of colons.</td>
</tr>
<tr>
<td>wo-</td>
<td>A hyphen indicates an abrupt cut-off or self-interruption of the sound in progress indicated by the preceding letter.</td>
</tr>
<tr>
<td>word</td>
<td>Underlining indicates stress or emphasis (usually conveyed through slightly rising intonation).</td>
</tr>
<tr>
<td></td>
<td>An arrow symbol indicates a marked pitch rise or fall.</td>
</tr>
<tr>
<td>=</td>
<td>Equal signs (ordinarily at the end of one line and the start of an ensuing one) indicate a “latched” relationship—no silence at all between them.</td>
</tr>
<tr>
<td>()</td>
<td>Empty parentheses indicate talk too inaudible to transcribe.</td>
</tr>
<tr>
<td>⟨word⟩</td>
<td>Words or letters inside such parentheses indicate a best estimate of what is being said.</td>
</tr>
<tr>
<td>hh...hh</td>
<td>The letter “h” is used to indicate hearable aspiration, its length roughly proportional to the number of h’s. If preceded by a dot, the aspiration is an in-breath.</td>
</tr>
<tr>
<td>w⟨word⟩</td>
<td>The letter “h” enclosed in parentheses indicates aspiration internal to a word (e.g., a laughter particle).</td>
</tr>
<tr>
<td>+</td>
<td>A plus sign indicates the point where a visible behaviour described at the following line in the transcript (e.g., a nod) starts.</td>
</tr>
<tr>
<td>⟨⟨words⟩⟩</td>
<td>Words in double parentheses indicate transcriber’s comments.</td>
</tr>
<tr>
<td>“word” “word” “word”</td>
<td>Double degree signs indicate a particularly quiet voice or whispering.</td>
</tr>
<tr>
<td>&gt;word&lt;</td>
<td>A combination of greater-than and less-than symbols indicates that the talk between them is faster or rushed. A combination of less-than and greater-than symbols indicate that the talk between them is slower.</td>
</tr>
<tr>
<td>&lt;word</td>
<td>The less-than symbol by itself indicates that the immediately following talk sounds jampacked.</td>
</tr>
<tr>
<td>#word#</td>
<td>British pound signs indicate that the talk between them is delivered with a smirky voice quality.</td>
</tr>
<tr>
<td>#word#</td>
<td>Hash signs indicate that the talk between them is delivered with a creaky voice quality.</td>
</tr>
<tr>
<td><del>word</del></td>
<td>Tilde signs indicate that the talk between them is delivered with a tremulous voice quality.</td>
</tr>
<tr>
<td>word</td>
<td>A boldface on a final consonant indicates that the consonant is produced more sharply than it normally would.</td>
</tr>
</tbody>
</table>

References


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