**Working title: Controlled, constrained or flexible: how interactional styles shape the goal setting process between people with chronic conditions and healthcare providers**

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 interactional styles and how these styles shape the negotiation of goals between people with chronic conditions and healthcare providers (HCPs), we drew on aspects of conversational analysis. Through close and repetitive readings of transcripts to analyse the data, three distinct types of interactions emerged in which goal setting activities were situated: controlled, constrained and open. To allow for closer investigation of the goal setting process, we looked at each of these groups separately noting choice of words and phrases, utterances and turn structure. Findings highlight that the interactional characteristics in appointments between people with chronic conditions and healthcare providers have implications for the notion of patient-centred care and collaborative goal setting. These different interaction styles have a tangible effect on how patients’ preferences are incorporated into the goal setting process in terms of x yz but also indicate that one style may not be preferable and beneficial to all patients.

**Introduction**

Healthcare policy in many western countries promotes a patient-centred approach, in which healthcare providers work collaboratively with individuals and their families to develop knowledge, confidence and skills to ‘effectively’ self-manage their chronic condition. A patient-centred approach promotes an understanding of the patient’s life and preferences, and the tailoring of chronic care management to be aligned with patient preferences (Wagner et al., 2005; Hudon et al., 2012). Such an approach acknowledges patients as more than passive recipients of ‘clinical knowledge and procedures’ (May et al., 2004, p 136) and values the individualised experience of health and illness (Willis / Lewis). This approach assumes that effective self-management will be achieved if healthcare providers and patients share knowledge, prioritise and set realistic and specific goals, problem solve and set action plans (Battersby et al., 2010; Bodenheimer et al., 2002; Lorig & Holman, 2003). The policy endorsement in Australia for patient-centred care (PCC) and self-management has been largely based on the work by Lorig and colleagues (1999; 2001) who pioneered the idea of the person’s central role in managing their health and established the potential of self-management for improving health status and reducing the burden of chronic conditions (Lorig et al., 1999; Lorig et al., 2001). Self-management is broadly viewed as an individual’s ability to manage the symptoms, treatment, physical and psychological consequences and lifestyle changes that come with their chronic condition (Barlow et al., 2002; Salder et al., 2014).

Goal setting has been widely used in rehabilitation and allied health as a way to support self-management (Hunt et al., 2016; Rosewilliam et al., 2011; Scoobie et al., 2011; Siegert & Taylor, 2004), and is increasingly being used to facilitate behavioural change for people with conditions related to lifestyle (add ref Lorig and Wagner). Goal theory first emerged in the 1970s when Ryan proposed the idea that conscious goals affect action (Ryan, 1970). It is this key assumption that goals motivate action that has seen goal setting become prominent for self-management. Setting a goal implies two main assumptions: first, that one wishes to change something in one’s life to move from the current state to a preferred state of being (Locke & Latham, 2002); and second, that actions and resources will be directed towards this desired state (Mann et al., 2013). In the health arena, this can be related to a desire to return to a state of health, thus requiring changes in behaviour or environment. The overall aim is that goal attainment will have a positive impact on desired outcomes, such as symptom control or wellbeing.

Goal setting is the process whereby manageable steps are identified and agreed upon to work towards achieving a desired outcome (the goal) (based on Nies, Hepworth, Wallston, & Kershaw, 2001 definition of goal setting). It includes discussion of the problem, exploration of patients’ needs, values and capabilities, patient education, and deliberation on optional goals and action plans (Lenzen et al 2014). Increased patient participation in goal setting is reported to increase patient satisfaction and assists providers with setting goals that are meaningful for patients (Scoobie, Parry, REf). Research suggests that greater agreement on goals between patients and healthcare providers goals improves goal ownership and active participation towards achieving these goals (Bodenheimer & Hadley, 2009; Sevick et al., 2007; Wagner et al., 2005).

Researchers exploring collaborative goal setting have placed emphasis on the importance of the patient having an *active* role in the process (Bodenheimer et al., 2009; Heisler et al., 2003; Huang et al., 2008; Wagner et al., 2005). To be truly collaborative, researchers argue goal setting discussions need to incorporate an individual’s needs, preferences, and values, and should not be constrained by a predetermined set of goal outcomes (Coulter et al., 2015; Huang et al., 2008; Mann & Goberman-Hill, 2011). However, research on the active participation of patients indicates a number of factors influence people’s participation in consultations, including prior expectations of healthcare consultations, cultural expectations and social position (Protheroe et al., 2013; Rocque and Leanza, 2015). Furthermore, people desire different levels of participation at different times (Kennedy et al., 2014; McDonald et al., 2007; Naik et al., 2009; Protheroe et al., 2013; Scambler et al., 2014), have differential capacity to be involved (Dubbin et al., 2013; Protheroe et al., 2013), and HCPs may not always be willing to share and let go of control in consultations (Mudge et al., 2015). [ *The assumption within patient-centered approaches that patients want to (and should) be involved and participate actively in decision making has been contested in various ways (Dalmy Landmark et al 2014] – discuss??*

Despite the evidence supporting the use of goal setting, some research suggests patients and providers may differ in what the goals and strategies should be for self-management (Boger et al., 2015; Lenzen et al., 2015); what health outcomes are valued (Boger et al., 2015; Gardiner et al., 2016); have different expectations of what their roles are (Mudge et al., 2015); and questions remain as to what extent goal setting goal setting is collaborative in practice (Rosewilliam, Scoobie, Parry, Lenzen)*.*

Much of the research on self-management outcomes has focused on intervention components (e.g. education, self-monitoring) and program content rather than considering the influence of interactions between patients and providers on outcomes (see review by Currie et al., 2015; Pearson et al., 2012). Where the interaction has been studied, evidence suggests patients recently diagnosed may prefer to take direction from the HCP, and at times patients may be reluctant to share information, or may not know what information is most relevant to the goal setting process (Schoeb et al; Hartley and Stockley et al., 2015; Parry, 2004; Rosewilliam et al., YR)). A PCC approach to goal setting can be problematic when patients do not have a goal in mind, are unable to articulate their goals or have insufficient understanding of which goals are contextually relevant. In these instances, HCPs may set goals based on their assumptions of what they consider appropriate for the patient rather than utilising interactional practices that encourage greater patient participation (Schoeb et al., 2009). (add in Dubbin’s work looking at PCC using observations of interactions – people’s different capacity to participate - ). A recent systematic review Currie et al, (2015), indicates that HCPs may not always be willing or able to share control and responsibility with patients due to individual, organisational and system constraints. Approaches to self-management from the healthcare perspective are also primarily based on an expert model, informed by evidence-based treatment guidelines with the goal of achieving clinical outcomes defined in quality outcome frameworks (QoF) (Dennis et al., 2008; Kennedy et al., 2014; Wermeling et al., 2014). Whilst some studies suggest the use of QoF improves the quality of care for people with chronic conditions (Campbell et al., 2009), other studies indicate that the use of QoF conflicts with the central tenant of patient-centred care – to treat patients as individuals (Blakeman et al., 2011; Gillam et al., 2012; Maisey et al., 2008).

Goal setting is a process that occurs over time, involving complex interactional relationships and the development of knowledge in which the patient’s experience is a crucial component. It is reported as challenging and time consuming (Hunt et al., Schoeb, Rosewilliam; Parry); influenced by both patient and provider characteristics and resources, as well as context and system constraints. These factors can lead to the development of goals that are mostly led by the HCP and which may not reflect the patient’s perspective. Despite the importance of goal setting to the patient-centered approach and notion of self-management, little is known about how patients and healthcare providers orient to the process of negotiating self-management goals, (see 21, 22, in Parsons et al., 2016; Rosewilliam, Scoobie, Parry)) and in particular, how the ideal of *collaboration* is enacted in interactions aiming to facilitate and support long-term behavioral change. This paper aims to address this gap and explores the impact of interactional styles between people with chronic conditions and healthcare providers on goal setting.

The study:

This paper draws on non-participant observations conducted during 2015 to 2017, as part of a larger longitudinal qualitative study exploring how interactions between people with chronic conditions and healthcare providers shape the negotiation and enactment of self-management goals. The broad study, included observations as well as follow up interviews with patients and providers on up to three occasions over a 12 month period to explore the participants’ perceptions of the interaction and goal setting process over time. The broad study aimed to:

1. Explore how patient-provider interactions shape the negotiation and enactment of goals for people with chronic conditions;
2. Identify and provide explanations for differences in perspectives about goals between people with a chronic condition and their HCPs; and
3. Contribute to and extend goal theory as it relates to (self-management in/of chronic conditions that are managed with lifestyle change).

The purpose of this paper is to explore how the goal setting process is shaped by the interaction between people with chronic conditions and healthcare providers and addresses the first aim.

Ethical approval was granted from the Sydney Local Area Health District Human Research Ethics Committee and the Australian Catholic University.

**Methods and analysis**

To understand how goal setting occurs in practice, it was appropriate to observe interactions between patients and providers in the natural setting of regular scheduled appointments over time. A total of 29 non-participant observations of interactions between 12 patients and 9 healthcare providers were conducted at healthcare sites across an Australian metropolitan city. Six patients were observed on three occasions, four patients were observed on two occasions and two patients were observed on one occasion. Participants were purposively sampled to capture a diverse range of information rich cases related to goal setting. The 12 patient participants had at least one of three conditions that were selected as examples to explore how self-management goals are shaped by patient-provider interactions. The three conditions selected were obesity, type 2 diabetes mellitus and chronic obstructive pulmonary disease. These conditions were chosen due to their chronicity, high prevalence, lifestyle risk factors and requirements for self-management which focus on sustained lifestyle behavioural change. Furthermore, people with these conditions are often involved in frequent and ongoing interactions with healthcare providers. Patients were recruited through healthcare providers or clinics that had agreed to have a non-participant observer present during a consultation. Recruiting healthcare providers first was considered by the research team to be the most effective and timely way to recruit matched pairs of patient and provider participants. Healthcare providers were approached by email and invited to participate. Patient participants were informed of the study either by the healthcare provider or clinic administration staff. Patient and healthcare provider participants were recruited if valid and informed consent was provided after reading and discussing the participant information sheet with the researcher. The 12 patients ranged in age from 45 to 76 years, included six females and six males, and all had multiple conditions. The nine healthcare providers included six female and three male participants, five were clinicians and four were allied health professionals, with experience in the management of chronic conditions that range from X to X years. Of the 29 interactions, 19 were between patients and clinicians, and 10 were between patients and allied health professionals. Settings included public hospital clinics and private practice. An overview of the patient and healthcare provider participants and number of appointments is shown in Table X.

INSERT TABLE X ABOUT HERE

With permission, appointments were digitally audio recorded and transcribed in full, and supplemented with field notes taken by the researcher. Data from two interactions observed are excluded from the findings of this paper. One patient consented to observation only without audio recording and the audio recording of one interaction was considered too poor for transcription – due to patient’s severe breathlessness, low speaking volume and interaction being conducted in a large open gymnasium room at the public hospital clinic. Therefore, the findings reported here are from 14 of the 15 matched pairs of patients and healthcare providers and total 27 of the 29 observed interactions.

*Types of appointments*

Three different types of scheduled appointments were observed which each served a different purpose. The first group were initial appointments (n=5) between patients and allied health professionals which mostly followed a structured format and included history taking, problem identification, goal setting, planning, and some patient education. The second type were review appointments (n=8) that were booked in by the healthcare providers and occurred at approximately 6 monthly intervals. These appointments primarily focused on reviewing biomedical results, medications and symptoms, and physical examination (e.g. neuropathic foot assessment, eye tests) or monitoring (e.g. blood pressure taken, blood glucose levels checked). The third group of appointments were for ongoing chronic care managements (n=16) and occurred weekly or monthly (mostly scheduled by the healthcare professional) or at time intervals at the patients’ discretion. Appointments for ongoing management between clinicians and patients were in some ways similar to the review appointments in that they included review of biomedical results, medication and symptoms however, however these appointments occurred at more frequent intervals and acute issues were addressed as well as broader chronic care management for multiple chronic conditions. Ongoing appointments between allied health providers and patients focused more on patient education and self-management support.

Appointments ranged in length from 20 minutes to 60 minutes, except for one appointment where the husband and wife (both patients) attended together, which went for 120 minutes. Initial appointments and those occurring at irregular time intervals were longer than appointments occurring more frequently or at regular intervals. Most appointments were conducted according to standardized consultation time slots. However, one allied health professional conducted initial consultations with patients over two appointments and these appointments included the most extensive goal setting phases of the data corpus. Clinicians at times also made accommodations to time and had consultations that ran longer than the scheduled time. (Can expand on time considerations – or discuss in another paper? Add something about time into intro/discussion if going to make more of this – i.e. what happens to goal setting in the interaction when providers make explicit reference to time constraints)

*Analysis*

After repeated readings of full transcripts, episodes related to goal setting were identified and collected for analysis to examine the process of *goal setting*. Goal setting is a circular and ongoing process in which problems are identified, the needs, values and preferences of the patient are established, goals and action plans are negotiated, followed up and reviewed. Sequences reflecting any of these stages of the goal setting process were included in analysis.

*Conversational analysis*

Analysis of interactions was guided by aspects of applied conversational analysis (CA) to explore *how, at the level of individual turns of talk, participants engaged in* goal relevant exchanges. CA is well established as an effective method for the systematic examination of patient –provider interactions, as it allows an examination of the interactivity of the patient and provider (Drew et al., 2001; Heritage and Maynard, 2006; ten Have, 2007). According to CA, interactions are connected in a series of turns and sequences of actions (ten Have, 2007) and *how one individual speaks can shape how the other responds.* CA provides benefits over other methods which quantify characteristics of each participant’s communication (e.g. Roter Interaction Analysis System *(RIAS) (Roter and Larsen, 2002)) as the actions and consequences of those actions can be examined* (Pilnick et al 2009; Heritage and Maynard, 2006).

By identifying and describing the sequential nature of interactions, CA acts as a way to privilege what participants’ display as *meaningful, relevant and consequential in the interactions, rather than the researchers’ interpretations (Parry, 2004).* This is an important consideration, as much of the research examining goal setting is based on qualitative research exploring either patients’ or providers’ perceptions of goal setting (e.g. Brown et al., 2007; Huang et al., 2005; Blakeman et al., 2006) rather than examining goal setting in practice. As Heritage (1984) stated, talking about an interaction and participating in the interaction are not the same thing. Therefore, one cannot assume that the way patients and providers talk about their experience of goal setting matches what is observed in practice (Schoeb et al., 2014).

Sequences related to problem identification, goal negotiation or action planning were examined to uncover patterns in what vocabulary choices (e.g. modal operators - want, need, will, may, might; adjuncts –generally, certainly, maybe, I don’t know, I think), use of turn taking, in particular adjacency pairs and their preferred responses (e.g. question/answer, proposal/accept/reject) and how turns were structured and topics initiated. This analysis involved repeated readings of transcripts and making detailed notes about the actions and consequences resulting from the interactional exchanges. [It is acknowledged that traditional conversational analysis provides a more rigorous analysis (e.g. breath sounds and intonations) of which are not included in this study due to time and resource constraints??]

Contextual information that may have shaped the goal setting process was also considered during analysis; e.g. the type of healthcare provider, the clinic setting, the type of scheduled appointment a, and characteristics or requirements unique to the interaction (e.g. all appointments at the public hospital clinics for patients with T2DM and/or obesity began with the patient being weighed).

*Findings*

Three main interactional styles in which goal setting was situated emerged from the data: controlled, constrained and (flexible?). Each interactional style encompassed a number of unique conversational behaviours. Interaction style remained mostly consistent within and across sequential interactions between patients and providers. (any exceptions ?). The interactions between patients and providers in which goal setting occurred were mostly either controlled or constrained, and only a few instances occurred in which goal setting was more open and flexible, and led by the patient. On the basis of this analysis the concept of a spectrum of collaboration in goal setting is proposed, in which differing degrees and types of negotiation occurred. The interactional style influenced how goal setting was enacted: it influenced whether goals were openly elicited from the patient by the healthcare provider or presented as options or imperatives (recommendations/advice/information) by the healthcare provider.

*Controlled interactions*Controlled interactions were primarily characterised by healthcare providers’ use of strong modal language (e.g. ‘I want’, ‘I think’, ‘You need to’) that implied a sense of necessity and certainty for and the goals and self-management strategies recommended by the healthcare provider. In this way goals and recommendations were presented as something the patient must do and collaboration was not encouraged. Recommendations were made based on problems mostly identified by healthcare providers which were made in relation to biomedical results or levels of functioning. Healthcare providers also took the role of problem solvers rather than exploring options with patients. Additionally, topics for discussion were more likely to be initiated by the healthcare provider than in the other types of interactions, with some healthcare providers using sequential language (e.g. firstly…secondly’; ‘lets continue’) to indicate the priority topics for discussion. Structured continuous goal setting activities were not present in these interactions,there were no open elicitations of patients’ goals and the goals and actions recommended by healthcare providers were rarely referred to explicitly as ‘goals’.

In the controlled interactions, the starting point for identifying problems was primarily reference to biomedical results. This is demonstrated in the this extract between Roberta, who is in her 50s and has multiple chronic conditions and Dr Li who she sees regularly for ongoing chronic care management. In this extract, Dr Li begins with what could be considered an opening for Roberta to share her perspective, however this opportunity is minimised when Dr Li refers to Roberta’s blood tests. This is then followed by a specific interrogative question (yes or no) which restricts the opportunity for Roberta to provide information on how she has been going:

Q3: Okay. How have you been Roberta? You had some blood tests done recently. Okay, who is at home now? Dennis is not home, is he?

A: No, no, no.

Q3: Good.

Discussion continues on Roberta’s living situation and then Dr Li turns the discussion back to the blood results. This is put on hold when he uses sequential language to indicate the priority is to firstly see how she has gone with her exercise. Although Roberta interjects to try and find space to discuss what is of most concern to her ‘I put on weight’, Dr Li continues to enquire about exercise:

**Q3: Now, you had some blood tests done -**

A: Yeah. How was it?

Q3: - recently. That is okay.

A: Oh that's good.

Q3: **Before I do anything with the results -**

A: **I put on weight.**

Q3: **How's your exercise going?**

A similar pattern is seen in the next extract between George, who is in his 40’s and has obesity and T2DM, and Jenny a clinician who he sees for 6 monthly reviews of his diabetes. Jenny states that it would be ‘really good’ to use George’s results as the starting point for the conversation. Jenny’s use of language choices of ‘well’, and ‘I think’ with emphasis added through repeated evaluative language (‘really + good’), coupled with reference to ‘your’ results, signals to George that the starting point for the conversation is determined by ‘*his’* results rather than his subjective experience:

Q: Okay. **Well, I think it'd be really good** for us to see **what your results are** so we can have a conversation around that.

A1: Yeah.

Whilst all goal proposals in the controlled interactions came as recommendations from the healthcare providers, patients differed in how they responded to these recommendations. The first example is taken from the interaction between Roberta and Dr Li and picks up from the extract discussed above. The extract continues from the enquiry from Dr Li asking how Roberta’s exercise is going which appeared to be a follow-up to a recommendation made at an earlier consultation:

Q3: ***How's your exercise going?***

A: I'm still doing it, but it's getting -

Q3: *What - what do you do?*

A: **My stomach is really annoying** **me**. Can you cut it off? No, no, it's - since I had that operation my -

Throughout the consultation Roberta discussed her concerns of her weight increasing, mentioned she would like her stomach cut off, and made reference to a negative body image. After some discussion in which Dr Li ruled out the possibility of an operation to address her weight/stomach concerns, Dr Li used strong modal language to state the problem (poor function and blood flow), recommended the goal (increase function and blood flow) and indicated the action to be taken (walking). Roberta’s use of ‘yeah’ and ‘Oh Okay’, indicated somewhat passive agreement and acceptance to Dr Li’s goal recommendation:

Q3: Sometimes. Yeah. Look, the - **what we need to concentrate on is actually concentrate on your function**. **We need you to do walking and walking and walking.**

A: Yeah. I'm try - I'm trying to but I'm finding it very hard.

Whilst Roberta answers with the preferred response (agreement/acceptance) to Dr Li’s recommendations, she extends her turn, drawing on her own knowledge. Over the next few turns Roberta indicated she finds exercise hard as ‘My right leg doesn't want to move much’ and ‘It's painful, yeah, as usual’, and ‘I find that my stomach is holding me back’. However, whilst Roberta actively shared information to expand on the problem from her perspective, Dr Li and Roberta did not engage in collaborative problem solving and goal setting. Rather than explore alternative ways for Roberta to exercise or address her concerns related to her weight and body image, she was instructed to do more and more walking to improve her function, pain and blood flow. This was repeated at the next two appointments (Insert example from time 2 and time 3):

Q3: Yeah, yeah. **So try to do more**. It's very painful, **but more and more and more** because you know the fibromyalgia thing that you have, the **more you walk** the less it becomes because the blood flow and washes the chemicals out.

A: **Oh okay.**

Q3: **So you need to get the blood flowing**.

A: **Yeah.**

Later in the conversation, Roberta again attempts to find space for her concerns about her weight, however was again directed to think about function:

A: Because I - I was 1 - 126 today, but last time I was 119.

Q3: Can I suggest, **Roberta, don't weigh yourself any more. If Lisa wants to weigh you, don't**. Okay, that doesn't help.

A: No. I asked her to weigh me.

Q3: Yeah, yeah. **I want you to think about your function**……I know. I know. **It's very difficult, but the important thing is our sugar is good, our blood pressure is good and your pulse rate is also good, so fitness-wise is good.** And your sugar in the mornings come down from 5.7 to 4.9 to 4.6.

Whereas, in this next extract, which also includes a recommendation from the healthcare provider, the patient indicates strong agreement for this recommendation. The extract is taken from an appointment between James who is in his 70’s, and has multiple conditions, and Maree a clinician. Both James and Maree do something different to the others who engaged in this approach. Maree asks the questions and James limits his responses to the question asked without expanding on the information he has been requested to provide. Also rather than using the authoritative language of ‘I think’ when referring to the problem or the recommendation, Maree refers to the knowledge of the problem as being something that is shared between her and the patient (‘as you and I understand’). She does this again by the use of ‘you know’ at line X. Whilst Maree used sequential language (e.g. firstly and secondly) to direct the agenda and prioritise the topics for discussion, she used ‘we’ in setting that agenda, co-implicating James in agenda setting by suggesting these were also things that he wanted to be addressed today.

In the extract below, Maree’s use of ‘first’ sets it up to prioritise the issues for discussion and indicates that she has other topics that will follow:

HCP 5: Yeah? Perfect. Okay, because there are lots of things that **we want to do** with you today. And **so first of all your lungs**, so coming down on the steroids what’s happened with those? Have you felt any different?

Discussion continues and then:

HCP 5: Alright, so that **was the first thing**. And then **the second thing was** - so now the testosterone level, how are you finding the injections? So they’re not too painful?

Maree then continues to build Jame’s knowledge on the problem and setting it up to return to later in the appointment::

HCP 5: Because the reason, **as you and I understand**, the prednisone - the normal dose that the - the amount you make yourself is about 5mg.

Patient 5: Yep.

HCP 5: And higher than 5mgs, particularly the range of seven to eight, has been shown to be associated with bone loss. And now we’re following your bone density and it’s okay but long term -

Patient 5: Yeah that’s okay….

HCP 5: **Because you know**, if we can bring it down that then **helps the diabetes and it helps the weight.**

Patient 5: Well that’s what I want down, **I want to get rid of the weight**.

HCP 5: Yeah, exactly.

In this extract, unlike Roberta who passively agreed to the recommendations made James makes a strong claim of ownership over this goal, by stating this is want *he* wants also. [For the discussion - As [Stevanovic (2013, p. 20)](http://www.sciencedirect.com/science/article/pii/S0378216614002380#bib0235) points out, “authority is not primarily about someone claiming authority, but it is about others accepting someone as an authority” (orig. emphasis).]

Another example - Aileen and Dr Li - recommendation made – need to exercise, increase function. On the second appointment the pattern is repeated – but some negotiation occurs as Aileen actively states that pain is the problem she needs to address. Whilst Aileen gets her preference – increase in pain medication – The HCP is in control of this and uses it to bargain with Aileen to get her to take up his recommendation for exercise to improve function

M2: How is the exercise going, Edna?

F1: <Laughs> Next question.

M1: \*0:31:41

**M2: The twisting one I wanted you to do.**

F1: Get out of here. I can’t twist, it’s too painful. Give me something to take the pain away.

**M2: Let’s have a deal, Edna. I’m going to increase your Jurnista to eight milligram. You’re on four**.

F1: Yes.

**M2: On the proviso when I see you in a months’ time you come back and tell me your \*0:32:01**

F1: I’ve been doing exercises, okay.

Another example – *George and Jenny 6 – use of ‘okay’ – is an attempt to balance the distance between the patient and provider, and acts as an acknowledgement of the patient’s right to accept or reject this proposal/option.* However, that only one option is presentedindicates to the patient that acceptance of this proposal is the preferred response (Raymond, 2003), making it more difficult for the patient to reject the proposal. The use of an interrogative (yes/no) also provides no opening for the patient to indicate their own preference.

So let's look at what we've achieved alright, so we've got your HbA1c and bringing it down. I actually think we could cut back your insulin a fair bit to see if we can then perhaps do some little <inaudible> \*00:15:25 for your tummy, okay. Because carrying the weight around here, this is what makes this - it’s the worst place to carry the - the weight, so I mean for a long time we've been working, yeah, to try and - and reduce that, but that was not our main goal. I think we said to you at one point it’s what your numbers are, that's more important. Now that we've got all of that sorted now, it would be nice if we could, you know, perhaps slim you, so you’re all \*00:15:58 is that reasonable?

Of course it is

In the controlled interactions expectations were made explicit through healthcare providers goal recommendations as ‘wants’ and ‘needs’ and supported by directive advice on what actions needed to be taken by the patient. The patient is provided with direct instruction to undertake an action towards achieving a particular goal, without the patient indicating a preference/desire for this type of goal (mostly passive agreement, and ambiguous acceptance/commitment. It is presented as something the patient must do and negotiation is not invited.

Controlled interactions occurred in different settings and between patients with different conditions and ages and severity of conditions, and different healthcare providers (clinicians and allied health professionals).

At the controlled end of the spectrum the presentation of results of biomedical markers played a pivotal role in the HCP defining what the goal should be and what action should be taken. Results were presented as facts rather than as information to elicit negotiated goals and plans of action. In this way, biomedical levels were not used to facilitate discussion on the patient’s experience or perception of how these levels affect them or to gauge preferences on how to manage the ‘problem’. Instead the HCP enacted a disease specific care process in which goals and actions appeared predetermined based on presentation of the results. Goals and actions were presented as directives underpinned by a view of necessity to control the condition. Patients were given specific instructions without choice options. Limited collaboration or negotiation occurred as agreement was not sought and patient participation was limited focus on presentation of signs and symptoms.

*Constrained interactions*

There were two main ways in which interactions constrained the goal setting process. Firstly, whilst patients and providers may have engaged in a structured goal setting sequence in which patients were asked to identify problems and goals the process was influenced by the use of narrow and contextually bound interrogative questions following the use of initial open questions. The second way goals were constrained was the ambiguous way in which healthcare providers structured their conversational turns. In the same turn or sequence they may have used strong modal language to indicate their goal preference whilst simultaneously asking for patient preferences. Healthcare providers in the constrained interactions were more likely to ask a goal type question than in the controlled interactions and goals were more likely to be named as such. More time was spent on goal setting activities than in the controlled interactions.

The following extract is from an initial consultation between Paul, who is in his 60s, has COPD and recently had prostate surgery and Simon, an allied health professional. Simon was taking Paul through a structured goal setting activity. Simon invited Paul into the goal setting process when he asked him to state what his biggest worry/problem is. He was given permission by Simon to provide a problem that was not limited to his chest condition and Paul took up this opportunity, stating his biggest problem is depression. Rather than use the words of Paul, Simon reformulates this worry drawing on an earlier reference Paul made to his depression being related to the stress of owning his own business. Whilst Paul was given an opportunity to contribute to the problem identification stage of goal setting, Simon’s condition specific interrogative question suggests that Paul did not provide the preferred response to the former open question. The use of this additional interrogative specific question sets up the preconditions for Paul to provide a response that is considered more contextually relevant and preferred by the allied health professional.

The extract begins with some lines from earlier in the appointment, in which Paul first raised his depression and a similar pattern occurred in which Simon redirected the conversation to focus on Paul’s lung condition. In both examples, the use of an interrogative (yes/no) question by the Simon acts to narrow Paul’s own definition of his problemby directing him to focus on his physical symptoms, and limiting the opportunity for the provision of other information. So whilst opportunities were present for Paul and Simon to enter into a goal discussion related to problems raised by Paul (e.g. depression, work pressures, worries about his children’s future, sense of loss) the goal topic was shaped mostly by the actions of the healthcare provider, with the context for the goals reinforced by the boundaries presented in the goal elicitation question (may also add that the appointment began with Simon discussing the problems of COPD and goals for rehabilitation in generic terms which set up for the goals to be contextually bound):

Q: Okay, and have you ever had any depression?

A: I think **we’ve all had a bit of depression**. I run my own business and yeah, it’s a bit –

Q: Yeah quite a lot of stress?

A: Yeah, **trying to work out how you’re going to do everything when you haven’t got time**.

Q: Yeah. **Now you said that you cough up quite a bit of phlegm?**

A: Yeah I do.

Discussion continues with information gathering on lung condition, medications and exercise behavior with some discussion on airway clearance. Discussion then turns to a structured goal setting sequence:

Q: Okay so what are your kind of **biggest concerns or any worries** you have about – it doesn’t just have to be about your chest condition? What’s **your probably biggest problem at the moment**?

A: Oh **depression is probably the biggest**. You’re depressed that you can’t do what you – I mean I’m 64 so yeah, you can’t do what you’ve done when you’re 54 or \*0:35:32.1. But it’s still okay. \*0:35:36.0. That’s the main thing.

Q: Yeah so work is probably like –

A: Yeah well I’m **worried about the kids,** the children are going to be all right, because I’ve got children, grandchildren and \*0:35:48.4.:

Q: Yeah. Do you have **any concerns with your chest at the moment?**

A: No.

Q: No?

A: No it’s not \*0:36:01.8. It is what it is and if you can help me at all.

Q: Okay **so do you have any goals or is there anything that you want to achieve by coming to the exercise program?**

A: Yeah, **I want to be able to run again properly**. Yeah that’s what I’d really like to be able to do. So \*0:36:21.8 a bit of running. We run up the stairs and by the time I get three quarters of the way up, because there’s about 150 \*0:36:29.0, about three quarters of the way up.

This shaping pattern was also observed in interactions which did not have a structured goal setting sequence and in which goal setting occurred as a fragmented process throughout the interaction. The next example, highlights how the problem identification stage and goal elicitation were not always related The next example is between Ricardo, who is in his 50s and has obesity, depression and T2DM and is a fulltime carer for his father who is in palliative care, and Emily a clinician at the public hospital clinic. Emily, attempts to engage Ricardo in goal setting by shifting the topic away from his problem talk towards reviewing his goal from the previous appointment (to do a food diary). Ricardo is discussing two problems – that he has not been doing exercise and that he is feeling exhausted. Ricardo’s reference to exercise may be in response to the repeated suggestions to engage in more physical activity that were made in the two earlier appointments with another healthcare provider at the clinic:

P **No exercising.**

HCP That’s not great. **Anyway.**

P I’ve been awfully busy for some reason. I think God I go to bed early because **I’m exhausted**. Put the PAP machine on and just go to sleep. **Full-time caring is a lot of work**.

HCP It is.

P And dad at the moment is bedridden. He’s a rough shot because he’s – they’ve upped his medication together with a further injection that’s left him bedridden. So as soon as I get up in the morning I begin.

HCP **How do you think your weight’s come down two kilos so obviously it’s not – it must be totally related to diet. You must be doing quite well with that at the moment?**

P No exercise because -

HCP That’s okay.

P - I’ve not been able to find the time and when I do have time I just want to sit down and rest.

**HCP So let’s talk about the diet because last time you were here you were going to do the food plan.**

P I’ve not been able to do that. I’ve not been able to sit down consistently to write that out. I’ve just -

HCP So I guess what do you want to do for yourself at this point in time? **What are your goals and how do you want to move forward?** I mean your weight’s come down but do you know why your weight’s come down? Can you correlate that to any change in behaviour?

Discuss this example further – in controlled patients were not asked an explicit goal question. Compare the way goal questions were asked in constrained interactions to flexible interactions.

Another way that the constrained format was observed was when healthcare providers asked the patients for their opinion, whilst they simultaneously expressed their opinion (Ambigious conversational turns). In the following example the healthcare provider uses high modal language which provides additional emphasis to the proposal being something that carries a sense of necessity for long term weight loss. Whilst some of the language in this turn was characteristic of controlled interactions, what makes this example distinct from those in the controlled group is that it was informed by information provided earlier by the patient (I think I am eating too much fruit), consideration of his reference to feeling exhausted and the way the questions are worded suggest to the patient a degree of choice. This is also accompanied by a ‘repair’ by the healthcare provider when she shifts from you ‘could work on’ to an expression of support ‘we could work on’– indicating to the patient that the responsibility is somewhat shared.:

HCP So could you work on – **this is what I think** **we could work on** but you need to do it, that cutting that fruit down and **saying I’ll have two serves of fruit at one time**. If I want more I can come back in half an hour and have it but I’ll only have two at any one time. We’ve got to eat to hunger, not eat to our emotions and comfort for long term successful weight loss. **…./ Do you want to just practice that? Is that enough for you? / I think that’s probably enough for you/ So what do you think about that**?

HCP But why don’t we just take on one thing at a time. **Let’s just work on the fruit** unless you want to work on adding just a five minute walk every day. **You tell me what you want**.

Next example - Ambiguous turns – also included mixed messages about what the expectations were for goals and actions to be taken. look at the position of where the proposal is in the turn construction uni – whilst the HEALTHCARE PROVIDER IS PREESENTING OPTIONS and asking the patient to choose, this follows the HCP already having indicating what she thinks the patient is capable of and what the goal should be. And follow on from generalised advice giving that was presented as an imperative.

*We’ve got to eat to hunger, not eat to our emotions and comfort for long term successful weight loss……****WHAT DO YOU THINK? So we’ll just work on thinking about the fruit, I can have it if I want it. So I’m not saying you can’t but how much do I actually need for my hunger? THAT’S – DO YOU FEEL OKAY WITH THAT?***

*I know it sounds contrary and quite like I’m contradicting myself but it’s actually we know that people who exercise have more energy in their day than those who don’t. But why don’t we just take on one thing at a time. Let’s just work on the fruit unless you want to work on adding just a five minute walk every day. YOU TELL ME WHAT YOU WANT. WHAT ARE YOU CAPABLE OF DOING AT THE MOMENT WITH HOW YOU’RE FEELING?*

*Flexible interactions –*

A less frequently occurring approach to goal setting was through healthcare providers use of information soliciting questions regarding how the patient may change their behavior to reach their own goals. These open elicitations drawing on the patient’s knowledge and incorporation of this knowledge with the providers’ knowledge allowed for greater opportunities to collaboratively develop the problem, the goals and actions.

Patients were more likely to state their goals in a way that was meaningful and extend beyond the biomedical

In flexible goal setting sequences, the patient’s experience and preferences were sought and there were limited attempts to convince, persuade or advise the patient. More than one option was presented and explored with the patient. Options discussed took into consideration the patient’s experience and preferences. Discussion by patients and providers went beyond signs and symptoms of disease. Opportunities for negotiation were created, and the extent to which negotiation occurred was co-constructed by both the patient and provider.

 *Features of flexible goal sequences:*

* The goal topics were more likely to be initiated by the patient
* When HCP initiated goal topics they were presented as optional and up for deliberation
* Patients and providers shared in turn-taking and at different times owned the turn
* Patients were provided with opportunities to participate and negotiate
* Patients provided with opportunities to come up with their own goals and options
* Questions were asked to ascertain confidence and willingness to work on the goal
* Patients turns longer than in the controlled approach

In defining the problems and the goals, the healthcare provider was more likely than in the other approaches to use the words of the patient

In the following sequence between Sean, who is in his 50s and is obese and Jenny a clinician – smoking example.

Discuss two examples Sean and Jenny – smoking example and Julian and Dr Douglas – work around the house and James and Christina – boat in water, ride bike

Example 1

Q: **So what impacts on you the most? In terms of your health now. Given all the stuff we've done, you know, fixed, we've improved a lot of things.**

A: Pains and tiredness and -

Q: Pains and tiredness.

A: Yeah.

Q: Okay. I mean that - but is that your - the flu thing that you've got this week? Because I don’t really want to put that in.

A: No, no, no, no, no, no. But I'm generally tired by lunch. Like I get up early in the morning, but I do things early, and then by - by 10 o'clock I'm prepping my lunch. By the time I have my lunch, I'm buggered. And I don’t want to do anything else.

Q: So it actually is aches and pains, isn't it?

A: Yeah. Well that's - what it boils down to, is you know, that I can't - you know, like can't complete a whole day. Like -

Q: And that's a mixture of things. Probably related to the rheumatoid and just your back and a number of things.

A: Yeah. And, well the back was a big part. Well slowly getting better, but it's still there.

Q: So I've actually added a new one, which is muscular aches and pains. And what -

A: Yeah, well that -

Q: What would you like that to be? If that - if we could - if you could set a goal to make that better, what would you like to see better? How would you know it was improved? What would you be able to do, that you can't do now, that would tell you yeah, that's a bit better?

A: I could work all day.

Q: In the garden or -

A: In the garden or doing anything. It could be like -

Q: And at the moment, you can only work - work in the morning, is that what you're saying?

A: Yeah.

Q: Up until lunch time?

A: Midday, yeah. Or no later than midday.

Q: So your ability to work in the afternoon would tell you, you're much better?

A: Yeah.

Q: So the goal would be the ability work around the house all day?

A: Yeah. Well - yeah, but if I was able to do that, then I'd be able to go to work.

Q: Well yeah. Great. No, so that's a bit unrealistic that you'd be able to do that, but if we can find a way to improve it a little bit even, that would be a plus.

A: Yeah, but that's what I'm trying to do, is trying to do more in a day. The obvious reason is tiredness and pain and being worn out.

Q: And that's probably related to having rheumatoid arthritis.

Summary –

In all three types of interactions, that patients expressed problems/issues that were important to them, which were different or additional to the problems introduced by the HCPs. What happened with this information differed across the three types of interactions. In the controlled, HCPs used strategies that blocked or limited this information from being incorporated into the development of goals, whereas in the constrained interactions it was incorporated to varying degrees, and in the flexible interactions it was central to what was agreed upon.

In the constrained, HCPs provided some opportunities for patients to present and extend on their problem presentation and attempted to incorporate this information into the setting of goals. However, the extent to which this information was incorporated was problematic resulting from both the actions of the patient and providers. Tensions were presented between HCPs utilizing aspects of both a traditional directive approach and a more patient-centred collaborative approach. *What differentiates this format from the controlled interaction is the way in which it is contingent on the HCP creating or accommodating the information within the formulation of goals (Chatwin et al 2014).*

In contrast to the controlled interactions, in which goals were presented as imperative recommendations made to patients using strong modal language, the healthcare providers in this group used low modal operators and adjuncts to suggest patients had some choice over the goals and strategies for self-management. Words such as ‘maybe’, ‘might’ and ‘could’ were used to minimise the distance in authority and knowledge between the participants, however goals were still primarily shaped by the healthcare provider and goal related advice remained mostly directive and generalised.

*In constrained interactions HCPs attempt to demonstrated to patients they are not relying on their medical authority alone (Heath 1992) and that they are attempting to be accountable for meeting the patient’s agenda.*

Discussion points

*Discuss Thille study* of communication practices (CA and discourse) that reports when HCPs focus on the relationship between behavioural goals and biomedical success, patients may engage in defensive maneuvers to negotiate responsibility and identity, disrupting problem solving and self-efficacy (also discussed in Entwistle article).

*Ultimately, patient-centered interactions strive to achieve a state of shared information, shared deliberation, and shared mind (Epstein et al 2010)*

*The issues and dilemmas that emerge within these appointments reflect these activities. For example*[*1*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#fn1)*: patients face the issues of how to put their concerns on the floor (*[*Robinson and Heritage 2005*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b73)*); how to show themselves to be properly oriented to their bodies ([Halkowski 2006](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full%22%20%5Cl%20%22b25%22%20%5Co%20%22Link%20to%20bibliographic%20citation),* [*Heritage and Robinson 2006*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b32)*,* [*Heath 2002*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b30)*); how to direct the doctor’s attention toward and away from certain diagnostic possibilities (*[*Gill and Maynard 2006*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b20)*,* [*Gill* et al*. forthcoming*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b21)*,* [*Stivers 2002b*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b83)*); and how to deal with diagnoses and treatment recommendations that may or may not correspond to their own views and preferences (*[*Heath 1992*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b29)*,* [*Stivers 2002a, 2006*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b82)*,* [*Peräkylä 2002*](http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01194.x/full#b58)*). (Pilnick et al 2009)*

Within the medical and sociological literature using a qualitative approach there are rich descriptions of how people manage their lives when faced with a chronic condition (Dumas, et al., 2014; Lewis et al., 2010; Thomas et al., 2008; Willis et al., 2011). Sociological concepts such as ‘biographical disruption’ (Bury, 1982; Bury et al., 2005), ‘new normal’, and the ‘lived experience’ (Lupton, 1999; Thomas et al., 2008) all attest to the importance of including social context and the need to understand patients’ priorities when setting goals for self management. The research from this perspective indicates the extent to which patients are able to develop self-management goals depends on their embodied experience of illness, the extent of disruption to their everyday lives, their health beliefs and social patterns such as education, social class, gender, ethnicity, and age (Bury et al., 2005; Ong et al., 2014; Willis, 2011).

Kahawati et al’s (2008) study of people with asthma showed that when given a choice up to 35% of the goals people set did not map to treatment guidelines. INSERT 2016 GARDINER STUDY PATIENT GOALS MAPPED TO HCPS/GUIDELINES. Rather, their goals related to losing weight, exercising, keeping healthy and reducing stress. Treatment guidelines for asthma, on the other hand, are designed so HCPs can educate their patients and achieve goals relating to lung function and medications (Kahawati et al., 2008). In their study with people with COPD Willis et al (2011) highlight some of the complexities of living with a chronic condition that extend beyond medical management. They show how illness representations and previous experiences of illness (both personal and others’ experiences) can shape SM goals. For example, fatalistic views about the capacity for health improvements, management of debilitating comorbidities, and seeing others suffer with and die from the condition can influence SM goals (Willis et al., 2011). Thus the context of the illness experience is important to goal setting, with patients developing their own strategies which may or may not accord with that of HCPs (Huang et al., 2008; Willis et al., 2011).

However, as our findings and those of others (REF) indicate that at an implementation level, goal setting continues to focus primarily on goals of healthcare providers which relate to a predetermined agenda defined by a set of biomedical markers.

In the initial appointments goal setting occurred primarily as a stepwise, standalone activity initiated by the HCP and followed on from the history taking and problem identification phases.

In the review appointments, whilst there was some goal setting and action planning, it was mostly an unstructured and fragmented process, mostly initiated by the HCP after weight was taken or when discussing results.

Goal setting in the ongoing SMS appointments s was mostly not explicit and unstructured, and included follow up of previously set action plans (or specific goals) and setting of new actions/goals. There was one exception where the GP engaged the patient in a standalone structured goal setting activity as part of the development of a care plan. In contrast, the ongoing appointments between patients and clinicians or allied health professionals focused primarily on patient education and support, with some goal setting and action planning. Goal setting in the ongoing appointments was mostly dynamic and fragmented and was either initiated by the HCP or preemptively by the patient who could activate the HCP into an opportunistic goal setting sequence by statements such as ‘I am not exercising’, or ‘I’m still smoking, for example.