UNIVERSITY OF SOUTHAMPTON

FACULTY OF ENVIRONMENT AND LIFE SCIENCES

HEALTH SCIENCES

Volume 1

MULTI-PARTY INTERACTIONS COMPRISING HEALTHCARE PROFESSIONALS, PATIENTS, AND THEIR PARTNERS DURING CONSULTATIONS FOR LOCALISED PROSTATE CANCER

by

Simon John Stewart

Thesis for the degree of Doctor of Philosophy in Health Sciences

August 2021

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

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MULTI-PARTY INTERACTIONS BETWEEN HEALTHCARE PROFESSIONALS, PATIENTS, AND THEIR PARTNERS DURING CONSULTATIONS FOR LOCALISED PROSTATE CANCER

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People with localised prostate cancer regularly attend their clinical consultations with their partner or spouse. Using conversation analysis, this thesis examined a corpus of twenty-eight treatment and diagnostic consultations comprising a patient, their partner, and a healthcare professional. This thesis addresses the overarching research question, how are co-present romantic partners involved in the conversation during clinical consultations for people with low to intermediate risk localised prostate cancer? Across this corpus, partners were almost entirely unaddressed by healthcare professionals, as they were explicitly invited to contribute for just 3% of their turns-at-talk. Sequential misalignments were evident where couples expressed preferences relating to treatment choices. These misalignments led to couples silencing themselves in service of conflict avoidance. The analysis also illustrated how discussions relating to the sexual impact of prostate cancer were communicated in a manner that minimised opportunity space for patient and partner contributions. Moreover, these discussions erased the relational impact through exclusive focus on individual, male sexual and reproductive function. This thesis identifies the structure of these consultations as dyadic, thus inhibiting opportunity space for partners to contribute. It argues that this structure is underpinned by the enactment of Kantian liberal autonomy. Accordingly, it proposes a shift away from the individualised interpretation of autonomy, towards an understanding of the patient and their autonomy as inherently relational.

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Academic Thesis: Declaration of Authorship

I, Simon John Stewart

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Multi-Part Interactions Between Healthcare Professionals, Patients, and their Partners During Consultations for Localised Prostate Cancer

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University.
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated.
3. Where I have consulted the published work of others, this is always clearly attributed.
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work.
5. I have acknowledged all main sources of help.
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself.
7. Parts of this work have been published as:

Stewart, Simon J., Roberts, Lisa and Brindle, Lucy (2020) ‘Romantic partner involvement during oncology consultations: A narrative review of qualitative and quantitative studies’, Patient Education & Counseling. Elsevier Ireland Ltd, p. 116544. doi: 10.1016/j.jns.2019.116544.

Signed: ....

Date: 30th August 2021 ....

Acknowledgements

My thesis was made possible by the support I received from my supervisors, Dr Lucy Brindle and Professor Lisa Roberts. Thank you both for your time, expertise, experience, and guidance. I will always be grateful that you believed that I could succeed in my PhD programme.

I am also grateful for the support I received by Professor Carl May during the earlier stages of my PhD journey, and in particular, during my master's thesis. Thank you, Carl for your wonderful insights during these times.

Throughout my PhD journey, I have had the privilege of receiving support and encouragement from many academics who were all instrumental in the accomplishment of my PhD goals:

Dr Merran Toerien: Your mentorship and pastoral support continue to be invaluable to me. From sharing your knowledge and experience, to talking about corona pirates, your passion shines as an inspiration to me in all that I do.

Professor Steven Clayman: You offered a teaching experience like no other, and you are my motivation in my quest to teach CA myself. Your hikes in the Hollywood Hills are legendary.

Professor Tanya Stivers: You gave me the privilege of being able to learn about CA at its global home, and the chance to do CA with some of the world's best analysts. I will never forget this experience.

Professor John Heritage: Your 1:1 sessions and guidance were instrumental as I developed my analytical thinking.

Professor Paul Drew: Without the courses you provided, my thesis would not be possible. You provided a truly outstanding learning experience that fostered engaged participation and learning. This has informed my approach to both research and teaching.

Professor Fiona Stevenson: You have provided ongoing support and encouragement during critical stages in my thesis journey. I look to you as a role model.

Professor Alessandra Fasulo: For your support, encouragement, and guidance. You make me believe that I can actually do this work for a living.

Professor Gerry Leydon: Your ongoing enthusiasm and support continues to serve as a voice that gives me confidence that I can succeed in whatever I choose to do.

Professor Cynthia Graham: For your encouragement, enthusiasm, and guidance. Our coffee chats always leave me feeling empowered about my future directions.

Dr Mike Bracher: You are a great friend and mentor. You helped to guide me through this PhD journey in so many ways, I cannot begin to count. From our reading group of two, to the now legendary Zoom Gym, your support has helped to succeed in this PhD. I am and will forever be thankful.

Professor Philip Zimbardo: Before I pursued an undergraduate degree, and before I understood your significance in the world of Psychology, I emailed you to ask for some guidance. The words you wrote to me continue to drive me as you told me to “keep pushing the boundaries!”. I have done so and hope to continue to do so.

Professor Stephen Reicher: During my undergraduate honours project, you were crucial in moving forward my thinking which has been so important in shaping my academic development.

Dr Emily Hofstetter: Your commentary on my early findings were crucial in driving my thinking. For this, I will always be grateful.

Professor Lesley Howells: You gave me my first opportunity as a psychology graduate. Your belief in me put me on the path I currently take.

Throughout my academic journey, I have had the privilege of being able to attend workshops at the Discourse and Rhetoric Group (DARG) at Loughborough, the Centre for Advanced Studies in Language and Communication (CASLC) at York, and the Anthropology lab at the Centre for Language, Interaction and Culture (CLIC) at UCLA. These workshops were a source of encouragement, inspiration, and professional development as I was able to engage with so many fantastic analysts in the pursuit of a shared goal of doing CA. Thank you to Charles Antaki at DARG, Merran Toerien at CASLC, and Marjory Goodwin at UCLA. Your data sessions were instrumental in driving my development.

It is often said that librarians are the unsung heroes of academia. In this, I would like to sing the praises of Health Sciences librarians Dorothy Byatt and Vicky Fenerty whose guidance was essential in the development of my first publication. Thank you both, and indeed, thank you to all librarians who are the true heroes of academia.

To Jonathan Lightfoot, at iSolutions: Your thesis writing workshops were crucial, and provided me with an invaluable skillset. They literally saved me time and tears! Thank you.

To my friends, I offer special thanks:

Wayne Taylor: You encouraged me to take another shot at further education. You helped me to set up a truly effective distance learning workflow, you advised me on study techniques, and motivated me to aim for the highest standards in education. I will always be thankful for this.

Steve Adams: At first a great colleague, and now an even better friend. You listen to my daily chatter, and I yours. You brighten my days by sharing your amazing vinyl collection, introducing me to the best beers, and I am so very thankful for our shared love of the video games we hardly ever get to play!

David Greenley: My long-time best friend. You were there from the very start. From our first meeting to today, you remain a true friend. No matter the ocean between us, you have been, and always shall be my friend. You shaped my formative years, and your example of true compassion in friendship will always inspire me.

Mike Bracher: I count among the very few friends I have made since I moved to the South Coast of England. You made me feel genuinely welcome to a completely new city (and country!). You have my heartfelt gratitude for our friendship.

To my family, there are no words that can express the gratitude I have for you all, and how much I appreciate you all. To my mum, and my sister, I love you both very much. To my parents and brother-in-law, your love and support continues to be source of courage and inspiration for me.

To my children Olivia and Melissa, I have come to learn more from you both than I could ever hope to teach you. I love you both more than there are stars in the sky.

Finally, to my partner Tuba. If I were to write down all the ways that you have supported me through my academic and life journey, I would not have space for my thesis! Thank you for being my best friend, my life partner, and for the years of love and kindness you have shared. Whatever journey lies ahead, it will be all the richer for travelling with you.

COVID19 and its impact upon this thesis

In the autumn term of 2019, I had the privilege of attending UCLA as a visiting graduate researcher. During my stay, I gained vital knowledge, skills and experiences for my research and future career. In December 2019, I returned from Los Angeles with a renewed determination to complete my thesis as I entered the final twelve months of my PhD programme.

Only a few weeks later, I became aware of the existence of the virus now known as SARS-CoV2, or COVID19. Looking back, it is all but certain that this virus had reached the west coast of the United States just as I was returning to the UK.

Before the UK introduced lockdown measures, I had already started to take personal precautions out of concern for my own health and that of my partner and our young child. By the time the UK went into its first lockdown, I had already taken my child out of school and moved them onto a schedule of home school activities. Since then, they have been able to attend in-person education for a total of twenty stress-filled days. My family and I have lived almost exclusively within the confines of our home, effectively isolating from all in-person social contact. Outside of online contact, life was effectively placed on hold.

During this time, my capacity to carry out my research activities was substantially reduced. My increased childcare responsibilities came along with the need to double as a primary school teacher as I tried my best to masquerade in a role that typically demands around three years of training. I have lived, worked, and taught within the confines of this home, all against the backdrop of the most dangerous pandemic experienced for many generations which has been the source of immense distress.

In all of this, I have tried, I have succeeded, and I have also failed. This past year has brought with it many trying times, some tears but also, much joy, much laughter, and much love. While this pandemic has been directly responsible for one of the most challenging years of my life, I will look back upon it as a time that I was able to gain my PhD, and a time when I had the good fortune of seeing my young child grow and learn every day before my eyes. For that, I will always be grateful.

Chapter 1 Introduction

1.1. Cancer and society

Across several societies and cultures, cancer is a word that is heavily loaded with meanings that have been constructed through the ways that people talk about it. The prevailing discourse of cancer relates to cancer as a concept, and the 'logical' response to cancer. These discourses have become deeply embedded as persistent societal, common sense knowledge structures. The salient and intuitive appeal of these constructions makes them readily available at the mere mention of the word in relation to any given topic. The word tends to produce an emotional reaction, with cancer often referred to in euphemistic terms such as 'the big C', as if saying the word 'cancer' was itself a dangerous or dreadful act (Stergiou-Kita, Pritlove and Kirsh, 2016). So deeply entrenched is this societal aversion to cancer, that it has become commonly understood that the 'logical' response to the detection of cancer is to objectify it as a 'thing', that demands urgent extraction from the body, often without due regard to any related consequences. The term "get rid of it" is a commonly expressed response to the news of a cancer diagnosis (Cohen and Britten, 2003; Wade *et al.*, 2009; Le *et al.*, 2016). Surprisingly, this term can be found in literature produced by cancer support groups, such as Prostate Cancer UK (PCUK, 2018a). The discourse of cancer as an entity that demands immediate eradication has led to the common understanding of cancer as an enemy agent that must be 'fought'. Formulating cancer this way enables it to become demonised as people fight against it in a battle or a war, that can be won or lost (Beisecker *et al.*, 1996; Akyüz *et al.*, 2008). Such metaphors of cancer can be seen to convey clear ideas with regards to the necessity of the 'fight' against cancer, and the logic of this response, rendering any response other than this as mute, or at least, suspicious (Sinding, 2014).

The crystallisation of this concept has led to the word 'cancer' being drawn upon metaphorically to describe the situated 'ills' of a given society. The cancer discourse has become strongly integrated into everyday conversation, with its meaning constructed and understood with particular ease. The word has come to be drawn upon to describe elements of society that have been deemed so strongly undesirable that they require urgent removal for the benefit of the remaining societal body. Accordingly, these elements become pathologized and constructed as 'societal cancers', particularly in mainstream media representations. Examples of societal elements and objects that have been constructed this way across several media publications include Muslims, Terrorists, Sectarians, and Head Scarves (Steuter and Wills, 2010). In the labelling of these elements and objects as cancers, the understanding that they require swift removal becomes readily apparent. The use of cancer as a metaphor for certain parts of society underlines what might be described as a second-order, or circular construction of cancer; a deeply embedded discourse drawn upon to produce another. The taken-for-granted understanding is that cancer, and anything described as cancer demands immediate, and unequivocal eradication. This is something that ‘everybody knows’. Moreover, this is not a new construct. This construction has been drawn upon historically. For example, Hitler’s political rhetoric included the construction and dehumanising of Jewish people as a ‘cancer upon the breast of Germany’ (Davis, 2007). In the production of this conditional construct, the meaning was made readily apparent, requiring no further clarification as to the required course of action. It is therefore of critical importance to understand that this construction of cancer, though highly intuitive, is not necessarily accurate. This understanding is of significance when considering prostate cancer, and in particular, for localised prostate cancer.

1.2. Prostate cancer

Typically, the prostate is a gland found in men. However, it is important from the outset to both understand and acknowledge that transgender women and some non-binary individuals will also have a prostate, and as such, are at the same risk of prostate cancer as those whose gender matches that which they were assigned at birth. The prostate is located underneath the bladder and around the urethra. Its primary function is to produce semen (the fluid that carries sperm). The prostate is normally around the size and shape of a walnut, although it tends to get larger with age (PCUK, 2019a). While the growth of the prostate is a relatively normal part of ageing in men, its growth can become problematic, placing pressure on both the bladder and the urethra (NHS UK, 2019). This enlargement is known as benign prostatic hyperplasia or benign prostate enlargement. Its symptoms can vary, but in general, they relate to both the urgency to pass, and difficulty in passing urine. However, instances of this type of prostate enlargement have been associated with increased risk of the development of prostate cancer (*ibid*). Indeed, the signs and symptoms of prostate cancer are similar to that of benign prostatic hyperplasia (Prostate

Cancer UK, 2019). Like many other cancers, prostate cancer starts due to abnormal development of cells. Normally, cells within the prostate, like all other human cells, grow, divide, and later die, with replacement cells being exact replicas of the old cells (Cancer Research UK, 2019c). This cycle of growth, division, and death is usually highly controlled, with biological processes within the cells ensuring that each part of the body has both the correct number and type of cells. It is when the cells in the prostate start to grow in an uncontrolled manner, that prostate cancer develops. Cancer cells differ from normal cells insofar as they fail to adhere to the instructions passed to them by the surrounding cells as they grow and divide, producing excessive numbers of cells (Cancer Research UK, 2019b). This uncontrolled growth is what leads to the development of a tumour. Moreover, these cancer cells do not necessarily maintain their adhesion to their neighbouring cells, which is what can give rise to cancer spreading to other areas of the body (*ibid*). Although most prostate cancers tend to progress slowly, with most instances of prostate cancer unlikely to spread beyond the prostate, others can grow more quickly, and can carry increased risk of spreading beyond the prostate (PCUK, 2019a). Accordingly, these cancers require a more radical interventionist, or curative treatment to prevent the cancer moving beyond the prostate.

1.2.1. Prostate cancer in the UK

In the United Kingdom, prostate cancer is the most common cancer in people with prostates, accounting for 26% of all new cases of cancers in this population group. This equates to over 47,000 new cases of prostate cancer in the UK each year (Cancer Research UK, 2019d). While prostate cancer has an estimated 85% survival rate, where survival is described as surviving for 10 or more years after diagnosis, prostate cancer mortality rates are worthy of concern, as their prevalence accounts for more than 11,000 deaths each year (PCUK, 2019a). Moreover, the latest projections indicate that prostate cancer is a growing concern in the UK, with incidence rates expected to increase from the current rates where 1 in 8 people with prostates are affected by prostate cancer to a rate in the year 2035 where it is projected to affect closer to 1 in 5 (Cancer Research UK, 2019d). Accordingly, prostate cancer is currently the second most common cause of cancer death in people with prostates in the UK, with steadily increasing mortality rate, second only to lung cancer (*ibid*).

1.2.2. Localised, and advanced prostate cancer

Prostate cancer can be categorised in several ways, such as cancer stage, which indicates the size of the tumour, and the extent to which the cancer may have spread throughout the body, and the grade of the cancer cells which indicates how the cancer cells compare to normal cells (Cancer Research UK, 2019e). Prostate cancer can also be categorised according to whether it is contained within the prostate or whether it has spread to other parts of the body. An advanced prostate cancer is that which has developed in the prostate, but has spread to other parts of the body, where cancer cells have been transported through either blood circulation, or the lymphatic system (PCUK, 2019b). Localised prostate cancer is a cancer that is entirely contained within the prostate gland, with no cancer cells either at the boundary or outside of the prostate (PCUK and Cancer Research UK, 2019). Crucially, localised prostate cancers usually grow slowly, and have a low risk of spreading beyond the prostate or leading to any problems for the person with this type of cancer (PCUK and Cancer Research UK, 2019). Indeed, prostate cancer does not always present with symptoms, which is one of the key difficulties in relation to detection and diagnosis (PCUK, 2019a).

1.2.3. Levels, grades, stages, and risk

Three measurements can be used to assess prostate cancer in terms of overall risk to the patient; The results from a blood test called the Prostate Specific Antigen test, a grading of the prostate cancer called the Gleason Score, and tumour size measured in stages, known as the T Stage (Cancer Research UK, 2019e). Prostate Specific Antigen (PSA) is a type of protein that is produced in the prostate, and has been used as an indicative marker of prostate issues, including prostate cancer, since the late 1980s (Polascik, Oesterling and Partin, 1999). The PSA test measures the levels of Prostate Specific Antigen found in a sample of blood, and it is measured on a scale of nanograms (ng) per millilitre (ml). The amount of PSA present in the blood tends to increase with age, but an increased level of PSA in a blood test may indicate a problem with the prostate, though not necessarily prostate cancer (Preston *et al.*, 2016). Indeed, the limitations of the PSA test as a tumour-marker are well understood, as elevated PSA levels can relate to both benign prostatic hyperplasia, and prostate cancer, leading to problems in the interpretation of measured PSA values (Polascik, Oesterling and Partin, 1999). As such, PSA testing alone cannot be used for diagnostic purposes. Grading of prostate cancer first requires the cancer to be detected, which is usually accomplished by way of a prostate biopsy, where small samples of the prostate are taken from the prostate and examined for the presence of cancer cells (Kasivisvanathan *et al.*, 2018). Upon examination, cancer cells are graded by how they compare to normal prostate cells. Cells are graded on a scale of 1 to 5 where cells graded 3 to 5 are considered to be sufficiently different to be reported as cancerous. The Gleason score is calculated by adding together the most common grade found with the highest of any other grade found in the observed sample (*ibid*). For example, if grades 3 and 4 are observed, the Gleason score is 7. Finally, the stage of the tumour, or T stage, is assessed through examination or imaging of the prostate, to assess the tumour's location and size. T stage is measured on a scale of 1 to 4, plus subdivisions of a, b, and c. Stage 1 is too small to be detected by examinations or scans, and is located entirely inside the prostate, to stage 4, where the cancer has spread to organs near the prostate such as the bladder (PCUK, 2019c). In combination, these measures are used to assess the risk groups of localised prostate cancer, with categories of low, intermediate, and high risk. These risk categories indicate the likelihood of the cancer spreading beyond the prostate (PCUK and Cancer Research UK, 2019).

1.2.4. Low and intermediate risk localised prostate cancer

Localised prostate cancer stands distinct from prostate cancers that have either breached the boundary of the prostate or have spread to any other part of the body, insofar as it is contained entirely within the prostate. For such localised prostate cancers, the cancer is divided into three distinct risk categories; low risk, intermediate risk, and high risk (PCUK and Cancer Research UK, 2019). Low risk is defined by a PSA level that is less than 10 ng/ml, a Gleason score of up to, but not higher than 6, and a T stage between T1 and T2a. Intermediate risk is defined by a PSA level between 10 and 20 ng/ml, a Gleason score of 7, and a T stage of 2b. High risk is defined by a PSA level that is higher than 20 ng/ml, a Gleason score of 8 – 10, and a T stage of 2c. The categorisation of localised prostate cancer into risk groups is one of several ways of helping patients and healthcare professionals to decide the most appropriate treatment. Other parameters such as age, broader health concerns, and attitudes towards treatment choices are also to be taken into consideration by healthcare professionals (*ibid*).

1.2.5. Treating low and intermediate risk prostate cancer

For low or intermediate risk localised prostate cancer, there are several treatment options with which patients will be presented for consideration. Treatment options can be divided into two distinct categories: 1: radical with curative intent, or 2: ongoing monitoring.

There are two monitoring options for low or intermediate risk localised prostate cancer: Watchful Waiting, and Active Surveillance. Watchful Waiting is a treatment option that involves regular blood tests in order to monitor changes in PSA levels over time, as well as the monitoring of any signs or symptoms that the prostate cancer may be growing (Cancer Research UK, 2016b). Watchful Waiting is not commonly used for localised prostate cancer, as it is only made available for people with health problems that prevent them from selecting any curative options. Accordingly, people who select Watchful Waiting have limited recourse to further options, should their cancer progress. Typically, patients can move from Watchful Waiting to Hormone Therapy in order to shrink or maintain the size of the tumour (*ibid*).

Active Surveillance is available for low and intermediate risk localised prostate cancer, where there is a possibility to later select a curative intervention, should it become necessary, or should the patient change their treatment decision. Active Surveillance involves increased regularity of monitoring when compared to Watchful Waiting. PSA levels are checked around once every three months, and the prostate is examined around once every six months. Additionally, a prostate biopsy is carried out after the first year (Klotz, 2010). This treatment programme changes over time, with PSA tests and prostate examinations becoming less frequent, should there be no signs of prostate cancer development. This treatment option is important as around 70% of men with localised prostate cancer will never require radical treatment options (Cancer Research UK, 2019a). However, research to date has indicated that Active Surveillance is regularly described as an alternative to treatment, separate from the suite of radical, curative interventions, instead of being described as a genuine treatment option (Le *et al.*, 2016).

There are several treatments that would be considered as radical interventions with curative intent. While techniques and delivery methods may vary, broadly speaking, they consist of surgical and radiotherapy options. There are several other treatment methods under development, such as ultrasound or cryotherapy but at present, none are available outside of clinical trials (PCUK, 2017a).

The overarching goal of surgical options for localised prostate cancer is to remove all of the prostate, removing the cancer with it. This operation can be carried out using several methods, such as robot-assisted keyhole surgery, or open surgery with the procedure carried out by hand (Cancer Research UK, 2016a). In having surgery for localised prostate cancer, it is likely to remove the cancer in its entirety; something that tends to be highly desirable among people with localised prostate cancer. In examination of the removed prostate, the success of the procedure can be assessed. The success of this procedure can also be assessed by a follow up PSA test around eight weeks after surgery, where PSA levels should drop to undetectable levels (PCUK, 2017b). Accordingly, the examination of the removed prostate and the follow-up PSA levels might identify when surgery has not completely removed the cancer and identify when a patient needs further treatment.

Radiotherapy options are available using two delivery methods. External Beam Radiotherapy, which in itself, is available in several configurations, is a treatment that is designed to destroy cancer cells, while attempting to minimise damage to the surrounding healthy cells within the prostate (PCUK, 2018a). As it targets the entire prostate, it is suitable for men with localised prostate cancer. Radiotherapy for localised prostate cancer is often administered alongside Hormone Therapy; a treatment that can reduce the size of the prostate, and accordingly, the cancer inside it (*ibid*).

The second method of Radiotherapy is called Permanent Seed Brachytherapy. Unlike External Beam Radiotherapy, the radiation used to treat the prostate comes from seeds that are implanted into the prostate, and act from the inside (PCUK, 2018b). The overarching goal of this treatment is also to destroy all cancer cells in the prostate, with the intent to cure it. This type of treatment is only available for patients with low risk, localised prostate cancer (*ibid*).

In treating low or intermediate risk localised prostate cancer, there is currently insufficient evidence to indicate that there is any clear advantage in selecting any one treatment option over another (Hamdy *et al.*, 2016). Accordingly, UK guidelines state that healthcare professionals should present all available treatment options as objectively as possible, and without any undue bias (NICE, 2014). This procedure has been recommended to encourage the participation and engagement of all parties during clinical encounters, and to encourage patients to make informed, and shared treatment decisions. This is of critical importance, when considering both the short, and long-term impact of localised prostate cancer, and particularly, the impact of its treatment.

1.2.6. Impact of prostate cancer diagnosis and treatment

Receiving a diagnosis of prostate cancer is understandably distressing. Research evidence indicates that men newly diagnosed with prostate cancer can experience clinically significant levels of anxiety and distress as a result of their diagnosis, which is of critical importance as it is relatively well-known that such high levels of distress can impair judgement and decision-making (Cohen and Britten, 2003; Hedden *et al.*, 2017). Given the prevailing understanding of cancer, distress following a cancer diagnosis is not unexpected. However, the emphasis on the patient's role in making the decision to treat prostate cancer, means it is important that such distress is identified and attempts made to alleviate it (Hedden *et al.*, 2017). Because there is no evidence to indicate that any one treatment for localised prostate cancer is better than any other, the decision to treat can itself be a source of distress and anxiety (Hamdy *et al.*, 2016).

The impact of treating localised prostate cancer can also be a significant part of the decision-making process as all treatment options have several side effects, described as biological, psychological, and social in their presentation. This biopsychosocial impact of prostate cancer treatment can be relatively long lasting, and in some cases, can be permanent (Ganz, 2001). As a treatment option, Active Surveillance is the least invasive of all options, and as such, has little or no physical side-effects, outside of the impact of regular blood tests and prostate examinations (Cancer Research UK, 2019a). It has been indicated that this treatment option is not selected as often as it might (Kim *et al.*, 2014). Indeed among patients, and regularly, clinicians, Active Surveillance is often thought of and presented as standing distinct from other treatment options, instead of being included as a valid, selectable course of treatment (Le *et al.*, 2016). Under such circumstances, selecting Active Surveillance can have a major impact on a patient's psychological wellbeing, with their anxieties related to the uncertainties of their cancer's status, and also concerns as to whether they had made the correct decision (Whelan *et al.*, 2003; Parker *et al.*, 2016). Although not exclusive to prostate cancer, the fear of cancer progression can be particularly salient, with the experience of uncertainty surrounding their cancer progression conceptualised as a trauma known as Damocles syndrome; with the threat of cancer progression described as hanging over the patient's head like the sword of Damocles (Muzzin *et al.*, 1994; O'Brien *et al.*, 2010). It is therefore of critical importance that men diagnosed with localised prostate cancer are encouraged to fully understand the consequences of selecting Active Surveillance as a treatment decision, as well as being reassured as to its validity as a treatment choice.

Surgery for localised prostate cancer, carries a risk of several treatment-related side effects. These side effects extend beyond the initial physical impact and have major implications for the patient's psychological and social wellbeing. Although some of these side effects are temporary, depending on the surgery outcome, the impact of surgery can be long-lasting, and in sometimes permanent (Ganz, 2001). After surgery, some level of urinary incontinence is relatively common (PCUK, 2017b). Likewise, there are several side effects of surgery that can be categorised as related to sexual function. The inability to obtain or maintain an erection is a relatively common side effect (Ussher *et al.*, 2013). Additionally, the removal of the prostate removes the ability to ejaculate, which precludes the possibility of conceiving a child through sexual intercourse.

Although less invasive than surgery, radiotherapy options, including external beam, and permanent seed brachytherapy also cause several treatment-related side effects. This includes similar effects to those caused by surgical options, such as urinary problems, difficulty in obtaining and maintaining an erection, and fertility issues (PCUK, 2018a). Moreover, radiotherapy can lead to bowel problems, and can often cause fatigue. Additionally, Radiotherapy can cause swelling of lymph nodes, and a weakening of the bones near the prostate, extending out towards the hips. As with surgery, these side effects may be temporary, but they can persist for longer, and in sometimes be permanent (Ganz, 2001). As with surgery, the impact of treatment extends beyond the physical effects as these side-effects lead to associated psychosocial concerns.

The psychosocial impact of cancer treatment relates to uncertainty of the cancer's progression, as well as the physical side effects of cancer treatment. A study that examined the experiences of people who had undergone treatment for prostate cancer in the UK found that the patients interviewed regularly expressed experiences of emotional distress, anxiety, and relationship problems (O’Brien *et al.*, 2011). They also spoke about their ongoing fear of their cancer recurrence, describing it as an ‘ongoing cloud above their heads’ (O’Brien *et al.*, 2011). Additionally, the psychosocial correlates relating to sexual function are relatively well understood as patients come to terms with changes that can challenge their identity (Laganà *et al.*, 2001). For men, the side-effects related to sexual function can present a particular challenge to their sense of masculinity or gendered identity (Bullen and Tod, 2013), as men have long been socialised to associate sexual function with their sense of gender identity (*ibid*). In this respect, for people with localised prostate cancer, the impact of diagnosis, the decision to treat, and both the prospect of, and the impact of cancer treatment is not necessarily an individual experience. Prostate cancer has profound social implications, and in particular for significant others with whom they share intimate relationships (O’Brien *et al.*, 2011).

1.2.7. A couple’s cancer

The biopsychosocial effects are rarely limited to the patient in isolation yet the impact upon couples has received scant research attention, with couples-related issues overwhelmingly unaddressed (Couper *et al.*, 2006; Wittmann *et al.*, 2009; Reese *et al.*, 2017). For their significant others such as spouses or romantic partners, the experience of prostate cancer can, and regularly does have implications for their emotional, and psychological wellbeing as diagnosis and treatment represents a risk to a couple’s future, as well as having potentially serious implications for their relationship, and particularly, their sexual relationship (Collaço *et al.*, 2018). In this systematic review of research into the experiences of couples affected by prostate cancer, the findings described how couples reflected upon the challenges they faced when dealing with the impact of prostate cancer upon their sexual relationship. The review highlighted the ways that couples grieved the loss of their sexual relationship, and the corresponding loss of intimacy, noting the difficulties couples reported in coming to terms with the fact that this aspect of their relationship may well be lost (e.g. Beck, Robinson and Carlson, 2013). Related research has served to illustrate how both patients and partners experience this sense of loss. In a study conducted in the USA, using focus groups to explore the experiences of couples living with the consequences of prostate cancer and its treatments, patients described their grief at the loss of their sexual identities, describing this as an ‘integral part of their marriage’ (Harden *et al.*, 2002). A separate study in Canada examined the experiences of couples adjusting to the impact of prostate cancer treatment (Walker and Robinson, 2012). This study highlighted the ways that partners can experience this loss just as keenly as do patients. As patients can experience a loss of desire to engage in sexual activity, partners often experience a loss of self-esteem as they in turn, feel less desired. This study also highlighted the complex interplay between desire and being desired, describing how a patient started to avoid making physical contact with their partner out of concern that they'd inadvertently give them the impression that they were initiating sex. This complexity is exemplified in Harden and colleagues study as they described a couple's reluctance to hold one another in bed as they were afraid to give each other impression that they were starting something they could not finish (Harden *et al.*, 2002). This study, along with the work of Walker and Robinson (2012) also highlighted that many patients reported experiencing a loss of their sense of masculinity due to reduced libido, and bodily transformations that was considered to be 'feminising'. This finding is underlined by a review of research into the psychosocial experiences of men after prostate cancer treatment where patients consistently reported feelings of lost or diminished masculinity (Chambers *et al.*, 2017). It is in this threat to the patient's masculinity that the impact upon couples can be particularly complex, and all too often, unaddressed.

The long-standing construction of masculinity as closely linked to men's sexuality is relatively well understood, and threats to a man's ability to enact this element of their masculine identity has implications for their sexual partner (Bullen and Tod, 2013). In this respect, men can feel particularly isolated from their partners, depending on how closely they identify with typical masculine constructs where men are expected to 'soldier on' instead of seeking help, which is considered to be a sign of weakness (Bullen and Tod, 2013, p. 10). This isolation can have a substantial impact on both the patient and their partner. With loss of sexual function, the additional work required for a partner to orient towards this shift in their relationship has been found to be a cause of anxiety and depression, and moreover, leads to feelings of isolation in the partner as they try to engage with their significant other during their cancer experience (Soloway *et al.*, 2005). The stressors upon the partner of a man with prostate cancer can also become apparent as they feel more heavily, the emotional burden of the prostate cancer experience. In research that examined the experiences and stressors for partners, of people with prostate cancer, they reported that partners felt compelled to set their own emotions aside, while working to orient themselves to the emotional experience of their significant other (the person with prostate cancer), who they in turn recognise as reluctant to express such emotions (Nanton *et al.*, 2010). Additionally, partners have been found to experience anxiety as they work to manage their relationship. There is often difficulty for partners, as they attempt to mitigate the person’s response to their diagnosis. There can also be anxieties related to the treatment decision, an emotional burden in trying to align with the person’s coping strategies, and anxieties about the adjustment of their relational roles as partners often have increased caring responsibilities placed upon them (Wootten *et al.*, 2014). Partners of people with prostate cancer have also reported having to adopt new roles relating to the cancer experience, taking on the role of counsellor as they bear some responsibility for the treatment decision-making process, in the role of confidant as they attempt to share the emotional burden, and as a coordinator who takes on the role of managing the more practical aspects of the cancer experience, such as arranging appointments, or scheduling medication administration (Bergner *et al.*, 2017). It can be argued that prostate, and several other genitourinary cancers should be considered as “couples’ cancers” due to the shared impact the cancer experience has upon both the patient and their partner. It is therefore surprising to note that the experience of cancer in clinical settings is yet to fully acknowledge this shared impact between a patient and their significant other, particularly during clinical encounters.

1.3. Communication in clinical encounters

The clinical encounter, such as a primary care or hospital appointment is an integral part of the medical care. It can be a site where information exchanged, and where important decisions can be discussed or made. Historically, the communication configurations of these encounters has been conceptualised in a rather rigid manner such as those proposed by Charles and colleagues (Charles, Gafni and Whelan, 1997). In this conceptual research into shared decision making, their proposed configurations of Paternalistic, Informed Choice, and the Shared Encounter indicate three distinct categories of communication styles. In this paper, the paternalistic encounter is conceptualised as something of a ‘traditional’ clinician-patient interaction in which the clinician is considered as dominant by holding the majority of discourse space, taking up the identity of the expert to the typically, more passive patient. By contrast, they considered the informed choice encounter to be where the clinician takes on a more passive approach, giving up a portion of their discourse space, and passing responsibility to the patient for key decisions. Placed between these two configurations Charles and colleagues proposed the concept of the shared encounter. This encounter is conceptualised as taking place through collaboration with at least two distinct parties who share information as they work towards a common problem, or to reach a shared understanding of it. In this, they orient themselves to building consensus towards an agreed course of action (*ibid*). The ways that communication is organised in clinical encounters has implications for the extent to which patients shift from a more passive position, to becoming more engaged, active participants. Research evidence has offered some support for these configurations, indicating that the ways that clinicians approach these encounters, and the communication practices that they employ can serve to encourage, or otherwise inhibit participation (Collins *et al.*, 2005; Land, Parry and Seymour, 2017). However, there is a substantial body of research that has challenged the concept of the three configurations of clinical encounters, noting that there are inherent limitations to this approach as it places an over-emphasis upon the quantity of discourse space as an analogue for participation (Heritage and Maynard, 2006a; Rapley, 2008). Instead, this research has emphasised communication practices during clinical encounters, highlighting the importance of accomplishing social actions that take place during clinical encounters (Heritage and Maynard, 2006a; Rapley, 2008). Accordingly, this work has conceptualised the clinical encounter to be a complex site of social action within which acts of coproduction, collaboration, negotiation, formulations, and resistance are all performed and accomplished as members of the encounter interact through multiple discrete, yet interrelated stages of the clinical encounter (Heritage and Maynard, 2006b).

1.3.1. Involving patients during consultations

In drawing upon concepts of the paternalistic encounter (Charles, Gafni and Whelan, 1997), efforts have been made to produce a shift away from this configuration, towards a more inclusive experience for the patient, where the patient's experiences and orientations are recognised and acknowledged. Given that these encounters will regularly have implications treatment decisions, it is important to note that the process of decision-making itself has been conceptualised as an inherently social activity. Rapley notes that "decision making is never just a solo activity but rather distributed over a range of people" (Rapley, 2008, p. 432). Indeed, Rapley goes on to note in the same paper that these decisions are also made across several steps that occur across time, rather than at a single encounter.

Efforts to increase patient involvement during clinical encounters have taken place relatively recently as research had indicated that these encounters were still largely dominated in terms of discourse space by the healthcare professional (Stevenson *et al.*, 2000; Cohen and Britten, 2003). Stevenson and colleagues observed consultations and then carried out interviews with participants. They found that consultations rarely met the criteria for shared decision-making as conceptualised by Charles and colleagues (1997). In their research, Cohen and Britten interviewed men with localised prostate cancer in the UK who tended to report that they felt like they had little to contribute to the consultation, and that the treatment plans were largely decided upon by healthcare professionals. This research also drew upon the earlier conceptualisation of the paternalistic encounter, while showing that as this approach was implied by the interviewed participants as being the result of the ways that clinicians dominated the consultation. It was similarly reported that the participants oriented towards the normative expectations of these encounters, as they believed they were less entitled to contribute, fearing that it would have been 'disrespectful' for them to do so (Cohen and Britten, 2003, p. 727). This is noteworthy as, other studies have indicated that, given the opportunity, patients want to be well-informed, active participants during their consultation (Beaver *et al.*, 2005). In this research, forty-one people with colorectal cancer in the UK were asked to talk about their consultation experiences. The interviews revealed that, while patients described their consultations as largely dominated by the healthcare professional, they also expressed the desire to be more active in this regard, stating that the lack of information presented a barrier to their ability to make decisions. This finding was supported by a large-scale, multi-nation survey into the decision preferences for men with prostate cancer, where they found that nearly all participants had expressed a clear preference to be active participants in clinical encounters, and in particular, decisions about their treatment (Feldman-Stewart *et al.*, 2011).

Research into patient involvement during clinical encounters has examined some of the ways that clinicians can act to encourage this transformation from the so-called paternalistic encounter, towards a more shared experience. In a conversation analytic study of encounters between patients and healthcare professionals, the ways that the healthcare professionals approached topics of conversation were identified has having implications for the extent to which patients were involved in the encounter, and how these approaches impacted upon the typical conversation trajectory (Collins *et al.*, 2005). In identifying two distinct approaches, this research argued that when the Healthcare professionals adopted a joint, or bilateral approach from the outset, this encouraged patient participation. By formulating questions and turns so as to elicit values and orientations from the patient (e.g., What do you think?), In examining clinical consultations in an ear, nose, and throat clinic, this research demonstrated that the features of the ‘bilateral encounter’ stood distinct from what was identified as the more one-sided, or ‘unilateral encounter’, where the patient’s opinions and orientations went unelicited. Moreover, this research demonstrated how these approaches could have implications for the trajectory of the encounter, as unilateral, and bilateral approaches at key stages of the consultation such as agenda setting, presenting results, and diagnosis could each have an impact upon patient involvement. It was argued that the approach to each stage of the consultation set the normative expectations of the encounter, with each stage both setting, and renewing these expectations. In this respect it can be argued that the construction of consultation through these unilateral approaches is reproducing the normative expectations of the more paternalistic encounter, and in contrast, the use of bilateral approaches from the outset is setting expectations of an encounter where collaboration is both expected and welcome.

The importance of the conversation techniques adopted by healthcare professionals was also outlined in a related, conversation analytic study that demonstrated the ways that clinicians made strategic use of open questions, explicit ceding of the floor, and the use of conversational silences were able to foster patient participation throughout the encounter (Wade *et al.*, 2009). In a study that examined recruitment into randomised control trials for prostate cancer treatment, Wade and colleagues argued for a shift toward these identified conversational techniques to facilitate what they described as “truly informed” consent (Wade *et al.*, 2009). This has clear implications for the clinical encounter in which treatment decisions are presented, and there is research evidence to support this implication. A study into consultations for Epilepsy demonstrated how conversational techniques can affect the presentation of treatment options (Toerien *et al.*, 2011). In a Conversation Analytic study, it was shown that the ways that healthcare professionals presented treatment options during clinical encounters could produce unintentional biases through the implicit indications of personal preference, with participants orienting towards these preferences, either through acceptance of, or resistance to them.

The conversational technique adopted by the healthcare professional is one of several elements that can influence the extent to which patients become more, or less active during clinical encounters, and by extension, their decision-making processes. As expectations and beliefs can be culturally shared over time, so can understandings about the normative expectations surrounding the clinical encounter, and indeed, the patient's condition. The use of lay-beliefs and constructions about a given condition is relatively common, particularly for conditions with which have been constructed in accordance with normative societal values. For example, a survey into the ways in which people made decisions in a sexual health clinic suggested that normative beliefs about the transmission of sexually transmitted infections influenced their decisions regarding condom use (Baker *et al.*, 1996). Likewise, a study in which patients with localised prostate cancer were asked about their treatment decision-making processes during their clinical experience indicated that the knowledge of others' experiences of cancer, their shared stories, and the normative constructions of cancer all influenced their treatment decision (Steginga *et al.*, 2002). Indeed, it has been indicated that patients tend to arrive at consultations, having at least initiated the decision-making process, with the contributions they make, and their subsequent decisions at least partially informed by what goes on prior to the consultation. Patients have also appropriated technological tools in order to share their experiences online as they engage in discussions around treatment recommendations, the experience of clinical encounters, while proving sources of mutual emotional support (Huber *et al.*, 2011).

Accordingly, the amount of knowledge that a patient has about their condition, and the extent to which they rely on the prevailing lay beliefs relating to it, have been found to influence the ways in which patients make their treatment decisions. Research has demonstrated the importance of eliciting such beliefs to ensure that patients made genuinely balanced decisions about their condition (Wade *et al.*, 2009). This demonstrates the importance of the ways that healthcare professionals might frame certain treatment options as standing distinct from others, leading to the perception of advantages in selecting one treatment over another, when in certain contexts, this advantage is not supported by evidence (e.g. Toerien *et al.*, 2011). For localised prostate cancer, there is evidence to indicate that there is no significant survival advantage in selecting any one treatment option over another. In one long-term study into the outcomes of treatment for localised prostate cancer, there were no significant differences in mortality rates for patients who were randomly assigned to either active surveillance, surgery, or radiotherapy (Hamdy *et al.*, 2016). This is of importance when considering research into treatment decision-making for prostate cancer that has indicated that Active Surveillance is underused. In a survey of oncology healthcare professionals, it was demonstrated that the majority of healthcare professionals believed that Active Surveillance was an effective treatment option, but that it was not selected by their patients as often as it should as patients were less interested in ‘management’ and more oriented towards the concept of a cure (Kim *et al.*, 2014). A related study explored the clinical encounter from the patient’s perspective (Le *et al.*, 2016). Using semi-structured interviews, this study also demonstrated how patients’ reliance upon the long-standing construction of cancer, compared to a conscious reframing of prostate cancer as the ‘exception’ to this norm, indicated that likelihood that the patient would actively engage with, and indeed, go on to select Active Surveillance. Accordingly, it can be seen as critically important for healthcare professionals to elicit the experiences and orientations of patients during the encounter, to foster patient involvement, and to ensure that the patient has made a truly informed, and shared decision. That patients can arrive with *a priori* assumptions about the clinical encounter and their condition, underlines the importance of a consultation that presents both fairly and equally the aspects of all treatment options while exploring the orientations of the patient. However, research has indicated that, instead of exploring these orientations, and, where applicable, challenging them, consultants tend towards reinforcing them (e.g. Kim *et al.*, 2014).

Research has demonstrated that there continues to be a pervasive biomedical emphasis placed upon clinical encounters for prostate cancer in Canada, where little time is afforded to discuss its psychosocial or sexual impact (Hack *et al.*, 2012). In a systematic observation of 156 prostate cancer consultations, this research reported that just 5% of the consultation talk was used to explore the psychosocial impact of prostate cancer. In a related study into the experiences of prostate cancer patients in the UK, it was shown that psychosocial and sexual needs were reported as the most frequently unmet needs during consultations (O'Brien *et al.*, 2011). By interviewing people with prostate cancer, this research demonstrated that the lack of invitation to discuss psychosocial and sexual concerns led to them feeling less compelled to discuss them. This was shown to lead to regret in the patients as they reported that this was something about which they wanted to speak. Crucially participants in this study reported that they felt less entitled to raise concerns about psychosocial and sexual issues due to the prevailing assumption of them being 'too old' for such concerns. The research evidence produced by surveys and interviews aligns closely with research evidence reported from direct observations of the consultations. Combined, they indicate a complex dynamic of conversational processes, reliance upon prevailing constructions, and outdated assumptions about sex that can all act to inhibit patient engagement with the clinical encounter.

1.3.2. Involving partners and companions during consultations

A noteworthy element of the clinical encounter is the involvement of a patient's companion when they attend the encounter. Despite clinical encounters largely being conceptualised and researched as a dyadic configuration, it has been noted that patients regularly attend their clinical encounters with at least one companion present. Research in primary care, reported that 48% of their 439-patient sample attended their consultation with a companion (Rosland *et al.*, 2011). The prevalence of companion presence has been reported to be higher in oncology settings where studies have reported between 75% and 86% of patients attending their consultations with a co-present companion (Beisecker and Moore, 1994; Eggly *et al.*, 2006). With research evidence indicating that partners of men with localised prostate cancer can experience clinically significant impact upon their emotional and psychological wellbeing (Wootten *et al.*, 2014; Bergner *et al.*, 2017), it is reasonable to expect that there would be increased companion attendance during clinical encounters for men with prostate cancer, with romantic partners comprising the majority of such companions. This is noteworthy as research into the attitudes of healthcare professionals towards the discussion of sexual and relationship concerns with patients and their partners has indicated that they too orient themselves towards the normative constructions, evidently sharing their patient's assumptions regarding age and sexuality (Ussher *et al.*, 2013). During interviews, while stating that there should be space made for patients and their partner to discuss sex and relationship, healthcare professionals were found to draw upon long-standing notions that older patients and their partners do not want to discuss sex during clinical encounters, while also claiming that it was an inappropriate topic for some patients. They also explained their reluctance to discuss sex and relationships during the consultation, stating that they were ill-equipped to discuss these topics with patients. That patients orient to this normative construction (O'Brien *et al.*, 2011) as do healthcare professionals (Ussher *et al.*, 2013), demonstrates a genuine need to challenge preconceptions relating to older adults and sexuality.

This prevailing attitude, and the mutual orientation by healthcare professionals, patients, and their partners might be a contributory factor in consultations where partners are afforded relatively little space to speak during consultations. Research evidence has indicated that partners get few opportunities to make spoken contributions during triadic clinical encounters (Carlsson *et al.*, 2013). In examination of fifty colorectal cancer consultations in Sweden, this research reported that healthcare professionals took up the majority of discourse space, while partners accounted for as little as 1% of all words spoken. Given that separate research has demonstrated the distributed nature of decision-making (e.g. Rapley, 2008), this finding can be considered to be problematic, as the process of making decisions about a cancer treatment will almost certainly be one that has been discussed between a patient and their partner prior to attending any clinical encounter. Supporting this argument are several related systematic reviews where it was found that companions such as relatives and partners formed part of a multifaceted decision-support network across which, information is shared to inform key decisions (Laidsaar-powell *et al.*, 2013; Laidsaar-Powell *et al.*, 2017, 2018). In support of these findings is research showing that, when asked to state their preferences, partners largely have the desire and expectation to be actively involved during clinical encounters. During telephone interviews, partners of people with cancer described their involvement in the encounter as active through activities such as note-taking, and asking questions during the consultation (Beisecker *et al.*, 1996). In a separate study of people with prostate cancer and their partners in the USA, surveyed participants reported that partners are actively involved in the process of making critical decisions for men with localised prostate cancer, and argued the importance of increased partner participation in the consultation (Zeliadt *et al.*, 2011). This desire and expectation of partners to be involved in clinical encounters should however be treated with caution, and not taken as being a universal expectation for patients and their partners. Research has demonstrated that the relationship dynamic between patients and their partners can have implications for the consultation process (Shaw, Scott and Ferrante, 2013). Through semi-structured interviews of fifty people who had attended prostate cancer screening appointments in the USA, this research indicated that different relational dynamics between a patient and their companion could impact upon the experience where the patient may be aligned with their partner, they may oppose their involvement, or yield to their influence. This research demonstrates that the partner involvement should not be thought of from the starting assumption of ‘more is always better’ and should instead be understood that partner involvement needs to be considered in relation to the situated desires and expectations of both the patient and their partner.

1.3.3. The impact of companions upon consultations

The presence of companions in the clinical encounter has been investigated to evaluate their impact upon it. Research seeking to compare accompanied and unaccompanied consultations has reported inconsistent findings. In comparing accompanied and unaccompanied breast cancer consultations in Italy, Del Piccolo and colleagues reported that there were no differences between the consultation types when measuring the number and types of questions asked (Del Piccolo *et al.*, 2014). As a highly constrained line of enquiry, this research is limited insofar as its focus was limited to talk that was coded as questions, instead of all talk and its complex functions within the encounter. It can be argued that this study under-represented the contributions that companions made during the consultations, through the exclusion of several elements of communicative actions that would have undoubtedly had some impact upon the communication during the encounter. An example of communicative actions that can impact the clinical encounter is the ways that a co-present companion might talk about a patient during a consultation. Mazer and colleagues suggested that companions may speak on behalf of a patient, or as the patient, in ways that can either facilitate or inhibit the patient’s autonomy during the encounter (Mazer *et al.*, 2014). Other comparative studies have sought to examine the structure, content, and duration of consultations to identify differences between accompanied and unaccompanied consultations. There is some evidence that suggests that the presence of a companion has a limited impact on these aspects of the consultation, with evidence indicating that patients occupied proportionately less discourse space in accompanied consultations when compared to unaccompanied consultations (Street and Gordon, 2008; Robson, Drew and Reuber, 2013). In examining forty-eight oncology consultations in the USA, Street and Gordon also reported considerable variation in companions' active participation. They noted that in some cases, companions exhibited high levels of active participation, while others were relatively passive during these encounters. While these studies offered good descriptive evidence for some of the differences between accompanied and unaccompanied clinical encounters, there were unable to offer any explanatory accounts for any observed differences. Critically, proceeding from the starting point of looking to identify differences between accompanied and unaccompanied consultations can be problematic, and arguably, unproductive as communication among a triad is surely going to proceed differently to that of communication between a dyad. In searching for such differences, one study made the headline claim that, during accompanied oncology consultations, companions ask more questions than do patients (Eggly *et al.*, 2006). This claim, while numerically true for the entire sample of participants in combination, was demonstrably incorrect as the results showed that there was no significant difference between the mean number of questions asked per patient and companion.

The mixed findings of this research highlight the limitations of comparative studies that apply gross categorisations (such as quantity of discourse space, or number of questions asked) across highly variable and complex interactions and measuring them as standardised objects of enquiry. While patterns are likely to exist, it is apparent that reductive coding of these encounters is unable to capture the complexity of these interactions and complex processes that unfold during consultations comprising a clinician, patient, and their companion. As Mazer and colleagues had suggested, companions can act to foster, or otherwise inhibit patient participation during clinical encounters. In examining primary care encounters, the behaviours of companions were considered as influential in either enhancing, or inhibiting the agency of the patient during the encounter, with patients whose autonomy was enhanced being more likely to be active in key decisions (Clayman *et al.*, 2005). Later research has supported this finding, showing that the behaviours of companions in primary care consultations can serve to facilitate patient involvement and understanding (Wolff *et al.*, 2015). In combination, both studies demonstrated that, in extreme instances, a dominant companion could reduce the level of patient participation to the point where the companion became the primary addressee during the encounter. Although these findings are of importance, some are limited in scope due to the systematic extraction of companion behaviour from the context of what is evidently a complex social interaction that takes place among at least three conversational members. For example, Mazer and colleagues did not report key elements of interactions such as pauses, gaps, and non-word utterances. These elements of interaction might have served to reveal reasons why companions were acting in the ways that were observed, such as a patient actively selecting the companion to speak by way of a non-verbal gesture, or a deliberate decision to not take up their turn to speak. Moreover, the illustrative examples used in this study could all be re-evaluated as products of co-construction based upon a topic that will inevitably relate to the patient. Nevertheless, the findings here demonstrate the dangers of assuming that more companion involvement is better, underlining the importance of learning more about the experiences of, and attitudes towards companions being involved in clinical encounters.

1.3.4. Attitudes and experiences relating to companion involvement

Research that has examined the experiences of patients and their companions during clinical encounters has largely focussed upon retrospective accounts of past encounters. One study into the involvement of partners for people with cancer reported that patients appreciated the involvement of their partner in therapeutic activities such as diet, exercise, and counselling. This involvement was of mutual benefit to the patient and their partner as it was said to help them both to counteract their fears and uncertainties of living with cancer (Klafke *et al.*, 2014). Similar research has examined the attitudes of patients and companions towards companion involvement in oncology consultations for patients who had been diagnosed with cancer in the past two years. When asked, both patients and companions reported that the presence of the companion was typically, but not always of mutual benefit (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). A noteworthy limitation of this study is that interviews were undertaken with participants up to two years after diagnosis. With the interview being so removed from the experience, artefacts of construction and recall bias are arguably inevitable. Furthermore, it is important to note that the main themes from this study were directly relatable to the research questions asked, and the main items listed from the interview schedule. This is indicative of an analysis where interview questions were the primary driver of the produced themes, limiting the inductive aspect of this research, where themes are expected to be largely data-driven. Another study into the attitudes and experiences of companion involvement, that also included clinician attitudes, exhibited the same methodological limitations (Laidsaar-Powell, Butow, Bu, Charles, *et al.*, 2016). Using interviews, this study elicited accounts from patients, partners, and clinicians, with an inductive, thematic analysis undertaken. Some of the presented themes were near to verbatim repetitions of the interview schedule, with one theme being a word-for-word repetition of the main research question. This is demonstrative of a deductive analysis, and not the use of a more inductive approach.

The limitations of drawing upon methods to elicit retrospective accounts from participants can be further elucidated when considering research comparing observations of consultations with patients' and companions' later accounts of the experience. One study of patient and companion preferences for participation in twenty oncology consultations in Singapore made systematic observations of accompanied oncology consultations and compared these to the patients' and companion's reflections of the experience using interviews and surveys. They found that there was substantial differences between the patients' and the companions' accounts of what happened during the consultation (Lee, Teo and Kanesvaran, 2018). These findings underline the limitations inherent to asking participants about their experiences, and subsequently accepting their accounts as unproblematic. The act of remembering can be argued to be accomplished by way of reconstruction, attributions, and formulations that take place in order to achieve social actions such as providing a favourable impression, or in anticipation of situated expectations (Horton-Solway, 2001). Moreover, the use of both an interview and survey in the work of Lee and colleagues could be considered as problematic as the survey sought to measure the experiences of patients and partners by way of fixed responses that actively constrained their accounts to a limited set of responses, limiting the scope of findings.

The limitations of eliciting retrospective accounts can also be demonstrated by earlier studies into companion involvement during clinical encounters. In a study that offered a possible explanation as to the variation in companion involvement during accompanied consultations, Ishikawa and colleagues recorded both patient and companion expectations relating to the involvement of the companion, prior to them attending the consultation together. They also measured the patient's post-consultation rating of their companion's helpfulness using a simple 5-point Likert scale (Ishikawa *et al.*, 2006). Crucially, the differences between patient expectations of their companion's involvement, the companion's expectations of their own involvement, and what was observed to take place during the consultation, were predictive of patient ratings of companion helpfulness. This further underlines the importance of guarding against assumptions relating to partner involvement, and furthermore, suggests that the involvement of a companion will only be welcome so long as the patient and partner are in alignment with the extent to which a companion has had a mutually agreed level of entitlement to contribute.

To date, research into companion involvement in the clinical encounter has considered how a companion might impact upon the structure of consultations, such as the quality and quantity of questions, and adjustments to allocations in discourse space. It has also considered how companions may facilitate or otherwise inhibit patient involvement, and it has explored the elicited attitudes and experiences of patients alongside their companions. While these studies have brought with them, valuable contributions to the topic of companion involvement during clinical encounters, they have largely overlooked the clinical encounter as a site of social actions where parties engage in complex conversational practices such as taking turns to speak, invitations, acceptances, refusals, interrogatives among many others. Within the context of localised prostate cancer, an in-depth examination of these triadic consultations has yet to take place, meaning that the conversational practices and social actions accomplished during these encounters have yet to be examined. One approach that is capable of elucidating these practices and resultant social actions is conversation analysis, which has been applied to communication in several healthcare settings.

1.4. Conversation Analysis of medical encounters

Conversation analysis is a qualitative approach that is used to examine every day social interactions (Stivers and Sidnell, 2013). It is an approach that has the potential to offer a systematic analysis of the conversational practices enacted, and the resultant accomplished social actions that occur during the triadic clinical encounter. Conversation analysis has been applied to several aspects of healthcare as it has the potential to impact upon the quality of the provision by improving the quality of communication between healthcare professionals and those with whom the interact (Drew, Chatwin and Collins, 2000). For example, the structural organisation of primary care encounters was analysed to demonstrate how the discrete stages of the encounter were all dynamically related, with each having implications for the next (Heritage and Maynard, 2006b). Related studies outlined how healthcare professionals might employ different communication practices to solicit patient's concerns, such as the strategic use of open or closed question formulations, and how patients produce particular narratives relating to their symptoms (Halkowski, 2006; Robinson, 2006b). In oncology settings, conversation analysis has been applied to several aspects of healthcare provision, such as end-of-life conversations (Lidén *et al.*, 2010; Maynard, Cortez and Campbell, 2016), telephone calls to a cancer helpline (Woods, Drew and Leydon, 2015), and to diagnostics and treatment-related clinical encounters (Leydon, 2008). These studies served to identify the situated conversational practices that regularly occurred during these encounters, while having the potential to improve communication practices where required and accordingly, improve service provision. These conversational practices have yet to be systematically examined in the context of triadic prostate cancer clinical encounters. The systematic study into how triadic consultations are managed has been argued to be an important developmental element of conversation analysis in healthcare provision (Barnes, 2019). This is the method that has been chosen for this thesis, and the rationale for selecting this approach is further outlined in Chapter 3. This thesis represents the first time that conversation analysis has been applied to triadic consultations within the context of low to intermediate risk localised prostate cancer. This is the original contribution that this thesis offers, as it offers an extension to the ever-evolving evidence base for healthcare communication in the context of oncology.

This is the original contribution to knowledge that this thesis will attempt to provide by offering an analysis of one such configuration within the context of localised prostate cancer.

1.5. Aims of this thesis

This research aims to address the current lack of knowledge relating to partner involvement through an investigation into partner involvement within the context of low to intermediate risk localised prostate cancer. In this, the research will make use of audio recordings of clinical consultations comprising a healthcare professional, patient, and their co-present romantic partner. These consultations were collected as part of the TrueNTH Understanding Consequences study of which this thesis is a part. For this research, partners are defined as significant others with whom the patient has an intimate relationship, such as a spouse or romantic partner. This thesis, which will include a series of related research papers, sets out to examine the content, structure, and conversational practices of the initial diagnostic and treatment consultations that comprise of a patient, their partner, and the healthcare professional. The subsequent knowledge produced from this research has the potential to highlight situations were partners of people with localised prostate cancer come to contribute to the encounter. It can also provide indications as to interactional consequences of such contributions, and the extent to which the consultation structure ratifies the partner as a conversational participant in the encounter. The triadic encounter is a particularly complex site of social activity as priorities and expectations of the patient and partner may not always be in alignment, yet a partner may still expect to make contributions that will inevitably have an impact upon the encounter (Shaw, Scott and Ferrante, 2013). The importance of research into partner involvement for localised prostate cancer is underlined by research indicating that both patients and their partners can experience physical and psychological morbidities as a result of a prostate cancer diagnosis, the subsequent clinical encounters, and treatments (Wootten *et al.*, 2014).

This research has the potential to elucidate the ways that partners come to be involved during localised prostate cancer consultations, and how their contributions are facilitated or inhibited. It can also serve to reveal the types of actions accomplished by partners, and the sequential implications for these actions. Accordingly, this research addresses the following research question: How are co-present romantic partners involved in the conversation during clinical consultations for people with low to intermediate risk localised prostate cancer?

1.6 Objectives

The objectives of this thesis are to:

- Critically review the currently available research into partner involvement within the context of oncology
- Examine the ways that partners can come to contribute to the consultation
- Examine the sequential organisation and implications of partner contributions during key consultation phases
- Assess ways that the consultation is structured relative to the patient and partner as a couple

1.7 Outline of this thesis

As a conversation analytical study, the research topics selected for this thesis were identified throughout the process of repeatedly listening to the recordings collected from the consultations, taking note of interesting features of these interactions, and performing systematic analyses of these observations. Accordingly, the empirical topics for this thesis were not formed prior to this analytical process. Instead, a broad and overarching research direction was formed through a systematic examination and review of the currently available research into partner involvement during oncology consultations. Chapter 2 contains this examination in the form of a literature review that has been published in the journal Patient Education and Counseling, and reproduced here by kind permission of the publisher, Elsevier.

In Chapter 3, the methodological principles of conversation analysis are outlined along with a description of some of the assumptions and core concepts that serve as the foundation of this approach to analysing social interactions. This chapter also outlines why this approach was chosen, before offering a description of how the analytical process was conducted. This includes an outline of the data collection sites, information about the collected data, and the process of doing conversation analysis on the collected data. The chapter also describes some of the ethical considerations that were identified throughout this research.

As the first empirical section, Chapter 4 offers a participatory framework of the consultations through an analysis that examines the turn-taking practices across all points of the consultations relative to partner contributions. This chapter outlines the ways that partners come to contribute to these consultations, the social actions that they accomplish, along with an illustration of the sequential impact these contributions can have. The chapter then focuses on one particular form of contribution that has previously been considered as problematic in both clinical and everyday settings where a partner responds to a turn-at-talk that has explicitly selected the patient as the next speaker. This focussed analysis has been prepared for submission to the journal, Social Science and Medicine.

Chapter 5 then offers an examination into the ways that expressions of preference are organised during these consultations, with particular focus upon the sequential consequences that arise from patients and their partners expressing preferences for or against particular treatment choices as well as expressing preferences for expert guidance. This analysis has been prepared as a research article for submission to Social Science and Medicine.

In the final empirical section, Chapter 6 offers a pilot analysis into the ways that the sexual impact of prostate cancer is communicated to patients and partners during these consultations. This chapter offers an analysis into two distinct approaches to introducing and outlining the sexual impact of prostate cancer during these consultations, as well as offering an indication as to the structural and sequential implications of these approaches.

In the final part of this thesis, Chapter 7 offers a summative discussion and assessment of the thesis. This chapter also considers the implications of the analytic findings, offers some explanatory accounts for the observed findings, before going on to acknowledge some of the limitations inherent to the research as it was carried out. The chapter closes with some suggestions for future research directions that can serve to expand upon the research contributions comprising this thesis.

1.8 Outputs from this thesis to date

1.8.1 Publications

Stewart, Simon J., Roberts, Lisa and Brindle, Lucy (2021) ‘Romantic partner involvement during oncology consultations: A narrative review of qualitative and quantitative studies', Patient Education & Counseling. Elsevier Ireland Ltd, pp. 64–74. doi: 10.1016/j.jns.2019.116544.

1.8.2 **In preparation**

Speaking Out of Turn: The Prosocial Effect of a Partner Speaking After a Patient has Been Addressed During Prostate Cancer Consultations. Submitting to Social Science and Medicine.

Sequential Misalignment and Conflict Management: Patient and Partner Preferences During Localised Prostate Cancer Consultations. Submitting to Social Science and Medicine

1.8.3 **Notable presentations**

29th November 2019, Centre for Interaction, Development and Diversity (CIDD) University of Portsmouth. Overview of research, pilot study, and literature review.

10th October 2019, Centre for Language, Interaction, and Culture (CLIC), UCLA. Overview of initial findings and literature review.

19th November 2020, Centre for Advanced Studies in Language and Communication CASLC, University of York. Overview of main research findings and discussion of implications.

10th December 2020, CA Data Sessions South. Presentation and workshop based upon main research findings.

Chapter 2 Romantic Partner Involvement

2.1 Chapter Introduction

"All the world's a stage, and all the men and women merely players"

-Shakespeare

This quote from the play "As You Like It" brings forth the idea that in everyday life, the world serves as a shared stage, or social platform, with each person delivering performances in the accomplishment of everyday life. Goffman considered these performances as related to the dynamic realisation of social settings such as a home, a restaurant, or a hospital, and the social roles such as a parent, or a spouse, or a doctor, and their potential audiences such as a group of colleagues, or friends (Goffman, 1990a). Goffman noted that such performances tended towards presenting a socially desirable, or idealised performance that related to both what people want to be known, and more importantly, what they want to be concealed. In this respect, Goffman considered self-presentation to always be a selective social practice.

Goffman further considered how groups seek to present themselves through the concept of the 'performance team', and how this 'team' can perform in equally idealised ways to create a socially desirable presentation (Goffman, 1990b). While the term 'teams' brings to mind larger groups such as a sports team or a group of colleagues, it applies equally well to smaller groups such as friends, relatives, and couples.

Romantic couples are a particular form of team. They typically share a form of exclusive intimacy in their relationship including the ways that they communicate, and the ways that the connect both emotionally and physically. As much as romantic couples share parts of their lives that they would consider to be private, it stands to reason that they would work together to moderate the extent to which they would present details of their lives in public settings, and through the course of everyday actions, work together as a team to present themselves in idealised ways, particularly when they are co-present as a couple, and more importantly, when others address them as, or in relation to their life as a couple. It is this understanding of romantic couples that is particularly relevant when considering the ways that much of the research in the presented review has been carried out.

The research in this chapter offers a narrative review of the currently available research into partner involvement during clinical consultations within the context of oncology. The purpose of this review was to systematically outline and evaluate this body of research, to examine critically the prevailing research methods, and to identify research directions that have yet to be addressed.

2.2 Abstract

2.2.1 Objective

To review the currently available research into romantic partner involvement during oncology consultations.

2.2.2 Methods

Studies were identified via database searches plus hand-searching. A narrative review was performed using the principles of Thematic, and Framework syntheses. The search strategy was performed according to the principles of PRISMA.

2.2.3 Results

From 631 results, 18 studies were included. The findings indicate that romantic partners are most valued by patients when they provide emotional, practical, and informational support. It is also indicated that psychosocial and sexual concerns are rarely discussed. Couples' self-reported satisfaction with consultations appears related to the extent of romantic partner involvement, the roles that they enacted, and the extent to which psychosocial and sexual concerns were addressed.

2.2.4 Conclusion

This review indicates that romantic partner involvement during clinical consultations enhances the couple's experience. However, there are methodological limitations to this body of research, which are discussed in this review.

2.2.5 Practice implications

Research to date has yet to offer an exploration of the social practices and conversational actions relating to romantic partner involvement during triadic oncology consultations. Future studies that draw upon recordings of these consultations, using methods capable of analysing situated social practices can address this gap.

2.3 Introduction

Communication in clinical consultations has mainly focused upon the patient-healthcare professional dyad. Some studies have sought to typify the encounter based on the extent to which patients are involved in treatment decisions (Charles, Gafni and Whelan, 1997; Cohen and Britten, 2003; Beaver *et al.*, 2005), while others have examined the conversational dynamics of these consultations (Heritage and Maynard, 2006a; Stivers *et al.*, 2018; Toerien *et al.*, 2018). With research emphasising dyad-based consultations, the influence of companions has received relatively little attention. This is noteworthy as research indicates that companions attend clinical encounters regularly, for example, in 16-25% of primary care encounters, and 36-57% for patients aged over 60 (Laidsaar-powell *et al.*, 2013). A review of research into companion involvement during clinical encounters found that studies offered descriptive evidence, noting that companions were typically helpful in supporting patients (Laidsaar-powell *et al.*, 2013). It noted that there were likely to be differences in relational dynamics depending on the companion. A more recent review of romantic partner involvement during treatment decision-making across multiple clinical contexts, noted that partners reported regular involvement, while noting a lack of direct observations as a key limiting factor of the research to date (Bracher *et al.*, 2019). A lack of research into companion involvement for oncology consultations was also reported (Laidsaar-powell *et al.*, 2013). This is noteworthy as research into companion attendance in oncology has indicated that companions attend more frequently than other clinical settings, with companion attendance reported to be between 64% and 86% (Beisecker and Moore, 1994; Eggly *et al.*, 2006; Laidsaar-powell *et al.*, 2013). However, the lack of large-scale, quantitative studies, makes this distinction uncertain.

It is well understood that the experience of cancer can affect the patient and anyone who cares for them (Germain *et al.*, 2017). This can be particularly pertinent for romantic partners, as cancer can have significant psychological, and sexual impact on couples, with some cancers referred to as couples' or relational cancers (Bullen and Tod, 2013). In this respect, romantic partners are a distinct sub-group of companions, with the experience of cancer impacting upon couples in such unique ways. This has given rise to the concept of the 'cancer couple' (Soloway *et al.*, 2005). Cancer can have profound effects on sexual relationships (Heijer *et al.*, 2012), as well as have implications for ongoing relationship roles, such as threats to masculine and feminine identities (Bullen and Tod, 2013; Ussher *et al.*, 2013; James *et al.*, 2017).

Of the research into companion involvement during oncology consultations, a qualitative meta-synthesis was conducted, which was limited in scope by constraints relating to the definition of companions to that of unspecified female companions, a patient sample of only African American men in the USA, and within the context of prostate cancer (Bergner *et al.*, 2017). While this review offers valuable insight into companion involvement, such constraints limit its generalisability.

Given the relative lack of research into romantic partner involvement during oncology consultations, there is value in carrying out a review of the currently available research. This is the primary aim of this review. For the purposes of this review, the term ‘partner’ is used. Partners are defined as spouses or romantic partners, distinct from relatives, friends, and carers.

2.4 **Methods**

2.4.1 **Search strategy**

After initial scoping, a search strategy was developed (Table 1). Searches were performed across six databases: Medline; PsychARTICLES; PsychINFO; CINAHL; EMBASE; and SCOPUS. The combined results were screened according to the principles of PRISMA (Moher *et al.*, 2009). Papers were selected in relation to eligibility criteria that were developed using an adapted version of the SPIDER framework (Cooke, Smith and Booth, 2012) (Table 2). Primary exclusion criteria were: Papers without focus on partner involvement; a medical area outside of cancer; and communication outside of clinical or community healthcare settings. The references in the included studies were also hand-searched for additional papers. At the stages of title, abstract, and full-paper stages of screening, a random 20% selection of papers were double-screened by all authors. This led to the final selection of papers.

Table 1: Search Terms

Search 1
(cancer OR cancer patient* OR cancer treatment* OR oncology OR neoplasm* OR tumour* OR tumor* OR malignancy OR malignancies)
Search 2
(partner OR partners OR husband OR wife OR spouse OR significant other*)
Search 3
(doctor OR doctors OR clinical OR medical OR hospital OR outpatient OR health OR nurs* OR advanced practice OR practitioner) N1 (appointment OR consultation OR encounter OR setting OR meeting)
Search 4
Search 1 AND Search 2 AND Search 3

Table 2: Inclusion and exclusion criteria

	Inclusion Criteria	Exclusion Criteria
Study Types	Qualitative studies, quantitative studies, that can include primary or secondary analyses of data from interviews, focus groups, surveys, or consultation observations. Papers written in English. Observations of, or retrospective reports about consultations.	Systematic Reviews and meta-analyses, non-empirical reviews, commentaries, and editorials. Papers that only report on prevalence of partner presence. Papers that do not distinguish partners from other companions in reporting of findings.
Participants	Patients, their partners, and healthcare professionals, with all participants being over 18 years old.	Children as patients, or adults who lack capacity. Companions who are not identified as partners.

	Partners include spouse, husband, wife, and significant others (romantic partners). Studies where all or most companions were identifiable as partners, and where analyses were explicitly related to partners (e.g. sex/intimacy)	
Settings	A consultation involving patient, partner, and healthcare professional. Any health, medical, or community setting in which an oncology or oncology-related consultation is taking place.	Settings outside of health, medical, and community settings. Medical area outside of oncology.

2.5 **Data extraction**

The data extraction, and narrative review combined inductive methods related to Thematic Syntheses, and deductive methods related to Framework Syntheses (Snilstveit, Oliver and Vojtkova, 2012). This approach was selected due to the diversity of the identified studies. The inductive approach related to the principles of thematic analysis in which themes are produced largely from the data through familiarisation, coding, and generation of themes, subject to ongoing review (Braun and Clarke, 2006). The deductive aspect related to the production of a provisional coding frame, constructed from key concepts found in most empirical research. For this step, each abstract was read to identify candidate codes such as methods, measures, and key findings. After this, an initial exercise of ‘open coding’ was performed through repeat readings of the full papers. These initial codes were grouped into higher-order narratives and incorporated into the provisional coding frame. This frame developed iteratively, leading to a final coding frame (Table 3). The coding exercise was carried out using the qualitative data analysis software, NVivo 12 (QSR International). **Codes** were organised into overarching themes, with each study re-assessed against the developed coding frame. The final coding frame and themes were reviewed by all authors, with both co-authors cross-checking and validating the data extraction throughout the process.

Table 3: Final coding frame

Name	**Description**
Duration of consultations	Comparisons between accompanied and unaccompanied consultations such as length and structure.
Extent of partner involvement	Measurements of how much a partner was or was not involved by content or discourse space.
Partner participation Level	Measures included discourse space and number of questions asked, and potentially related factors.
Partner roles	Descriptions of roles described by participants and observed by researchers.
Advocate for patient	Describing roles in which the patient's perspective and values are represented by the partner.
Emotional support	Describing roles where the partner engaged in supporting the patient's emotions.
Informational support	Supporting understanding, asking questions, keeping records, interpretation, taking notes.
Practical support	Everyday tasks such as transport and mobility, schedules, or occupational concerns.
Psychological Social and Sexual Support	The quantity and quality of psychological and sexual support during accompanied consultations.
The need for psychological, social, sexual support	Impressions on the importance of these topics during consultations.
Satisfaction with consultation	Reports of measures described as post-consultation satisfaction as expressed by patients and partners.
Measures and instruments	Tools used in the research.
Non-validated	Non-validated tools such as bespoke SSI or survey.
Direct observation	Including audio and video recording, and ethnographic field notes.
Retrospective measures	Including interviews and surveys.
Validated	Validated tools such as standardised schedules/surveys.
Direct observation schedule	Structured observations which conform to a validated schedule.
Retrospective survey Schedules	Validated survey schedules and assessment tools.
Medical area	Type of cancer, or oncology in general.
Method	How the data were collected.
Participants	Populations that were involved.
Sample	Size and type.

Study design	Cross section/Longitudinal/Pre-Post.
Methodological concerns	Critical evaluation of methods, data, results, and interpretations.
Study focus	Questions and answers.

The study assessed the quality of the included papers two ways. All studies were subjected to a standardised quality assessment using the Qualsyst tool, which allows for evaluations of qualitative and quantitative methodologies. Qualsyst scoring was cross-checked and validated by the co-authors using a random 50% selection of quality ratings, with inter-rater reliability calculated at 85% and 81% for qualitative and quantitative studies respectively. Differences were discussed and resolved among all authors. Further detailed methodological appraisals were made throughout the review, which are outlined in the discussion section.

2.6 **Results**

2.6.1 **Study Characteristics**

The initial searches returned 631 papers. After screening, 18 papers were selected (Table 4). All but one of the studies were situated in the context of diagnosis and treatment decision consultations. One study (Cordella, 2011) included pre- and post-treatment consultations. There was variation in the selected studies relating to objectives, participants, and methods (Table 5). Four studies explored attitudes and experiences relating to partner involvement (Davison *et al.*, 2002; Sinfield *et al.*, 2008; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016), seven examined communication types and topics during the encounters (Rees and Bath, 2000; Srirangam *et al.*, 2003; Zeliadt and Penson, 2011; Forbat *et al.*, 2012; Hack *et al.*, 2012; Ussher *et al.*, 2013; Mazer *et al.*, 2014), two compared accompanied with unaccompanied encounters (Jansen *et al.*, 2010; Huber *et al.*, 2016), four examined the role of partners (Beisecker *et al.*, 1996; Nanton *et al.*, 2010; Cordella, 2011; Huber *et al.*, 2016), four assessed post-consultation satisfaction (Zeliadt and Penson, 2011; Hack *et al.*, 2012; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Primeau, Paterson and Nabi, 2017), and one examined the expressed support needs of couples (Gietel-Habets *et al.*, 2018). Nine studies related to prostate cancer (Davison *et al.*, 2002; Srirangam *et al.*, 2003; Sinfield *et al.*, 2008;

Nanton *et al.*, 2010; Zeliadt *et al.*, 2011; Hack *et al.*, 2012; Huber *et al.*, 2016; Le *et al.*, 2016; Primeau, Paterson and Nabi, 2017), Seven were situated across multiple cancers (Beisecker *et al.*, 1996; Jansen *et al.*, 2010; Cordella, 2011; Forbat *et al.*, 2012; Ussher *et al.*, 2013; Mazer *et al.*, 2014; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016), and two were related to breast cancer (Rees and Bath, 2000; Gietel-Habets *et al.*, 2018). Five studies included partners as a sub-group of companions (Beisecker *et al.*, 1996; Jansen *et al.*, 2010; Cordella, 2011; Mazer *et al.*, 2014; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016) and only one of these failed to make explicit the number of partners included in relation to their sample (Cordella, 2011). All five studies were included as their analyses specified findings only relevant for romantic partners. Four were included due to 65%-75% of companions identified as romantic partners (Beisecker *et al.*, 1996; Jansen *et al.*, 2010; Mazer *et al.*, 2014; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016), and the fifth due to the analysis making specific references to romantic partner-centred activities (Cordella, 2011).

Studies varied in relation to recruitment. Six studies involved patients, partners, and healthcare professionals (Cordella, 2011; Forbat *et al.*, 2012; Hack *et al.*, 2012; Mazer *et al.*, 2014; Huber *et al.*, 2016; Primeau, Paterson and Nabi, 2017), nine involved patients and partners (Beisecker *et al.*, 1996; Davison *et al.*, 2002; Sinfield *et al.*, 2008; Jansen *et al.*, 2010; Nanton *et al.*, 2010; Zeliadt and Penson, 2011; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016; Gietel-Habets *et al.*, 2018), two studies included partners only (Rees and Bath, 2000; Srirangam *et al.*, 2003), and one involved only healthcare professionals (Ussher *et al.*, 2013). Sample sizes varied with mean samples per study of 18 healthcare professionals (range of 7 – 38), 60 patients (range: 9 – 166), and 43 partners (range: 7 – 111). There was diversity in the analytic focus of these studies, with focus on partners only (Rees and Bath, 2000; Srirangam *et al.*, 2003; Cordella, 2011), the patient-partner dyad (Beisecker *et al.*, 1996; Davison *et al.*, 2002; Sinfield *et al.*, 2008; Jansen *et al.*, 2010; Nanton *et al.*, 2010; Zeliadt and Penson, 2011; Hack *et al.*, 2012; Mazer *et al.*, 2014; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016; Primeau, Paterson and Nabi, 2017; Gietel-Habets *et al.*, 2018), healthcare professionals only (Ussher *et al.*, 2013), or the patient-partner-healthcare professional triad (Forbat *et al.*, 2012; Huber *et al.*, 2016).

Table 4: PRISMA flow chart

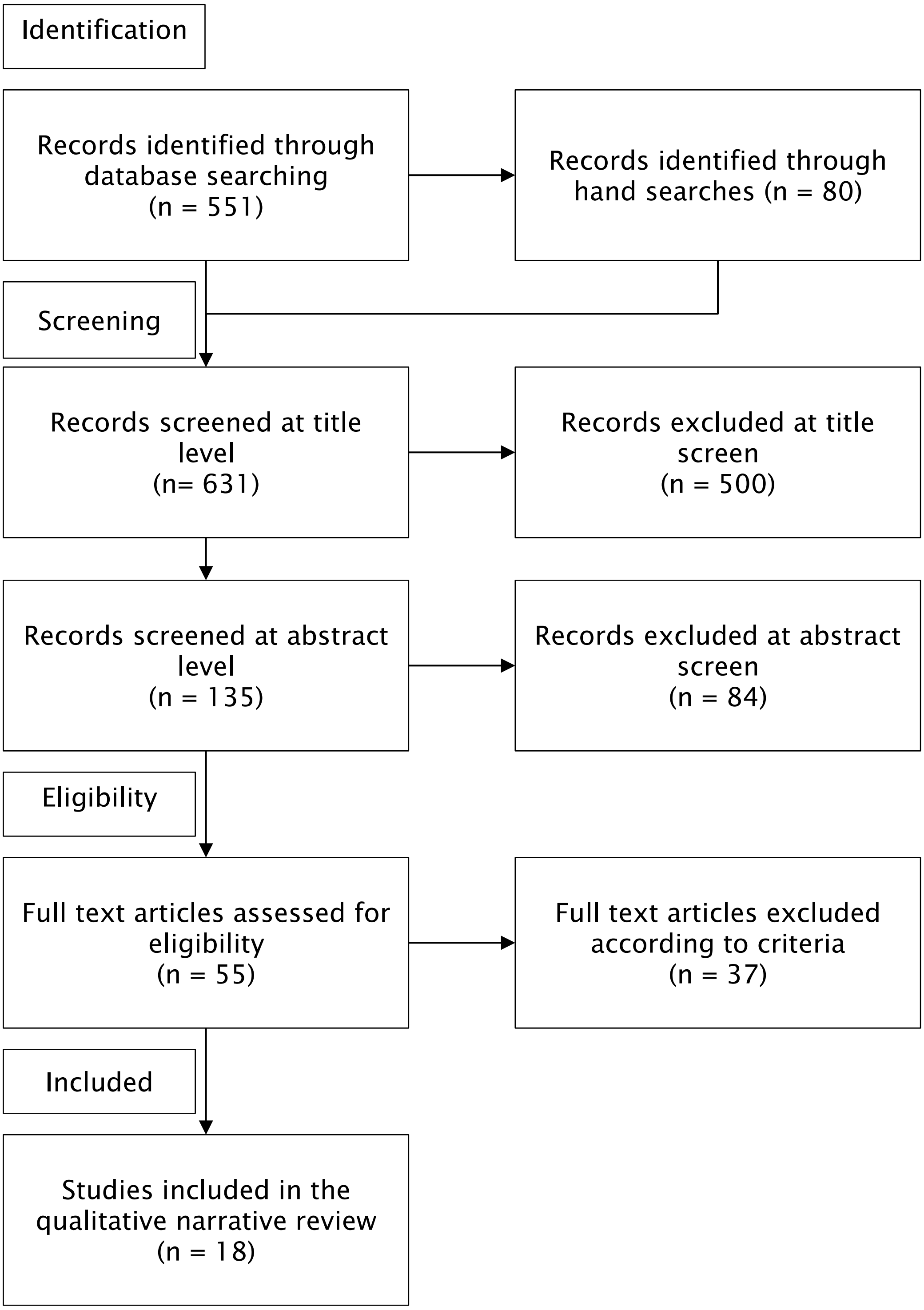

Table 5: Summary of included studies

Author	Year	Country	Aims	Design	Participants	Measures	Analysis
Primeau, Paterson & Nabi	2017	Scotland	Exploring Models of Supportive Care in Men and Their Partners/Caregivers	Interviews	19 Patients, 7 Partners, 7 HCP	Bespoke interview schedules	Thematic analysis of interview data
Cordella	2011	Chile	Examining the three-way exchange in cancer medical encounters	Analysis of Medical Encounter	9 Patients, 9 Companions 9 HCP	Bespoke content analysis	Discourse Analysis
Laidsaar-Powell *et al.*	2016	Australia	Attitudes and experiences of family involvement in cancer consultations	Interviews	33 Patients, 25 Partners, 3 Children, 4 Other	Bespoke survey and bespoke interview schedule	Thematic analysis of interview data
Forbat *et al.*	2012	England	Discussing the sexual consequences of cancer treatment	Analysis of Medical Encounter	60 Patients, 31 Partners	Ethnographic field notes	Analysis of notes taken during ethnographic observation
Rees & Bath	2000	England	Information flow in consultations	Survey	109 Partners*	Bespoke survey	Analysis of survey responses
Hack *et al.*	2012	Canada	Analysis of prostate cancer patients' primary treatment consultations	Analysis of Medical Encounter	156 Patients, 111 Partners	Medical Interaction Process System (MIPS)	Analysis of interactions using MIPS
Nanton, Osborne, & Dale	2010	England	Examining partner activity in prostate cancer	Interviews	20 Patients, 9 Partners	Bespoke interview schedule	Thematic analysis of interview data
Mazer *et al.*	2014	USA	Pseudo-surrogacy in	Analysis of Medical Encounter	34 Patients, 23 Partners, 5 Children, 3 Siblings,2	Bespoke interview schedule	Thematic analysis of interviews

			triadic medical encounters		Friends, 17 HCP		
Author	**Year**	**Country**	**Aims**	**Design**	**Participants**	**Measures**	**Analysis**
Beisecker *et al.*	1996	USA	Perceptions of the role of cancer patients' companions	Interviews	18 Patients, 11 Partners** 6 child/parent	Bespoke interview schedule	Thematic analysis of interview data
Gietel-Habets *et al.*	2018	Netherlands	Support needs of couples with hereditary breast and ovarian cancer	Interviews and survey	122 Patients, 61 Partners	Bespoke survey and interview schedules	Thematic analysis of interview data and analysis of survey responses
Ussher *et al.*	2013	Australia	Healthcare professionals on talking about sex after cancer	Interviews	38 HCP	Bespoke interview schedule	Discourse analysis
Jansen *et al.*	2010	Netherlands	How companions aid recall for older cancer patients	Survey	100 Patients, 47 Partners, 24 Adult-children	Bespoke survey	Analysis of survey responses
Davison *et al.*	2002	Canada	Identify and compare information and decision preferences	Survey	80 Patients, 80 Partners	Bespoke survey	Analysis of survey responses
Le et al.	2016	USA	Couples' attitudes towards Active Surveillance	Interviews	15 Patients, 15 Partners	Bespoke interview schedule	Thematic analysis of interview data
Srirangam *et al.*	2003	England	Partners' influence on patient preferences	Surveys	82 Patients, 82 Partners	Bespoke survey	Analysis of survey responses
Sinifeld *et al.*	2008	England	Experiences of patients and partners	Interviews	35 Patients, 10 Partners	Bespoke interview schedule	Thematic analysis of interview data

Zeliadt *et al.*	2010	USA	Evaluate extent of partner involvement	Surveys	166 Patients, 166 Partners	Bespoke surveys	Analysis of surveys
Huber *et al.*	2016	Germany	Comparing accompanied and unaccompanied consultations	Analysis of medical encounter	30 Patients, 14 Partners	Qualitative and Quantitative CA	Qualitative and quantitative CA

2.7 **Findings**

The review produced four themes: 1) Extent of partner involvement; 2) partner roles; 3) psychosocial and sexual support; and 4) satisfaction with the encounter. The extent to which partners were involved was examined through studies considering types and frequencies of partner contributions. Partner roles were examined in studies seeking to describe these roles, and how they related to the patient's experience. Psychosocial and sexual support was examined through studies that considered the amount of talk related to these topics, and perspectives relating to psychosocial and sexual support. Satisfaction with the encounter was examined by considering the ways that partner involvement related to retrospective reports of participants' satisfaction.

2.7.1 **Extent of partner involvement**

Eight studies described the extent of partner involvement. This included quantifying the amount and type of partner contributions, and qualitative descriptions of partner contributions. Four studies used qualitative methods, analysing interviews or observations (Beisecker *et al.*, 1996; Sinfield *et al.*, 2008; Forbat *et al.*, 2012; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016), while two used quantitative methods such as surveys, or content analyses (Davison *et al.*, 2002; Srirangam *et al.*, 2003). One study employed mixed methods through qualitative coding, and quantitative analysis (Hack *et al.*, 2012). Data collection methods varied: Two studies recorded consultations directly (Hack *et al.*, 2012; Huber *et al.*, 2016), one employed a non-participant ethnographic observation (Forbat *et al.*, 2012), and five used post-consultation interviews and surveys (Beisecker *et al.*, 1996; Davison *et al.*, 2002; Srirangam *et al.*, 2003; Sinfield *et al.*, 2008; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016).

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In studies examining the extent of partner involvement, two studies reported low levels of partner involvement during clinical encounters, measured by the percentage of talk they contributed (Forbat *et al.*, 2012; Hack *et al.*, 2012). One study coded the consultations by participant utterance, noting that partners contributed 7% of all utterances. This was considered low, compared with measures of patient utterances at 21.5%, and healthcare professional utterances at 71.5% respectively. While the other study did not perform systematic measurements, it noted that partner involvement was minimal outside of exceptional cases where the patient had marked cognitive or physical impairments. Likewise, another study that observed triadic prostate cancer encounters noted exceptional instances where partners could become so dominant as to become the primary addressee (Huber *et al.*, 2016). While this indicates that the extent of partner involvement can vary, these studies were unable to explain the differences.

For studies examining preference for involvement**,** findings were mixed. When asked separately, partners and patients expressed preferences for partner involvement (Davison *et al.*, 2002). This finding is limited due to the use of five fixed survey responses that were transformed and reduced into three 'types' of preference; active, collaborative, and passive, which lacked any further definition.

For studies examining perceptions of partner involvement, findings were also mixed**.** One study into patient preferences for prostate cancer treatment indicated that partners reported limited influence upon treatment decision-making (Srirangam *et al.*, 2003). When asked to assess their influence on a scale of 0 (none) to 10 (major), the mean score of 4.8 belied the fact that most responses were at the extreme ends of this scale. The study could not explain this variation. In an interview-based study into the experiences of patients and partners during cancer consultations, partners reported that, although they were treated well by the healthcare professional, they often felt excluded (Sinfield *et al.*, 2008). One study examined the perceived extent of partner involvement by interviewing eighteen patients and seventeen partners using opportunity sampling from a single location (Beisecker *et al.*, 1996). Using an interview plus six-point survey question it was reported that partners perceived themselves as more involved than patients perceived them to be. While this study offered potential insight into these differing perspectives, it did not use matched patient-partner pairs, limiting the validity of the findings, as they were not comparing patients' accounts to their partners'. By contrast, one study into the attitudes and experiences of partners during cancer consultations claimed that successful partner participation in consultations was the product of active negotiation between the patient and partner prior to the encounter (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). This study noted that practices such as role-clarification and discussion of expectations pre-consultation were largely appreciated and led to a better experience for couples. When considering these findings, it indicates that partner involvement tends to be low, but this can be influenced by negotiation to clarify the partner's role.

2.7.2 **Partner roles**

Ten studies explored partner roles (Beisecker *et al.*, 1996; Rees and Bath, 2000; Srirangam *et al.*, 2003; Sinfield *et al.*, 2008; Jansen *et al.*, 2010; Nanton *et al.*, 2010; Cordella, 2011; Mazer *et al.*, 2014; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016), six were qualitative studies (Sinfield *et al.*, 2008; Nanton *et al.*, 2010; Cordella, 2011; Mazer *et al.*, 2014; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016), and four were quantitative (Beisecker and Moore, 1994; Rees and Bath, 2000; Srirangam *et al.*, 2003; Jansen *et al.*, 2010). Of these, two studies analysed direct observations (Cordella, 2011; Mazer *et al.*, 2014), while eight used retrospective data such as interviews or surveys (Beisecker *et al.*, 1996; Rees and Bath, 2000; Srirangam *et al.*, 2003; Sinfield *et al.*, 2008; Jansen *et al.*, 2010; Nanton *et al.*, 2010; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016). The retrospective data collection procedures took place between twelve months and ten years after the participants' experiences, making participants' recollections susceptible to recall bias.

There was variation in the ways that roles were defined. Upon examination of the role descriptions across these studies, it became apparent that the diversity of labels belied the homogeneity of the roles described. Twenty-six role categories across these studies were categorised into four distinct roles: Patient advocacy; emotional support; informational support; and practical support (Table 6).

Table 6: Role categories

Category	Labels
Advocate	Social communicator, Middleman, Advocate, Pseudo-surrogate, Storyteller, Negotiator.
Emotional Support	Emotional Support, Moral Support, Counsellor, Confidant, Emotion Manager.
Information Support	Secretary, Reporter, Information Supporter, Information manager, Record Keeper, Information Accrual, Interpreter.
Practical Support	Coordinator, Carer, Financial Assistant, Health Advisor, Care Manager, Transportation Support, Medication Manager.

2.7.2.1 Patient advocacy

Advocating for the patient was described in four studies, with descriptions including social communicator; middleman; and pseudo-surrogate (Beisecker *et al.*, 1996; Cordella, 2011; Mazer *et al.*, 2014; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). These labels related to representation, support, and presenting information on the patient's behalf. Two studies coded patient advocacy directly from recorded consultations (Cordella, 2011; Mazer *et al.*, 2014), and in the other two, the role of advocate was elicited through interviews (Beisecker *et al.*, 1996; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). In retrospective studies, data collection was significantly removed from the experience, taking place up to two years after the consultation, introducing a risk of recall bias.

In observational studies, advocacy was described as arising from ways that partners supplied information to support and protect the patient's position, such as important aspects of the patient's life, and conveying information on the patient's behalf. One observational study reconceptualised advocacy as 'pseudo-surrogacy' (Mazer *et al.*, 2014), reframing it as a spectrum, showing that different aspects of advocacy within the consultation might serve to facilitate or inhibit patient contributions as partners spoke for, as, to, or with the patient. In interview-based studies, participants described ways in which they supported the patient during the consultation, describing advocacy as a key reason for their attendance, either to act as the patient's voice, or to bring a supporting perspective (Beisecker *et al.*, 1996; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). Although the findings in this area were largely descriptive, the combined findings indicate that advocacy was largely perceived by participants in positive terms, although one study suggested it may negatively impact upon patient autonomy (Mazer *et al.*, 2014). This claim was not explicitly present in the data, and instead was offered as a speculative comment.

2.7.2.2 Emotional support

Emotional support was described in three studies, labelled as moral supporter; counsellor; and confidant (Nanton *et al.*, 2010; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Bergner *et al.*, 2017). All three studies adopted a qualitative approach, drawing on retrospective accounts elicited from topic guides. Crucially, in the two studies where these guides were made available, it was evident that questions were leading, with preferences for certain responses. For example, one study guide elicited the "benefits" of partner involvement (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). These studies reported that patients placed value upon their partner's emotional support, noting that it encouraged them to express themselves (Bergner *et al.*, 2017). Emotional support was also described as not necessarily enacted through talk, and that 'being there' for the patient was often sufficient (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). In one study where patients and partners recalled their experience, partners described how they downplayed the impact of cancer, offering positive appraisals to protect the patient from the uncertainties of their diagnosis (Nanton *et al.*, 2010). For example, partners actively normalised their life with the patient, talking of 'setting aside' their own emotions for the patient's sake. Combined, these findings suggest that patients value their partners' emotional support, while also showing that it is of value to the partner. However, these findings should be interpreted cautiously due to the data collection methods.

2.7.2.3 Informational support

Informational support was described in nine studies using several terms including reporter; secretary; and information manager (Beisecker *et al.*, 1996; Rees and Bath, 2000; Srirangam *et al.*, 2003; Sinfield *et al.*, 2008; Jansen *et al.*, 2010; Nanton *et al.*, 2010; Cordella, 2011; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016). These descriptions were present in five qualitative studies (Sinfield *et al.*, 2008; Nanton *et al.*, 2010; Cordella, 2011; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016), and four quantitative studies (Beisecker *et al.*, 1996; Rees and Bath, 2000; Srirangam *et al.*, 2003; Jansen *et al.*, 2010). All but one of these studies used retrospective accounts elicited from interviews or surveys. In these studies, participants placed value on partners' support in sourcing information before the consultation, providing medical history during the encounter, or helping the patient to understand medical terms (Beisecker *et al.*, 1996; Rees and Bath, 2000; Srirangam *et al.*, 2003; Sinfield *et al.*, 2008; Cordella, 2011; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016). In one study, when partners were asked about their roles during the consultation, they described activities including keeping a history of the patient's health, and recording anything they saw as important to the patient's condition (Nanton *et al.*, 2010). Communication in medical encounters regularly involves taking a medical history (Heritage and Maynard, 2006b). In supporting the patient, partners can become integral in this process as couples can co-produce the narrative. One study into the role of partners, demonstrated that their presence led to a statistically significant increase in recall when compared to the recall of patients who attended alone (Jansen *et al.*, 2010). In this, informational support is not only valued by patients, but can benefit patients, partners, and healthcare professionals.

2.7.2.4 Practical support

Practical support was described in three studies, including descriptors such as coordinator; carer; and financial assistant; (Beisecker *et al.*, 1996; Nanton *et al.*, 2010; Cordella, 2011). Two studies adopted a qualitative approach, with a third taking a quantitative approach (Beisecker *et al.*, 1996). All but one of these studies made use of retrospective interviews that were undertaken up to two years after the consultation, introducing a risk of recall bias. Practical support related to how partners described their involvement in the daily aspects of the patient's life, such as scheduling appointments, encouraging positive behaviours, providing transportation, and managing medication. Practical support was considered by partners as important to patients' wellbeing (Cordella, 2011), with many partners becoming carers in an official capacity, as defined by the NHS (NHS England, 2018).

2.7.3 Psychosocial, and sexual concerns

Psychosocial, and sexual concerns were identified in seven studies (Davison *et al.*, 2002; Forbat *et al.*, 2012; Hack *et al.*, 2012; Ussher *et al.*, 2013; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Primeau, Paterson and Nabi, 2017; Gietel-Habets *et al.*, 2018) with all but one of these studies treating **these** concerns as interrelated (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). One study adopted a quantitative approach, using fixed surveys and questionnaires (Davison *et al.*, 2002). Four studies adopted a qualitative approach (Forbat *et al.*, 2012; Ussher *et al.*, 2013; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Primeau, Paterson and Nabi, 2017), while two adopted a mixed methods approach (Hack *et al.*, 2012; Gietel-Habets *et al.*, 2018). Of the mixed methods studies, one study applied qualitative coding to observations followed by a quantitative analysis of coded units (Hack *et al.*, 2012), and the other collected qualitative data using focus groups, and performed a statistical analysis of fixed response questionnaires (Gietel-Habets *et al.*, 2018). Critically, the focus groups took place up to three years after the consultation, making responses susceptible to recall bias. Moreover, the fixed-response surveys were informed by the focus groups, constraining the scope of the survey.

Studies approached this topic two ways; the extent to which these topics should be discussed (Davison *et al.*, 2002; Ussher *et al.*, 2013; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Gietel-Habets *et al.*, 2018), and the extent to which these topics are discussed (Forbat *et al.*, 2012; Hack *et al.*, 2012; Ussher *et al.*, 2013; Primeau, Paterson and Nabi, 2017; Gietel-Habets *et al.*, 2018). It is important to note that most of these studies took place in the context of prostate cancer, involving only male patients, and female partners (Davison *et al.*, 2009; Forbat *et al.*, 2012; Hack *et al.*, 2012; Primeau, Paterson and Nabi, 2017), with only one study reversing this configuration (Gietel-Habets *et al.*, 2018). This bias should be acknowledged as limiting the scope of this research**.**

2.7.3.1 The need for psychosocial and sexual support

Four studies described the importance of discussing the psychosocial and sexual impact of cancer (Davison *et al.*, 2002; Ussher *et al.*, 2013; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Gietel-Habets *et al.*, 2018). They described the challenges that couples faced throughout the cancer experience, with couples expressing a desire for psychosocial and sexual support. These studies elicited responses from patients, partners, and healthcare professionals using interviews, focus groups, and questionnaires designed to examine the extent to which participants expected such support to be offered. The need for psychosocial and sexual support was further underlined by studies that described how the sexual impact of cancer could have implications for both masculine and feminine identities (Forbat *et al.*, 2012; Ussher *et al.*, 2013; Primeau, Paterson and Nabi, 2017), in which concerns relating to body image impacted directly upon patients' sexuality (Ussher *et al.*, 2013; Primeau, Paterson and Nabi, 2017).

In a study of couples with hereditary breast and ovarian cancer, it was reported that 61% of participants considered that psychological support should be offered as standard practice with a further 17% of participants expressing that it should be an obligatory provision (Gietel-Habets *et al.*, 2018). This sentiment was echoed in a separate study that examined the experiences of partners during oncology consultations. The participants reported that they would have benefited from psychological support, adding that they felt unable to discuss sexuality during the encounter (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016).

In a study involving only healthcare professionals, participants were asked to talk about their attitudes towards discussing sex during consultations. They considered that sex needs to be discussed routinely during cancer consultations (Ussher *et al.*, 2013). In this study, participants noted how physical changes to the patient had implications for the sexual wellbeing of couples. Healthcare professionals largely constructed their talk relating to sexual concerns in biomedical terms, relating sexuality to a constrained concept of physical functions.

2.7.3.2 Psychosocial and sexual support in consultations

Five studies examined the extent to which psychosocial and sexual concerns were discussed during consultations (Forbat *et al.*, 2012; Hack *et al.*, 2012; Ussher *et al.*, 2013; Primeau, Paterson and Nabi, 2017; Gietel-Habets *et al.*, 2018). The studies indicated that psychosocial and sexual concerns were not discussed routinely. This contrasts with studies indicating consensus among patients, partners, and healthcare professionals relating to the need for such discussions (Davison *et al.*, 2002; Ussher *et al.*, 2013; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Gietel-Habets *et al.*, 2018). Despite recognising this need, these studies indicated that this topic was rarely raised by healthcare professionals, and was reported as an unmet need by couples (Forbat *et al.*, 2012; Hack *et al.*, 2012; Primeau, Paterson and Nabi, 2017; Gietel-Habets *et al.*, 2018). One study into prostate cancer consultations underlined this by demonstrating that talk relating to psychosocial concerns made up only 5.9% of all consultation talk (Hack *et al.*, 2012). Most noteworthy were the findings from the study involving only healthcare professionals (Ussher *et al.*, 2013). Despite taking the position that discussions around sex should be routine, participants in this study also took a contradictory position, stating that they rarely discussed sex during the consultation. They justified this by claiming they lacked the necessary training, and that the topic was inapposite, arguing that it may embarrass couples. Additionally, they drew upon institutional boundaries, stating that it was not their job, noting that it should be discussed elsewhere, such as with a clinical psychologist. When considering these findings, it becomes apparent that there is a need for psychosocial and sexual support to be provided prior to treatment, and that patients and partners believe that they would benefit from this. Correspondingly, while healthcare professionals also believe this, they do not consider themselves equipped to fulfil this need. Consequently, it is a topic that receives insufficient attention.

2.7.4 Satisfaction with the encounter

Four studies attempted to measure satisfaction with the consultation (Zeliadt and Penson, 2011; Hack *et al.*, 2012; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Primeau, Paterson and Nabi, 2017). The extent of partner involvement, the roles they assume, and the extent to which psychosocial and sexual concerns are discussed in consultation were considered in relation to patient and partner reports of satisfaction with the encounter.

Two studies adopted a qualitative approach (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Primeau, Paterson and Nabi, 2017), one employed mixed methods (Hack *et al.*, 2012), and one used a quantitative approach that relied upon post-consultation survey responses (Zeliadt and Penson, 2011). While these were typically collected shortly after the experience (up to six months after), the fixed responses of the surveys limited the findings. A single study used recordings from direct observations (Hack *et al.*, 2012), while three relied upon retrospective responses (Zeliadt and Penson, 2011; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Primeau, Paterson and Nabi, 2017). In measuring satisfaction, two studies measured patient satisfaction (Hack *et al.*, 2012; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016), one study measured partner satisfaction (Zeliadt and Penson, 2011), and one measured patient and partner satisfaction (Primeau, Paterson and Nabi, 2017).

2.7.4.1 Partner involvement and satisfaction

Two studies considered how the extent of partner involvement in the consultation related to reports of satisfaction (Zeliadt and Penson, 2011; Hack *et al.*, 2012). Studies measured satisfaction using post-consultation surveys and interviews. No reliable association was reported between partner involvement and post-consultation reports of satisfaction. One study reported an inverse association between post-consultation reports of satisfaction and partner assertiveness as measured by a patient survey, completed within minutes of the consultation. However, this effect did not persist over time, with no association between the two measures after twelve weeks (Hack *et al.*, 2012). This stands in contrast to qualitative research reporting that partners' participation in the consultation led to positive evaluations from couples afterwards, as their involvement gave partners a sense of purpose during times when they typically 'felt helpless' (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016).

2.7.4.2 Partner roles and satisfaction

One study discussed partners' roles in relation to patient and partner satisfaction (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016). It reported that informational, and emotional support roles taken on by partners were valued by patients and partners. Patients reported that their partners' emotional support gave them strength and comfort, and that this emotional support could be expressed both verbally, and through non-verbal actions such as hand holding or just ‘being there’. The role of advocate was also evaluated as having a positive impact upon patients’ experiences of the encounter, as patients endorsed this role while reflecting upon their experience (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016).

2.7.4.3 Psychosocial, sexual concerns and satisfaction

While several studies noted the extent to which these topics were covered during consultations (Forbat *et al.*, 2012; Hack *et al.*, 2012; Ussher *et al.*, 2013; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Primeau, Paterson and Nabi, 2017; Gietel-Habets *et al.*, 2018), only one study examined the association between the extent of psychosocial and sexual discussion, and reports of post-consultation satisfaction (Primeau, Paterson and Nabi, 2017). In this study, that happened to be the only randomised control trial, a ‘treatment as usual’ group was compared against an intervention-based group where couples attended a seminar in which the psychosocial and sexual impact of cancer was discussed. The half-day seminar covered topics such as managing emotions, psychological impact, and sexual dysfunction. Outcomes were measured by comparing interview responses. The intervention group reported high levels of satisfaction with the intervention and reported significantly fewer unmet needs post-consultation. It is important to note that this was reported through interview questions directed only towards the intervention group, with questions explicitly requesting evaluations of the intervention. Participants were also aware that this was something ‘over and above’ treatment as usual. This is of methodological concern, as equipoise was not maintained, which is essential in delivering a randomised control trial.

2.8 Discussion and conclusion

2.8.1 Discussion

This paper reviews the available research into partner involvement in oncology clinical consultations. The identified studies described the extent of partner involvement, the reported roles of partners, the prevalence of psychosocial and sexual discussion, and how these three themes might relate to reports of participant satisfaction.

The studies in this review indicate that partner involvement during oncology consultations is valued by patients. Although findings suggest partner involvement was typically low, there is a shared preference reported by patients and partners for partner involvement. Research in this area has offered insight by quantifying partner involvement during consultations, and eliciting patient and partner attitudes in relation to partner involvement. Research has yet to examine more qualitatively, what partners accomplish during consultations, when they contribute, and how their contributions impact upon the interactional trajectory. Such research may allow for the development of a participatory framework in which patient and partner expectations relating to partner involvement can be elicited and managed by healthcare professionals.

Likewise, the ways that partners might support patients during the consultation has been studied extensively. However, the support roles of advocacy, practical, informational, and emotional support can be argued to also relate to the category-bound support activities that romantic couples are expected to provide across all contexts (Schegloff, 2007). This underlines how romantic partners differ from non-romantic partners. Romantic couples share a degree of physical, psychological, and emotional intimacy that is typically not present in non-romantic relationships. They are likely to cohabit and therefore, spend more time together, share more of their lives, and are likely to co-experience disease in unique ways. It is therefore of concern that this review has highlighted a disconnect between the need for psychosocial and sexual support, and the prevalence of such support during consultations. With the prevailing assumption that sexuality and genitourinary concerns remain social taboos (Ussher *et al.*, 2013; Huber *et al.*, 2016), it is apparent that research needs to develop communicative frameworks that seek to normalise these topics, challenging the normative assumptions of healthcare professionals in relation to sex, intimacy, and age (Ussher *et al.*, 2013). In the research by Laidsaar-Powell and colleagues, one spouse noted,

> *"We've been married for 50 years and we feel that we are a 'twosome', We don't really do things individually. Where there is suffering involved, we'd rather be in it together"* (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016).

The research identified by this review offered relatively little insight into the experiences of the cancer couple. Accordingly, an in-depth exploration of the unique ways that cancer can impact romantic couples is beyond the scope of this review. However, this should be considered as topic for future research.

As an overarching concern to this review, the findings in many of these studies have methodological limitations that necessitate discussion. These limitations could not be highlighted by the Qualsyst calculation, underlining the limitations of this tool.

2.8.1.1 Sampling strategies and statistics

In statistics, there are practices to ensure that analyses offer a good explanation of observations, such as a power calculation for sample sizes (Field, 2013a), evaluating the distribution of results to ensure an appropriate analysis (Field, 2013c), and evaluating statistical models to assess how well they explain findings (Field, 2013b). These procedures were notably absent in the reporting of all quantitative studies in this review, apart from one study that evaluated a model of associations between sociodemographic factors, and post-consultation satisfaction. The low model evaluation scores, combined with findings that were short of statistical significance underlined that the model offered little explanatory value (Hack *et al.*, 2012). Statistical tests intended to explore associations between partner involvement and sociodemographic variables such as marital status and education, were performed on samples as low as 18 (Beisecker *et al.*, 1996), introducing potential for statistical errors. Additionally, effect sizes were absent in all statistical reporting. Several studies also reported statistics that did not reach statistical significance as ‘trends’ (Jansen *et al.*, 2010; Hack *et al.*, 2012; Gietel-Habets *et al.*, 2018).

2.8.1.2 Emphasis upon retrospective accounts

While five studies examined consultations directly (Cordella, 2011; Forbat *et al.*, 2012; Hack *et al.*, 2012; Mazer *et al.*, 2014; Huber *et al.*, 2016), they were typically constrained in scope, with content-driven focus such as share of talk (Hack *et al.*, 2012; Huber *et al.*, 2016), partner roles (Cordella, 2011; Mazer *et al.*, 2014), or prevalence of key consultation topics (Forbat *et al.*, 2012). Retrospective accounts were used in thirteen studies (Beisecker *et al.*, 1996; Rees and Bath, 2000; Davison *et al.*, 2002; Srirangam *et al.*, 2003; Sinfield *et al.*, 2008; Jansen *et al.*, 2010; Nanton *et al.*, 2010; Zeliadt and Penson, 2011; Ussher *et al.*, 2013; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Le *et al.*, 2016; Primeau, Paterson and Nabi, 2017; Gietel-Habets *et al.*, 2018). While these methods are used frequently in social sciences (Maynard and Schaeffer, 2006; Wooffitt and Widdicombe, 2006), they can introduce several limitations relating to recall bias, social desirability bias, and the impact of interview questions. Such biases might lead to an under-representation of negative experiences, particularly in research where there may be an implied evaluation of the couples' relationship (Goffman, 1990b). Accordingly, findings from these accounts should be interpreted with caution.

In studies using retrospective accounts, participants were asked to reflect upon experiences that occurred up to three years earlier (Beisecker *et al.*, 1996; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Gietel-Habets *et al.*, 2018), and in one study, up to ten years earlier (Rees and Bath, 2000). No study offered justification for this. It is inevitable that participants would not recall events accurately. Instead, interview questions would have made salient certain concepts, leading to reconstructions of events affected by recall bias (Althubaiti, 2016). Related to this is the social desirability bias; a desire for participants to present a favourable impression as they are asked to give an account of their experiences, and by extension, themselves (Wooffitt and Widdicombe, 2006). In this, participants manage their self-presentation to create a favourable impression (Potter and Wetherell, 1987; Goffman, 1990b; Horton-Solway, 2001). Asking couples about their joint activities implicitly asks them to evaluate their relationship (Goffman, 1990b). Notably, there were few reports of any adverse effects of partner involvement, indicating that responses were influenced by this bias. Related to this is the understanding that carrying out research interviews or surveys proceeds as a joint activity, in which questions can affect responses (Mishler, 1986). The way questions are framed, elaborated, or re-phrased is important (Wooffitt and Widdicombe, 2006). This was highlighted when examining available interview schedules. In one study, separate interview schedules were prepared for different groups, and then responses compared (Primeau, Paterson and Nabi, 2017). In another, the generated themes could be located by examining the interview and research questions (Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016), underlining the production of meaning as a collaborative activity. When considered together, the limitations of recall bias, social desirability bias, and the influence of interview questions limit the findings produced from retrospective accounts.

2.9 Conclusion

Of the studies relating to partner involvement during oncology consultations, there is a tendency towards describing aspects of involvement rather than explaining them. This review suggests that patients value their partners being involved in oncology consultations, indicating that partners that provide advocacy, and practical, informational, and emotional support are valued. However, the emphasis and reliance upon participant recall also means the factors that influence partner involvement, such as how they come to be involved, when this involvement occurs, and the impact it has upon the consultation have yet to be examined.

2.10 Practice implications

It is evident that partners want to contribute during oncology consultations. Likewise, it is evident that these consultations will necessitate addressing the patient and partner as a couple. Research to date has examined the extent of partner involvement, the role of partners, and the prevalence of psychosocial and sexual support discussions in oncology consultations. However, it has over-emphasised participants’ reflections. The current research does not offer an exploration of the social practices and conversational actions enacted during these encounters. Observational, micro-analytical approaches can identify what partners accomplish during consultations, when they contribute, and how their contributions impact upon the consultation. Such approaches may allow for the development of a participatory framework in which patient and partner expectations relating to partner involvement can be elicited and managed.

Declarations of interest

None

Acknowledgements

The lead author would like to acknowledge the support they have received from the ESRC South Coast Doctoral Training Partnership. Additionally, they would like to acknowledge the guidance and mentorship of Dr Mike Bracher who offered support and advice for the development of the coding framework for this review.

Funding

The lead author was funded and supported by the Economic and Social Research Council South Coast Doctoral Training Partnership, Ref: ES/J500161/1

2.11 Chapter Discussion

One of the key messages from this narrative review is that there are limitations inherent to asking any participants to reflect on past experiences, and these limitations are equally relevant when asking couples to reflect on their experiences and activities, especially if a substantial period of time has elapsed. It can be argued that to better understand the consultation experience comprising a healthcare professional, patient, and their romantic partner, a method that makes use of data recorded directly from this setting can serve to offer valuable insights that are otherwise inaccessible through methods reliant upon data from retrospective accounts.

The research within this review indicates that, in oncology settings, patients and their partners have both a desire and expectation to share all aspects of a cancer journey as a couple, including any clinical encounters that are involved. To that end, the analytical chapters in this thesis focus on a corpus of data recorded from treatment and diagnosis consultations in the context of low or intermediate risk localised prostate cancer, where each consultation comprises a healthcare professional, the patient, and their co-present partner. Ahead of these chapters, the next chapter offers an outline and description of conversation analysis as the chosen analytical approach to this research.

Chapter 3 Methodology and Methods

3.1 Introduction

This chapter offers a detailed description of the methodology and methods involved in carrying out this research. This chapter outlines the key features, principles, and assumptions that serve as the foundations of conversation analysis, while explaining why this approach to analysis was chosen over some analytic methods. In addition to outlining how this research is part of a wider research project, this chapter describes how the data were collected, describes key aspects of the consultations, how participants were selected and recruited, and explains how the dataset was produced for this research. This chapter closes by outlining the key ethical considerations that were addressed during this research.

3.2 Methodology

3.2.1 Chosen method: Conversation Analysis

Conversation analysis is a qualitative approach that is used to examine every day social interactions (Stivers and Sidnell, 2013). By making use of data recorded directly from the site of activity, including both video and audio recordings, conversation analysis has the potential to offer a systematic analysis of the conversational practices enacted, and the resultant accomplished social actions that occur during the triadic clinical encounter; that is to say, what is being done through talk. The use of conversation analysis upon encounters comprising a patient, partner, and healthcare professional can arguably overcome the limitations inherent to the more rigid, gross categorisation of consultations, and the reliance upon eliciting retrospective accounts from participants. The overarching goal of conversation analysis is to discern the regularities that exist within, and across different conversation types, and to understand how everyday social activities such as invitations, refusals, assessments, and others are accomplished by participants, and how these have implications for the overall organisation of the conversation.

The corpus of data for this thesis was analysed according to the principles of conversation analysis (CA). As a qualitative method, CA can examine both the granular, and broader aspects of naturally occurring interactions. It is used to examine how people within a given conversation accomplish everyday social actions through talk, allowing for an analysis into the regularities of these social actions as situated both within, and across contexts. In the case of this research, CA is employed to examine the conversational practices that occur during consultations comprising a patient, their partner, and a healthcare professional during clinical consultations for men with localised prostate cancer. In particular, it is used to examine the ways that partners come to take part in the conversation, and the processes that might serve to facilitate or otherwise inhibit partner involvement.

In the study of naturally occurring and institutionalised interactions, CA is based upon a set of assumptions relating to everyday social actions, with conversation being an element of social action that is considered to be nearly ubiquitous across all aspects of social life. CA can be applied to everyday interactions such as chatting with friends, talk with work colleagues, or more structured, institutional talk such as job interviews, or medical appointments. This ubiquity of talk is what led to the consideration in CA that talk is the 'primordial site of organised social life' (Schegloff, 1992). CA is based upon the theoretical understanding of talk during conversations and in interactions as orderly, structured, and a product of shared social practices to which all participants attend. It is argued that in everyday conversation, there is "order at all points", which is what enables its systematic empirical investigation (Sacks, 1992, p. 484). This assumption stands in contrast from earlier impressions of conversation as too chaotic to be subjected to any empirical enquiry (ten Have, 2006). Indeed, prior to the development of CA, the prevailing belief was that ordinary conversations were too unstructured to allow for systematic empirical study (Chomsky, 1965). The primary objective of CA is to discern the regularities, procedures, and practices that might serve as the foundations of social actions in conversation, while identifying the interactional consequences that might follow certain social actions (Drew, Chatwin and Collins, 2000).

3.2.2 **Development of CA**

Although CA is considered to be a relatively new, albeit burgeoning method for analysing social interactions, its development began in the 1960s and was influenced by the work of Sociologists Harold Garfinkel, and Erving Goffman. Garfinkel's concept of "ethnomethods" or "members' methods" describes the taken-for-granted knowledge resources that all parties use to accomplish everyday social actions (Garfinkel, 1967). Garfinkel considered how the social organisation of everyday activities related to the accomplishment of practical reasoning and actions, arguing that members' methods were drawn upon to construct a stable social world, and used to navigate everyday social interactions. Goffman brought attention to the importance of analysing interactions as socially organised phenomena that should be studied independently from the people who are interacting (Goffman, 1983). Goffman described the procedures that underlie the ability to take part in meaningful discourse as "the greasy parts of speech"; that is to say, the mechanisms that allow these actions to occur and function as intended by members (Goffman, 1964). Goffman's concept of the "Interaction Order" (Goffman, 1983) can be seen as a key influence in the development of CA as an analysis of interaction sequences where each speaker's turn is conceptualised as an action that is an interactive product of what was seen to have been accomplished by the previous speaker's turn (Drew and Heritage, 1992).

The three people who are widely regarded to be the founders of CA as it is understood today are Harvey Sacks, Emanuel Schegloff, and Gail Jefferson. Together, they sought to develop ways of analysing the socially organised structures underpinning social interactions. The goal of this was to develop a method that could describe and explain the ways that social practices, and actions are constructed in conversations, as well as how these practices shape interactions (Stivers and Sidnell, 2013). Accordingly, it was argued to be of critical importance that the data used were recordings of naturally occurring interactions such as conversations among family members, or friends. This included face-to-face interactions, and telephone calls. Both video and audio data have been used in the development and application of CA. For example, Sacks used audio-recordings of calls to an emergency psychiatric helpline to demonstrate how speakers could, by implication, elicit a caller's name by offering their own name first ("This is Mr Smith, may I help you?") (Sacks, 1992, p. 6). The same work also demonstrated how speakers could employ rhetorical devices to refuse this implicit request by using what was described as a "skip move" as callers stated that they could not hear this implicit request. As an exemplar, this demonstrates how CA can serve to elucidate the intended function of an utterance beyond its grammar and syntax, and instead, it can offer an analysis of the social actions accomplished through talk.

CA makes use of audio or video recordings of naturally occurring interactions. CA has also been applied to institutionalised interactions such as medical appointments and work-focussed interviews (Heritage and Maynard, 2006b; Robinson, 2006b; Toerien *et al.*, 2013). Using audio and video recordings allows for direct observation of these interactions, and for a detailed analysis of the social processes that occur throughout. In this respect, the analytic emphasis is not constrained to the meanings constructed, but also allows for a systematic analysis of how talk is produced, and how it is received. This method of analysis requires an acknowledgement of speech elements such as pitch, volume, emphases, pauses, overlapping talk, and so on. To that end, these elements must be rendered as accessible and analysable. In analysis, CA proceeds with the assumption that “no order of detail in interaction can be dismissed *a priori* as disorderly, accidental, or irrelevant” (Heritage, 1984b, p. 241).

In order to apply CA to audio or video recordings, it must first be prepared for analysis. This includes the production of a transcripts that serve to facilitate the detailed examination of the talk being analysed. Such detailed transcript renders systematically the orders of interaction relating to temporal and sequential organisation of talk, verbal, and non-verbal elements, pauses, hesitations, partially completed words, and so on. A transcription convention was developed by Gail Jefferson which uses a selection of symbols that denote these elements of interaction (Jefferson, 2004). The use of a standardised transcription convention is a useful aid for the analysis of interactions that attends to the production and recognition of meaningful social actions contained within a given interaction. Examples include the ways that an invitation can be designed, how it is accepted, and how it is declined. However, it is important to note that the analysis is always performed on the data, and not the transcripts.

3.2.3 **Key Concepts**

The development of CA has led to the production of several key concepts that appear to apply to most conversational situations. It is important to stress that while these concepts are present in most interactions, they typically serve only as an entry point to analysis. A key principle of CA is that analyses develop as inductively as possible. That is to say that the data are examined absent of *a priori* assumptions about it. This is often referred to as “unmotivated looking” (Walker, 2013, p. 456), where data are tended to more directly, with analyses less reliant on pre-formed theoretical models or hypotheses. This has led to the production of key practices and concepts that are present across most conversational situations:

1. **Turn design and turn-taking:** During everyday conversation, talk proceeds interactively, and is a product of the dynamic between what a speaker accomplishes during their turn to speak, and what the other speaker did during the previous turn. These turns at-talk are shaped by what has come before them, and also shape what is to come next. Accordingly, turns-at-talk have been described as both context shaped, and context renewing (Heritage, 1984b, p. 242). In this respect, turns in a conversation are designed to accomplish something at the given point in the conversation. The successful intended accomplishment of a turn-at-talk requires intersubjectivity between the speakers; the recipient of a turn must understand the turn as it was initially designed to be understood. For example, turns can be designed to accomplish a transition to a new topic in the conversation (for example, “Oh! While I remember”, “Anyway…”, “Speaking of which”). Turns can also be designed in relation to their intended recipients, with the same turn formulated differently depending on the relationship between the speaker and the selected recipient (Drew, 2013).
2. **Turn Constructional Units and Transition Relevance Place:** The act of spoken interaction proceeds under the conditions of turn-taking. Typically, this means that each party in a conversation takes their turn, and the conversation normally proceeds with turns-at-talk restricted to one speaker at a time. Turn-taking in conversation requires an act of coordination among speakers. The management of this act relies on particular indicators that signpost the end of a turn, and project possible points where a turn is due to come to an end. The Turn Constructional Unit (TCU) is a turn-at-talk that can be recognised as “possibly complete” (Clayman, 2013). A full turn is typically built from a number of TCUs; however, the completion of a TCU usually brings about a Transition Relevance Place (TRP). This is the place in a turn where the possibility exists that a turn is about to come to an end, providing an opportunity for a change of speaker. The completion of a turn can be

made salient through changes in prosody, emphases, or the final syllable in a turn. Additionally, speakers may act to prevent yielding their turn through the interjection of filler particles to indicate the intent to continue a turn (retaining the floor).

3. **Sequence organisation:** Turns-at-talk occur sequentially, with TCUs built collaboratively to form sequences in conversation. The organisation of these sequences demonstrates the impact that one turn can have upon the next in what Sacks described as the concept of 'nextness' (Sacks, 1987). An example of this sequence organisation is the concept of the adjacency pair (Drew, 2013). This is where a turn-at-talk (a first pair part) warrants a particular type of response (the second pair part). This could be an invitation followed by a response, a pair of greetings, or a summons and a response (Stivers, 2012). Sequences such as adjacency pairs can also be expanded. For example, a pre-expansion can signpost the initiation of the first part of an adjacency pair, while an insert-expansion might be used to seek clarification or further information in relation to the first pair part. Post-expansions can serve to indicate the acceptability of the previous turn, they can also allow for a sequence to be closed, or further expanded (*ibid*).
4. **Social action:** One of the primary goals of CA is to outline and explain the accomplishment of social actions that occur during talk. Social actions relate to what is being 'done' when people take turns-at-talk (Sacks, 1984). Social actions can include requests, information provision, agreement, disagreements, offers, refusals, and so on. It can be argued that social actions are important, as the performance of a particular social action can in turn, constrain the next turn to that which is conditionally relevant to the prior. It can be further argued that the absence of any conditionally relevant, and typically expected next turn can have consequences for the trajectory of the interaction, making the analysis of social actions fundamental to the enterprise of CA (Stivers, 2012). Research has shown that the ways that healthcare professionals solicit concerns can be in or out of alignment with the patient's expectations, with misalignment having consequences for the trajectory of the encounter (Robinson, 2006b).
5. **Preference organisation:** This concept relates to the design of turns that implicitly construct a preference regarding the information they convey, or the normatively expected responses (Pomerantz and

Heritage, 2013). The study of preference organisation has led to the understanding of how rejections of requests are performed, and how requests can be designed to minimise rejection (Pomerantz and Heritage, 2013). This organisation of responses that conform to the preference organisation of turns-at-talk has been demonstrated to be a shared social action as speakers orient to the preference in both initiating turns and their responding turns. For example, confirming responses to invitations are typically produced by a speaker without delay, and are designed in a manner that demonstrates alignment with the speaker who initiated the invitation. Conversely, a rejection of an invitation is typically performed with a delay to the start of the response, and the rejection is typically cushioned between a preface to, and an account for the rejection (Sacks, 1987). In these alternatives, both speakers can be seen to orient these actions relative to a socially organised preference. The delay that precedes a rejection or disconfirming response tends to be understood well enough by speakers that they can use it to reorient their turn so that the rejection or disconfirming response becomes more permissible.

6. **Repair:** The concept of intersubjectivity is what is said to enable conversations to continue as coordinated social actions (Heritage, 1984b), and while conversations typically operate this way, with each party oriented towards the goal of conversation maintenance, there will inevitably be occasions where the ongoing intersubjectivity of a conversation becomes problematic in some way. Repair is a concept whereby a speaker attempts to address a possible problem within produced talk. This could be to address a problem produced by speaker themselves, or another party (Schegloff, Jefferson and Sacks, 1977). In self-initiated repair, a speaker may cut off from what they are saying at any point of a turn-at-talk to correct course, or to offer a more reformulation of the initial turn. This reformulation of the turn, within the turn demonstrates that the speaker has reflexively identified an inadequacy of their turn relative to what the receiver might understand, and adapts it within the same turn-at-talk. (Kitzinger, 2013) Likewise, a speaker might elect to self-repair at the end of their turn, or they may wait until the end of the next turn to self-initiate a repair about their earlier turn (Schegloff, 1992). Repair sequences can be considered as a troubleshooting system within conversation, where the progressivity of

an interaction is placed on hold while a trouble source is addressed, prior to the resumption of the normative progress of the interaction (Kitzinger, 2013). It has been argued that in the organisation of repair, there is a joint preference for self-repair, with certain types of other-initiated requests for repair typically leading to awkwardness in a conversation, and rarely producing a genuine repair solution (Schegloff, Jefferson and Sacks, 1977). When others initiate repair, it is typically produced in a manner that gives the speaker the opportunity to clarify or otherwise correct the course of the conversation (Kitzinger, 2013). This initiation can range from the affordance of an opportunity for the speaker to reformulate the previous turn, can offer an indication as to the potential problematic area, or can offer a candidate solution to the area in need of repair (Schegloff, Jefferson and Sacks, 1977). Repair is therefore an important aspect of conversation as it is one of the “greasy parts” of speech that allow for continued intersubjectivity, preventing the interaction from breaking down prior to its intended conclusion (*ibid*).

3.2.4 **Choosing Conversation Analysis**

CA was chosen as it is an approach that could examine more closely the conversational actions of partners during clinical consultations for men with localised prostate cancer. Specifically, CA was chosen as a method that could be applied to data produced from direct observation of the consultation, where these social actions are organised, constructed, and available for analysis. This approach was chosen over such as sociological ethnography discourse analysis as outlined in this chapter, as well as other approaches that typically rely on participants to offer retrospective accounts of their experience, which were considered as inadequate for this research. It is argued that while members within a conversation are typically competent to attend to the social practices and norms involved in navigating ordinary conversation, they are far less likely to be able to reflect upon these acts in order to describe them (Sidnell, 2013). In this respect, members can be described as typically capable in the use of these methods, but not necessarily aware of how they use them. Accordingly, alternative research methods, such as research interviews would have been problematic as they would have required the participants to reflect upon an experience that is not necessarily accessible to them through the act of remembering. Previous research into partner involvement has relied heavily upon the use of retrospective accounts to learn more about companion and partner involvement in clinical consultations, and while this research has made valuable contributions to knowledge in this topic, it is unable to access the social actions that are understood to be carried out without members being conscious of these acts. Moreover, the act of remembering, which is what is being asked of participants during research interviews, can be argued to be accomplished through its own constructions, attributions, and formulations to achieve particular social actions such as giving a favourable account of the events under investigation (Horton-Solway, 2001). By carrying out an observation and analysis of the site where these social actions were performed, this research can access a level of understanding that is not possible through retrospective accounts. However, it is important to note that CA is not the only approach that can make use of data drawn from direct observations. Accordingly, there is value in considering briefly, a selection of approaches that also draw upon observational data in their analyses.

3.2.5 **Sociological Ethnography**

This approach can be considered as influential in the development of CA due to its concerns with making use of observations to examine the mundane regularities of everyday life, and can be seen to have inspired CA concepts such as turn-taking (Stivers and Sidnell, 2013). As an approach to clinical communication, ethnography can be employed to examine the meaningful, situated social actions that are accomplished within a specific context, and has been considered as a useful approach to better understand decisions in healthcare (Goodson and Vassar, 2011). Within the context of prostate cancer, a non-participant ethnographic study sought to examine the experience of patients while discussing the sexual consequences of treatment This ethnographic observation led to the production and analysis of field notes that enabled the researchers to describe the ways that psychosexual concerns were raised, and how infrequently they were discussed (Forbat *et al.*, 2012). However, this approach meant that a systematic measurement of how social actions relating to psychosexual concerns, such as turn design, and sequential organisation was not possible. Indeed, any approach that does not make use of recordings cannot allow for an analysis at such a granular level that is required for this research. Recordings enable such detailed analyses through repeated observations of the data, whereas by contrast, it is impossible for any observations recorded by way of field notes to capture all aspects of an interaction due to inherent limitations of the method of data collection (Heritage and Stivers, 2012). Accordingly, ethnography is not well-equipped to answer the research questions being asked in this thesis.

3.2.6 **Discourse Analysis**

As an approach to that examines the construction and use of language, Discourse Analysis (DA) can be seen to have been influenced by CA, and has indeed incorporated several of its characteristics (Potter and Wetherell, 1987). DA differs from CA in its typically ‘top-down’ approach to analysis. That is to say that it examines how broad, sociocultural knowledges are drawn upon by individuals to construct and navigate everyday social life. For example, it can identify the discourses that people draw upon to account for their actions and decisions (Wetherell, 1998). DA can be applied to healthcare settings in a similar way to CA, offering an analysis of clinical communication through direct observation of the interaction. It can be used to examine the ways that the doctor-patient relationship is constructed in terms of relational dynamics, the everyday discourses drawn upon to make sense of health matters, and how sociocultural norms might shape the healthcare encounter (Lupton, 1992). DA has been applied to several areas of healthcare communication (e.g. Miller and Silverman, 1995; Horton-Solway, 2001; Cordella, 2011). In a study that examined constructions of sexuality after cancer in Australia, DA outlined the contradictory ways that healthcare professionals constructed sexual communication with patients (Ussher *et al.*, 2013). They constructed the sexual impact of cancer as a legitimate and necessary topic, while taking up the position that the topic was inapposite during consultation. Noteworthy was that the majority of healthcare professionals who accounted for their reluctance to discuss sex with their patients, cited situational factors for their apparent failure to raise the topic, while a minority of healthcare professionals who claimed success in this area, cited dispositional qualities for this success. In this respect, DA was able to examine the construction of causal attributions as applied to the context of sexual communication during consultations.

As an approach that shares similarities with CA, DA was considered carefully for inclusion in this research, as it has the potential to examine the discourses drawn upon by all participants to account for their contributions, and the identities they take up in relation to the encounter. Discourse analysis places emphasis upon the ways that language both constructs and is constructed by sociocultural understandings of the world, and how individuals draw upon these to navigate everyday social interactions. In this respect, the emphasis on such a macro-level analysis means that DA is not best-paced to address the research questions in this thesis, which require an analysis that examines communication at a more granular, or micro-level; the machinery of the conversation, or the ‘greasy’ parts of communication (Goffman, 1983). In this respect, CA has been demonstrated as a reliable method to analyse social actions performed during medical encounters, including the overall structural organisation of these encounters, and how they can be organised into several discrete, yet interrelated sequences, with each sequence having potential implications for the next (Heritage and Maynard, 2006b). For example, Robinson’s research into earlier stages of the medical encounter highlighted how the ways that Physicians solicit concerns from a patient has the ability to influence the trajectory of the consultation through the design of turns as questions that the patient considered as appropriate or inappropriate (Robinson, 2006b). In the event of a question deemed to be inappropriate, the patient would typically initiate repair on the ‘stronger side’ by offering candidate solutions to the perceived breach (Kitzinger, 2013). It can therefore be argued that this level of fine-grained analysis is best accomplished through an observation of the interaction as it happens, and with a method of analysis designed to attend to this micro-level of interaction. Nevertheless, it has been argued that a synthesis of CA and DA might offer a more elegant analysis than either approach can provide separately (Wetherell, 1998). Accordingly, such a synthesis of approaches may be worth considering for future studies.

3.3 Methods

3.3.1 Data collection sites for ‘TrueNTH’ study

Data were collected from four clinical sites in England. The sites for data collection were selected as part of a wider research project, “TrueNTH Decision Support: Understanding Consequences”, to which this thesis contributes. In the wider research project, sites represented varying degrees to which these sites had established a programme of Active Surveillance. The sites were chosen accordingly to assess the impact of a complex intervention upon patient reported outcomes and treatment decisions made during consultations.

The overall aims of the wider project were to help people with prostate cancer, and their families to better understand impact that low and intermediate risk prostate cancer, and its related treatment has on both patients and those who care for them.

The study objectives for the ‘TrueNTH’ study were:

1. To design and evaluate an evidence-based clinical training package that ensures men are fully informed about their treatment options, with information presented in an unbiased manner, while making space to address their beliefs and concerns.
2. To design and evaluate of a complex intervention to improve access to information and preference-sensitive treatment decision support for both the patient and those who care for them.

It is important to acknowledge that the healthcare professionals recruited into this study had some awareness about the main aims of the study, and the overarching interest in the implementation of preference-sensitive decision-making. It is therefore possible that this had some impact upon the collected data.

The TrueNTH study comprised two parts. The first was the development of a complex intervention to improve support for preference-sensitive decision-making. This included the development of training to improve the quality of patient-clinician communication about low and intermediate risk localised prostate cancer. The second was the evaluation of this complex intervention. The intervention was developed at sites 1 and 2 and evaluated at sites 3 and 4. Consultations for this thesis were all collected at the pre-implementation phase of the wider study.

The TrueNTH Understanding Consequences study involved the use of conversation analysis for the following objectives:

1. Inform the development of clinical communication training about low/intermediate risk localised prostate cancer and its treatments
2. Better understand how companions are included during consultations and the consequences of their inclusion or exclusion for the consultations.

This PhD, as part of the primary analysis uses conversation analysis to examine the ways that romantic partners come to contribute to the consultation, the sequential impact of their contributions, and the ways that the configuration of the consultation has implications for the extent to which romantic partners take part in the consultation.

3.3.2 Prostate cancer consultations

The consultations that were collected across these sites were from two consultation types: biopsy results, and treatment information. Treatment information consultations were carried out by urologists, clinical nurse specialists, and oncologists whereas biopsy results consultations were carried out by urologists or clinical nurse specialists.

The primary purpose of the prostate cancer consultation is to ensure that the patient and any companion as appropriate, understand the status of the prostate cancer in terms of diagnosis, grade of cancer, the risk of the cancer spreading, and an understanding of the treatment options available. Additionally, the impact of both the prostate cancer, and the subsequent treatment are to be outlined. The intention is that consultations are configured in a way that helps patients to make informed decisions about their treatment choices.

3.3.3 Recruitment and participants

Participants were recruited to the wider research project “TrueNTH Understanding Consequences”. There were two distinct phases involved in this research, and participants for this research came from both the development and evaluation phases of the primary project, prior to the implementation of the intervention. Potential participants who were expected to receive a diagnosis of low to intermediate risk localised prostate cancer were identified by a Research Nurse. These potential participants were sent an introductory letter informing them that they may be approached by a researcher during their next hospital or clinic visit. Information sheets and consent forms were presented prior to the consultations taking place. For this research, there is an emphasis upon multi party interactions comprising a patient, their partner, and a healthcare professional during prostate cancer consultations. Accordingly, a collection of these consultations was selected upon the basis of the consultation proceeding with a partner present. These consultations were screened to ensure that the companion present was a romantic partner, distinct from a friend or relative.

3.3.4 **Data**

Consultations were audio-recorded, with each consultation comprising a healthcare professional, patient, and partner, and were collected over a period of fourteen months. For the purposes of this research, ‘partners’ relates to romantic partners such as spouses, life-partners, and romantically involved significant others.

The first five audio-recordings were then fully transcribed using the transcription convention developed by Gail Jefferson (2004), with subsequent audio-recordings transcribed verbatim, except for key analytical sequences that were subjected to full Jefferson transcription. This convention renders a transcript that is suitable for conversation analysis as it includes elements of interaction such as pauses, word emphases, pitch, volume, non-word utterances, timings, and overlaps; elements of interaction otherwise absent from verbatim transcription methods (Table 7). All transcripts were fully anonymised to prevent identification of participants. This included removal of names, locations, and any other elements judged to be potential identifiers of any participants.

Table 7: Jefferson transcription symbols (Jefferson, 2004)

Symbol	Definition and use
[yeah] [okay]	Overlapping talk
=	End of one TCU and beginning of next begin with no gap in between (sometimes a slight overlap with speaker change). Can also be used when TCU continues on a new line in transcript
(.)	Brief interval, from 0.08 and 0.2 seconds
(1.4)	Time (in absolute seconds) between end of a word and beginning of next.
Word Wo:rd	Underlining indicates emphasis Placement indicates location of emphasis
wo::rd	Colon indicates prolonged vowel or consonant
↑word ↓word	Marked shift in pitch, up (↑)or down (↓). Double arrows can be used with extreme pitch shifts.
.,_¿?	Markers of final pitch direction at TCU boundary: Final falling intonation (.) Slight rising intonation (,) Level/flat intonation (_) Medium (falling-)rising intonation (¿) Sharp rising intonation (?)
WORD	Syllables or words louder than surrounding speech by the same speaker
°word°	Syllables or words distinctly quieter than surrounding speech by the same speaker
<word	Indicates a hurried start of a word, typically at TCU beginning
word-	A dash indicates a cut-off.
>word<	Right/left carats indicate increased speaking rate (speeding up)
<word>	Left/right carats indicate decreased speaking rate (slowing down)
.hhh	Inbreath. Three letters indicate ‘normal’ duration. Longer or shorter inbreaths indicated with fewer or more letters.
hhh whhord	Outbreath. Three letters indicate ‘normal’ duration. Longer or shorter inbreaths indicated with fewer or more letters. Can also indicate aspiration/breathiness if within a word (not laughter)
w(h)ord	Indicates abrupt spurts of breathiness, as in laughing while talking
£word£	Pound sign indicates smiley voice, or suppressed laughter
#word#	Hash sign indicates creaky voice
~word~	Tilde sign indicates shaky voice
(word)	Parentheses indicate uncertain word; no plausible candidate if empty
(( ))	Double parentheses contain analyst comments or descriptions

3.3.5 Participants

The participants for this research consist of healthcare professionals, Patients, and Partners. The corpus of data comprises twenty-eight patients and their co-present partners, and fifteen healthcare professionals. Patient information was collected for all consultations, including information relating to consultation type, information about the prostate cancer such as grade and risk, the treatments recommended, and the treatment chosen. Where no information was recorded in relation to partners, consultations were screened to ensure that the patient-companion relationship was that of a partner with whom the patient shared an intimate relationship.

3.3.6 Using conversation analysis on the data

The consultations in this research are audio-recordings collected by the research team for the TrueNTH research project. The data included consultations both with and without partners. To produce an appropriate collection for Analysis or partner involvement in triadic consultations, only consultations with partners were included. Crucially, the amount and type of partner contributions were not a factor in the selection of consultations for the collection to be analysed. The audio-recordings were screened to identify the type of companion in attendance, and where the companion type was not documented, a judgement of the companion-patient relationship was discerned through the examination of the consultation’s content. The final collection of consultations comprises twenty-eight consultations comprising a patient, their partner, and a healthcare professional.

The analysis of the data was informed by guidance offered in key CA texts (ten Have, 2006; Sidnell and Stivers, 2013). While the process is not prescriptive, analysis typically involves repeat listening to recordings, while recording initial impressions, production of transcripts using the conventions developed by Gail Jefferson (Jefferson, 2004), and an early analysis of the data using recordings and transcripts combined. This early analysis places emphasis on the core concepts of CA such as turn design, units of turn construction, preference orientations and so on. The data were further explored during data sessions with the research supervisory team and other CA researchers within the university. Although emphasis was placed upon sequences within which partners made contributions, the entire consultation was analysed in relation to how partners might come to be involved, and moreover, excluded from taking part in the consultations.

3.3.7 **Transcription**

Verbatim transcripts for all consultations were produced, and while these transcripts made for an essential entry point to the process of transcription, the transcripts for this research had to be fully reproduced in order to include sufficient detail to render the transcripts amenable to CA. The consultations varied in length ranging from 15 to 50 minutes, each requiring extensive listening and measurement of elements of talk in order to apply the appropriate notation symbols to denote the key prosodic features of talk-in-interaction. The process of producing a transcript of this calibre is extensive and proceeds over multiple steps: The first pass of transcription proceeds with the aim of producing an exact replication of the words spoken (known as verbatim transcription). Next, a light version of the Jefferson convention is applied, which includes increased phonetic listening, identification of turn boundaries, pauses, and gaps (Jefferson, 2004). The next step is to apply more detailed transcription notation to elements of interaction such as pitch, intonation, volume, emphases, overlaps, cut-offs and so on. It is important to note that the aspects of transcription such as the identification of, and selection of elements such as gaps, pauses, emphases, and Transition Relevance Places (TRP) is more than a transcription exercise but is also an analytic decision. There is no way to demarcate transcription from analysis in this endeavour.

For this project, five consultations were transcribed in their entirety using this detailed transcription convention. For the remaining consultations, key sequences considered as important to the research were selected for this type of transcription. Nevertheless, all data were subjected to the same level of detailed analyses, with transcripts only used as representative renders of the data.

3.4 **Ethical Considerations**

Although this research makes use of data previously collected for the TrueNTH Understanding Consequences project, there were several ethical considerations that are to be addressed and acknowledged. Initial approval was granted as part of the TrueNTH project. A further, non-substantial amendment was granted to allow the analysis contained within this research to be presented as a PhD thesis. These analyses were bound by the ethics agreement of the TrueNTH Project and its connected protocol (NHS Rec No 15/EE/0132). Approval for this thesis was granted on the basis that the PhD forms part of the primary analysis of the wider project, and that the candidate was added as a member of the research team. The analyses, presentation, and use of data complied with the TrueNTH project protocol as agreed by the project Chief Investigator (CI). The audio-recordings were held in accordance with the agreements in place for the TrueNTH project, meaning that they were kept on the University of Southampton’s secure file storage system and accessed only by authorised devices using a secure Virtual Private Network connection (VPN). No recordings were held outside of this system and were rendered inaccessible outside of authorised devices. Transcripts were fully anonymised with any possible identifying features such as names and locations removed in their entirety. In adherence with the anonymity requirements of the TrueNTH ethics agreement, this anonymisation process also meant that participant ID codes could not be added to the presented excerpts in this thesis. This was due to concerns that features of particular consultations could inadvertently identify participants through triangulation. In place of participant codes on each excerpt, a table of non-matched participant codes was produced for each chapter and placed in the appendices. In reporting and presentation of data, only anonymised excerpts from transcripts were used, and these transcripts were not made available to anyone, after attending workshops or presentations. Adhering to the ethical obligations of the TrueNTH protocol is of importance as the research in this thesis represents a primary analysis of these data. A data access agreement was produced, which placed requirements upon the CI to ensure that any transcript excerpts were appropriately anonymised. Additionally, inclusion of all extracts in this thesis were subject to the final approval of the CI.

Regarding participant consent, participants were afforded full rights to withdraw from the research upon request, in accordance with the ethical approval granted to the TrueNTH project. Because these data were collected previously, no contact with participants was made. As such, assessments of risk in relation to data collection were not necessary. Nevertheless, due to the sensitive, and potentially emotive nature of the consultations, ongoing checks as to the wellbeing of the researcher were made to ensure that the material had limited impact upon them.

In relation to research quality, analyses and impressions were subjected to ongoing evaluation and data sessions by the researcher’s supervision team. Data sessions are a fundamental practice for conversation analysis and a key method of continued professional development for conversation Analysts. The ethics committee placed constraints upon the use of the audio recordings due to concerns relating to the recording of cancer consultations and its potential detrimental impact upon healthcare delivery. However, these concerns are not supported by existing evidence (Parry *et al.*, 2016). Nonetheless, this meant that the data could not be used in data sessions or workshops outside of supervision meetings.

Chapter 4 Partner Contributions

4.1 Chapter introduction

"Speak when you're spoken to!" - Idiom

This idiom has connotations in everyday language relating to an adult, usually a parent, imposing a negative sanction upon a child for an act that has been judged as 'speaking out of turn'. This sanction implies some form of moral order in which the child should not speak unless they have first been addressed, presumably remaining silent otherwise. The alternative formulation "don't speak until you're spoken to" makes the meaning particularly clear. As much as this might be considered to reflect an authoritarian style of communication, attributing this act of negative sanction to a particular type of individual (e.g. Adorno *et al.*, 1950), it also speaks to wider structures of social interaction, the socially organised norms to which interlocutors are expected to adhere, and critically, the negative sanctions bestowed upon those who do not.

Everyday social interaction has been conceptualised as a highly ordered, organised activity, where members of any given situation draw upon taken-for-granted knowledge for accomplishing everyday social actions. Garfinkel described these as ethnomethods, or members' methods (Garfinkel, 1967). In using such methods, members are able to construct some form of stability in the social world and make sense of everyday social relations. Garfinkel's ethnomethodology considers these methods as a set of situated 'rules' within a given situation that, while indexical, are not treated as problematic. In this respect, members who are competent in their orientation to these methods can monitor the ongoing conduct of themselves and others relative to these members' methods. Closely related to this what Garfinkel described as the interaction order; a 'syntax' of social conventions that inform everyday social interactions (Goffman, 1983). Among the many conventions considered between Goffman's ethnomethodology, and Garfinkel's interaction order, are the norms that are drawn upon to ratify the participants involvement within a particular interaction. This is of particular importance in the case of multi-party, and formal interactions where participants must be formally recognised and sanctioned to take part in the interaction. Interactions in formal settings such as courtroom or clinical settings will proceed in orientation to the situated rituals that afford certain interlocutors greater licence to initiate talk than others (Goffman, 1983; Heritage, 2011). By contrast, interlocutors taking part in an everyday social interaction can proceed in a more egalitarian manner, with each interlocutor more-or-less, having the same rights to contribute (Goffman, 1983). Indeed, Sacks noted the ways that conversational practices can be used to configure groups into sanctioned and unsanctioned participants, noting that the ways that conversations are constructed can, by implication, include or otherwise exclude participants based upon their situated entitlement to contribute (Sacks, 1992). In drawing upon Goffman and Garfinkel's earlier work, Harvey Sacks, Gail Jefferson, and Emanuel Schegloff developed a model for turn-taking as part of their conversation analytical approach to everyday and situated social interaction (Sacks, Schegloff and Jefferson, 1974).

In this model, they demonstrated some near situation-invariant ways in which turn-taking is organised, observing that overwhelmingly, interlocutors speak one at a time, speaker change occurs frequently, the size of turns can vary, but are normatively constrained to one turn construction unit (TCU) at a time, and that transitions between speakers are particularly well managed with interlocutors working to minimise silences between turns as well as minimising overlapping talk (Sacks, Schegloff and Jefferson, 1974; Clayman, 2013). The regularities of turn-taking have since been studied across multiple languages and cultures, giving rise to the understanding of certain turn-taking practices as near-universal (Stivers *et al.*, 2009). Within this turn-taking model Sacks and colleagues proposed a set of practices relating to the ways in which interlocutors obtain a turn-at-talk, particularly within multi-party interactions. In this, they noted that the primary method of obtaining a turn-at-talk is for the current speaker to select the next speaker (Sacks, Schegloff and Jefferson, 1974; Stivers and Robinson, 2006). This model indicates that, when the current speaker selects the next speaker, it confers exclusive rights and obligations to the selected next speaker to take the turn, indicating that no other interlocutor has the same rights and obligations to initiate a turn at this transition point. Additionally, if the next speaker is not selected during the prior turn, the conversational floor is in essence, open to the next speaker taking the initiative to self-select as the next speaker. Finally, regardless of whether a next speaker was selected, if nobody initiates to speak next, the current speaker can continue. Further to this, when the current speaker is active in the selection of the next speaker, the conferring of primary rights and obligations for the selected next speaker to provide the next turn is itself highly organised as research has offered evidence of a primary preference for the selected next speaker to provide the next turn-at-talk (Stivers and Robinson, 2006). This provides a form of empirical support to the idiom “speak when you’re spoken to”. However, the same research notes what is described as a second order preference for the current speaker to receive a response instead of no response, even if this response is produced by someone other than the selected next speaker.

The clinical consultation is a situated site of social action within which, roles such as doctor and patient are formally recognised, with socially organised and formal participatory frameworks drawn upon to shape the configuration of the interactions as they unfold (Heritage and Maynard, 2006a). Within this context, the membership categories themselves can be considered as sufficiently salient to inform the interactional shape of the medical encounter (Schegloff, 2007; Stokoe, 2010). There is a long-standing, historical appeal to the notion of medical encounter unfolding as a largely paternalistic interaction (Charles, Gafni and Whelan, 1997; Driever, Stiggelbout and Brand, 2020). However, research that has examined clinical interactions has rigorously demonstrated that patients and those who accompany them are rarely as passive as conceptualised by the concept of paternalism (Stivers, 2005; Koenig, 2011; Holmes, Toerien and Jackson, 2017). In this respect, patients, and those who accompany them, can be argued as interlocutors of agency during the clinical encounter. Nonetheless, as a social interaction, it will inevitably be expected to unfold in orientation to the situated social practices and norms as described by Garfinkel, the syntax of social conventions as described by Goffman, and the regularities of turn-taking as conceptualised by Sacks and colleagues (Garfinkel, 1967; Sacks, Schegloff and Jefferson, 1974; Goffman, 1983; Clayman, 2013).

Accordingly, the research paper presented in this chapter investigates the turn-taking practices as enacted within the context of clinical consultations for people with localised prostate cancer. Specifically, it attends to the situated practice of next speaker selection for diagnostic and treatment consultations comprising a healthcare professional, a patient, and their co-present partner. For this research, a partner is classified as a spouse or romantic partner, standing distinct from a friend, carer, or relative.

The initial analysis examines the turn-taking practices across the entirety of the twenty-eight consultations. It organises them by the methods of speaker selection as well as showing how these turns were distributed across the phases of the consultations. The chapter continues by offering an analysis of each of the 4 methods of partner contribution. Following on from this, the chapter offers a complete research paper that analyses a specific turn-taking practice where partners self-select to speak after the patient has been selected as the next speaker. Following on from this, the chapter offers a summative discussion of all of the analytic findings in this chapter, together with additional concluding remarks.

4.2 Initial analysis

4.2.1 Selection of partner turns-at-talk

Prior to the development of the research article, exploratory analytical work was undertaken to identify and organise all turns-at-talk delivered by a partner during the 28 consultations. Partners' turns-at-talk were selected upon the bases of these turns either serving to accomplish or were designed in a manner indicative of accomplishing an intervening social action. Such actions included requests, offers, responses, and evaluations. The selection process excluded turns-at-talk, such as minimally produced turns that took place during extended periods of healthcare professional talk. For example, "Uhuh?" and "Okay.", otherwise known as continuers. During these sequences, continuers can be seen to be produced in accordance with the normative rights and obligations of a participant who has adopted the stance as the recipient of a story or extended narrative (Mandelbaum, 2012). While these turns at talk are by no means passive acts, their production within the sequential organisation of the telling of a story only serve to grant further licence for the storyteller to continue their telling. Additionally, turns during farewell sequences were excluded as all consultation "business" was concluded ahead of these sequences. Turns were not excluded upon the basis of turn length, as a relatively short turn in terms of discourse space can serve to accomplish a specified social action. For example, the turn "oh really?", produced after an evaluation, or news delivery would be included due to its sequential import indicating a freestanding solicitor of elaboration (Maynard, 2010a).

4.2.2 Next speaker selection

The initial analysis examined the sequential location and the organisation of partner contributions during the consultations. In order to better understand the ways that participants come to contribute to the consultation, this stage of analysis attended to the partners' turns-at-talk across all phases of the consultation. In doing so, this analysis centred upon the conversation analytical concept of next speaker selection (Sacks, Schegloff and Jefferson, 1974; Lerner, 2003). This concept comprises turn allocation, which is the technique used to allocate the next turn at talk to a co-participant, and recipient design, which is the ways that a turn-at-talk displays orientation and sensitivity to a particular interlocutor (Sacks, Schegloff and Jefferson, 1974). Central to the understanding of next speaker selection is an understanding of turn-taking in everyday and institutionalised interactions (Sacks, Schegloff and Jefferson, 1974; Stivers *et al.*, 2009; Clayman, 2013; Hayashi, 2013). The model of turn-taking outlines the ways that turns-at-talk are locally managed and distributed among participants during interactions, where it has been shown that typically, speaker change regularly occurs, overwhelmingly, one party speaks at a time, participants work to minimise overlapping speech, while also minimising gaps between speaker turns. In this respect, speakers turns are built from a series of turn constructional units (TCUs), in a manner that projects a place in which the a change of speaker becomes possible, known as the transition relevance place (TRP) (Clayman, 2013). In this turn-taking system, the next turn can be allocated three ways. (Sacks, Schegloff and Jefferson, 1974; Hayashi, 2013).

1. The current speaker can select the next speaker
2. The next speaker can select themselves
3. The current speaker may continue

The primary method for a speaker taking a turn at talk is when they have been selected as the next speaker (Sacks, Schegloff and Jefferson, 1974). There are several ways in which this can be accomplished, such as directing gaze to the selected next speaker, or using an explicit address term while asking a question or making a request (Lerner, 2003). Additionally, speaker selection can be considered as tacit, only identifiable through an examination of the sequential context of a given turn. In examining the question-response system during multi-party interactions, speakers overwhelmingly selected the next speaker, underlining the primacy of this method of obtaining a turn-at-talk (Stivers, 2010). Likewise, research into questions and responses has shown that in multi-party interactions, there is a primary socially organised preference for the selected speaker to respond, alongside a ‘second-order’ preference that prioritises receiving a response compared to no response, even if it is not provided by the selected next speaker (Stivers and Robinson, 2006). This research demonstrates that, when the selected speaker becomes hearable as having failed to respond at the transition relevance place, and a hearable gap has emerged, the second order preference enables a non-selected party to offer a response without negative sanction, provided they initially orient to the selected speaker’s primary rights to respond. This was shown to be accomplished through the non-selected participant delaying their response until it has become apparent that the selected next speaker had failed to take their turn.

4.2.3 **Partner contributions by speaker selection**

In examining partners’ turns-at-talk in the current research, four overarching methods were identified in relation to how partners came to take their turn. These methods were informed by previous research on speaker selection (Stivers, 2001; Lerner, 2002, 2003). A total of 237 partner turns were identified across all 28 consultations. In the collection, partners could self-select to speak while initiating, or inserting a new action within the consultation, such as making a request, or offering information. They could also self-select after the healthcare professional had selected the patient to speak next. Additionally, they could take their turn after the patient selected them as the next speaker, or they could take their turn after the healthcare professional selected them as the next speaker. Partners overwhelmingly obtained a turn-at-talk through the process of self-selection either by initiating or inserting a new action, or by self-selecting after the healthcare professional had selected the patient as next speaker. (Table 8).

Table 8: Distribution of partner turns by speaker selection

	Self-Selection, Initiating or inserting Action	Self-selecting after patient selected	Responding to HCP selecting partner	Responding to patient selecting partner
Total partner contributions	215 (90.7%)	15 (6.3%)	3 (1.3%)	4 (1.7%)

The table illustrates that the vast majority of partner turns (97.0%) came about due to the partner selecting themselves to speak, either to initiate a new action, or to respond to a turn after the patient was selected as next speaker. Patients selected partners as the next speaker for 1.7% of partner turns, while healthcare professionals selected partners for 1.3% of turns. It is important to note that there were no examples of partners passing on an opportunity to speak after being selected as next speaker.

4.2.4 **Partner contributions by phase of consultation**

Partner turns were also organised in relation to the consultation phase in which they took place to better understand the distribution of partner contributions throughout the consultation. Turns in each phase of the consultation were further organised by methods of next speaker selection (Table 8).

Partner Contributions

Table 9: Distribution of partner turns by consultation phase

	Opening	History Taking	Results	Treatment Choices	Next Steps	Closing	Total
Total	15 (6.3%)	3 (1.3%)	32 (13.5%)	143 (60.3%)	37 (15.6%)	7 (2.9%)	237
Self-select initiating	**9** **(60%)**	0	**27** **(84.4%)**	**135** **(94.4%)**	**37** **(100%)**	**7** **(100%)**	**215**
Self-Select after HCP selects patient	**3** **(20%)**	**3** **(100%)**	**4** **(12.5%)**	**5** **(3.5%)**	0	0	**15**
HCP Selected Partner	2 (13.3%)	0	1 (3.1%)	0	0	0	3
Patient Selected Partner	1 (6.7%)	0	0	3 (2.1%)	0	0	4

The table illustrates that partners were largely unaddressed in the consultations. There were four instances in which the patient addressed their partner which occurred in two consultations. The single instance during the opening was a patient requesting the partner's assistance, with the other three instances taking place in a single consultation where the patient solicited their partner's evaluation of the treatment choice (i.e., "Are you happy with that?").

Turning to healthcare professionals addressing partners, outside of three instances, healthcare professionals did not address the partner directly at all. These instances, accounting for just 1.3% of all partner contributions, comprised a healthcare professional confirming if a partner was present at a previous consultation, one confirming that the partner was "a partner", and an instance when a healthcare professional asked a partner what another healthcare professional had told them during a previous consultation. Accordingly, being selected as next speaker accounted for a total of seven partner turns at talk (3.0%). This table illustrates that the most common method of partners taking a turn-at-talk across each consultation phase was the process of self-selection. The paucity of turns that were a result of either the healthcare professional or patient selecting the partner as next speaker meant that these methods could not be subjected to a systematic analysis. Moreover, this dearth of examples where the partner is selected as next speaker is indicative of an overall structural organisation within which the partner is not a sanctioned participant. These findings stand in contrast to findings from studies in other clinical settings. For example, in the context of neurology, companions comprised mainly of spouses, were selected as the next speaker for 47.8% of their contributions, and are formally sanctioned participants in the consultation (Doehring, 2019).

4.2.5 **Healthcare professional selects partner as next speaker**

There were three instances in which a healthcare professional selected the partner as next speaker. Two of these instances were located at the opening of the consultation, and the other during a sequence involving the presentation of results and diagnosis. In both instances during the consultation opening phase, the healthcare professional asks the partner a polar question, in which the typical response would be ‘yes’ or ‘no’.

In excerpt 1, the healthcare professional asks if the partner was present at a previous consultation.

Excerpt 1: Were you there?

```
1 HCP:   O:kay.
2 PAT:   >Yiknow?<=
3 HCP:   =So >weh- y-< >weh you< the:re on:n (.) [monday,]
4 PAR:                                           [Yes of ]
5        course  I was [the:re (0.3)        ↓°yeah°.]
6 HCP:                 [So Yeah you wer- >ther-< Yeah].
7        Yeah righ- right o:kay.
```

The partner initiates their response in overlap, at the onset of the healthcare professional’s final word in their turn, and in doing so, they respond in a manner that indicates that the question was inapposite, “yes of course I was there”. As an interjection, “of course” is a marked upgrade when compared to a typed response of “yes”. It can be seen to challenge the fundamental assumption of the healthcare professional’s polar question insofar as “no” being a possible response, while simultaneously challenging the legitimacy of asking the question (Stivers, 2011, 2019). Instead of displaying a change of state, upon receiving a response to the question, the healthcare professional displays their orientation to the design of the partners response by initiating their next turn in overlap with the end of the partner’s turn, re-framing their initial question as a statement indicative of this being something they already knew (Heritage, 1984a). That the turns on lines 3 and 6 are both initiated with “so” also indicates that the healthcare professional was essentially re-doing this action while incorporating his status change. In this exchange, the epistemic rights over this question can be seen as contested. The marked interjection “of course” indicates that the partner has taken a moral high ground, asserting that any alternative would be unthinkable (Stivers, 2019).

In the other example from the consultation opening phase, the healthcare professional initiates a sequence to confirm the identity of the patient (Excerpt 2).

Excerpt 2: You are a partner?

```
1 HCP:   An:d uhm (.) so yo:h (0.3) mister ((Name)), an:d=
2 PAT:   =(([Name]))
3 HCP:      [you ] a::re >#a# [partneh< (0.4) yeah ].
4 PAR:                        [((Name)) (.) Yes:s  ] I- yeah.=
5 HCP:   =S:o- a:nd- (.) u:hm (0.8) thee:e uh:h (2.0) ((five
6        taps of computer keyboard)) plan tda:y is to throu:gh
7        (.) you:r results,
```

While the healthcare professional’s turn design on lines 1 and 3 are formulated as statements, the action they accomplish is to request confirmation. It is the turn in line 3 where the healthcare professional selects the partner as next speaker. In doing so, their turn is hearable as reaching a trouble source as they elongate the word “are” in the manner indicating a word search. In absence of a solution, the healthcare professional selects the somewhat unusual address term “a partner”. In overlap, the partner initiates a strong repair with an embedded correction, providing their name (Albert and de Ruiter, 2018). Once again, the healthcare professional re-initiates with “yeah” to offer an affirmation that projects the impression that this knowledge was already available to them. With no further attendance to this sequence, the healthcare professional initiates a transition away from it, initiating the new action with “So, and”. In doing so, the healthcare professional sequentially deletes the trouble source and its solution, and they fail to offer acknowledgement of the partners name being new information (Lerner, 1989). The acquisition of the partner’s name is therefore treated as inconsequential, as the consultant makes a marked transition to the next phase of the consultation.

The only other instance where a healthcare professional selects the partner as next speaker, in its sequential context, is a result of the partner self-selecting to initiate a new action, informing the healthcare professional that they had spoken to another consultant earlier that day.

Excerpt 3: What did *he* have to say?

```
1  PAR: We actually spoke to doc- tuh mistr- to (.) doctor
2       ((name)) this morning, [a:n-     ]
3  HCP:                        [↑oh↑ good]
4       (0.3)
5  PAT: [Yh:h]
6  PAR: [Uh:h] ↑you↑ ↓know↓ becus:s (.) I thin:k they >want
7       to<get (.) the appointments tge:theh,
8       (.)
9  PAR: Uh:m i:n th same da:y, [ and (.)  so-   ]
10 HCP:                        [>and whadid he:e] haveteh say.<
11      (0.3)
12 PAR: Well he:e (0.8) uh:m when we sa:w the actual sc↓an, (.)
13      uh:hm
14      (0.3)
15 PAR: uh::h it wus:s >°uh- to me-°< (.) we:ll (.) t- I think
16      t' both of us:s (0.5) it (.) l:looked >a bit<worse than
17      than we'd im[agined.]
18 PAT:             [assit  ]=
19 PAT: =Ye:s yes [we thought (.)] cos we thought it was a
20      lower grade than:n (.) °y'nuh°
21 PAR:           [Tobee hone:st ]
22 HCP:           [Mhm.          ]
```

23 (0.3)
24 PAR: We- no I think we (.) unde'stood the gr↓a:ade,
25 (.)
26 PAT: [Yes:s] yes,=
27 HCP: [((Coughs))]]
28 PAR: =we [understood (.) the three plus] fou::r,=
29 HCP: [((mouse clicking 2 times))]
30 PAT: =Oh:h- O:oh yes we >did< [under£sthand£ tha'] [°yeah°.]
31 HCP: [((Mouse clicks))]
32 PAR: [Uh::m]
33 (.)
34 PAR: But [hadn (.) rea- yiknow we tho:ot]
35 HCP: [((Mouse clicks twice))]
36 (0.3)
37 PAR: [Uh we hadn realised that there was like (.) y'know it
38 was the first mention of a actual (.) tumour]=
39 HCP: [((Typing, nine firm strikes of the computer keyboard
40 during the partner's turn at talk))]
41 PAR: =I suppose I,
42 (.)
43 PAT: We hadn [(.) heard] the £we:rd mentioned befhore that£
44 nh,
45 PAR: [we hope-]
46 PAR: I think [(.) an' where it wa:s (0.7)] I think (0.3)
47 that was uh:m,
48 HCP: [((double click of mouse))]
49 (1.5)
50 PAT: U::h (3.2) [You know, (0.9)] Hh:ow (.) uhm=
51 HCP: [Four mouse clicks]
52 HCP: =((tut)) Weh #is n:eh# >I me-< is not tha- I mean its:s
53 (.) is the:ere budits not=
54 PAR: =Yes.
55 (1.4)
56 HCP: >Yiknow<. Its eh:hh,(2.0) >certnlee< something the:ere,

In line 1, the partner initiates, offering a newsworthy piece of information to the healthcare professional. Their response on line 3 (oh good) is delivered before the actual news has yet to be delivered. The turn “oh good”, a change of state token, followed by an evaluation, would make sequential sense had it been in response to the actual news, rather than the preannouncement that did not offer sufficient information to warrant such an evaluative response (Heritage, 1984a; Maynard, 2010b). The partner continues nonetheless, and in providing this newsworthy information, the partner offers an account, which is hearable as incomplete, noting that they had spoken to another healthcare professional for logistic purposes (organising appointments on the same day). The healthcare professional initiates their turn in overlap. They produce the turn in a compressed manner, rushing into the turn, asking “what did he have to say”, selecting the partner to speak. The emphasis on the word “he” is noteworthy, as the prosodic cues indicate that “he” is the functional reference, and not what was said. The gap between this and the partner responding, along with the turn-initial “well”, signals that the query was not expected within the organisation of this sequence (Heritage, 2015). For the next forty-seven seconds, the patient and partner co-construct their experience of not having realised that they were faced with a cancer diagnosis. During this time, they both regularly produce turns that create space for the healthcare professional to resume their turn. Instead, the healthcare professional is heard to click a computer mouse and tap a keyboard regularly throughout. After these forty-seven seconds of the patient and partner outlining their surprise at the presence of cancer, and the extent of the diagnosis, the healthcare professional initiates a turn that is not fitted to what has been said, and is instead, they initiate with an audible tut on line 52, a well-prefaced turn, and a claim that there’s “certainly something there”. This turn fails to orient to the partner’s and patient’s account of shock while failing to acknowledge that the partner and patient have provided information as a response to a question which they asked. Indeed, it is clear that the healthcare professional did not address what was said. Had they attended to this lengthy joint account they would have recognised that it was not fitted to the question posed on line 10. Moreover, the patient and partner state that they have already seen a scan and know ‘what is there’. Sequentially, the healthcare professional deletes the 47 seconds of account and his own question, then moves directly to discussing the results with appeal to the scan imagery

4.2.6 **Patient selects partner as next speaker**

Patients selected their partner as next speaker a total of four times in two consultations: One instance during a discussion of results, and three during discussions around treatment choices. Excerpt 4 takes place at the start of a results phase, where the patient requests assistance from the partner.

Excerpt 4: He’s partially sighted

```
1  HCP:  >So ↑these↑< gra:phs (.) come frm:m (.) professuh
2        ((name))
3        (0.3)
4  HCP:  [((tapping keyboard and clicking mouse))]
5  PAT:  [°D’you want [teh:h°]                   ]
6  PAR:               [°Yes  ] mh ye:s°          ]
7  PAT:  .hh [Akshy I-  I got- I’:ve got  the:e-  ]
8  PAR:      [My husband is parsh’lly si:ghted so-]=
9  PAT:  =I:m partially sighted so,=
10 HCP:  =Oho:kay,
11 PAT:  I’m a little bit eh:m lost (.) with the=
12 HCP:  =((continues to type on [computer keyboard))     ]
13 PAT:                          [Bt my wife- [mh- hhh    ]
14 PAR:                                       [(°unclear°)]
15 HCP:                                       [((Couhgs)) ]
16 HCP:  S:o professor ((name))
```

The sequence begins with the healthcare professional introducing information on their screen. While they are heard to type onto a computer keyboard, the patient initiates a turn to the partner on line 5 which is performed noticeably more quietly than surrounding talk and is projected as a turn that takes place outside of the primary business at hand. The partner responds in the same manner on line 6 when responding to this request. During this time, the healthcare professional is heard to type on the keyboard. The patient and partner then offer a proactive account for their interaction, offering the explanation that the patient is partially sighted. The healthcare professional offers a minimal change of state token on line 10 “Oh okay” before continuing to type. The patient continues their account on line 11, indicating the implications of their visual disability. During this, the healthcare professional continues to type on the keyboard. They then proceed to describe the graph on line 16, failing to orient to the previous sequence, despite it having clear implications for the patient's ability to receive the information to be displayed.

The only other instances of a patient selecting the partner all take place during discussions relating to treatment choice, with the patient selecting the partner to ask for their evaluation of the selected treatment choice. These sequences are only present in a single consultation, in which the patient asks the partner "are you happy with that?" at two locations, which results in three partner turns. Excerpt 5 illustrates this action as the patient has summarised their understanding of the treatment choice.

Excerpt 5: You happy with that?

```
1  HCP:  Thassit,=
2  PAT:  =Y- you happy withat.
3        (.)
4  HCP:  [Yeah. ] Yeah,=
5  PAR:  [°yeah°]
6  PAT:  =>Aksha- we:e happy withat< ahaha (.) haha=
7  HCP:  =Oh:h good, £no:o I know£ £that's uh£
8        (.)
```

The healthcare professional confirms this understanding on line 1 with "That's it". The patient addresses their partner asking, "you happy with that?". While it is relatively clear in the sequential organisation that this turn is designed for the partner, the healthcare professional fails to orient to this recipient design, and initiates in response on line 4. The response overlaps directly with the partner who is barely heard to produce their response which is notably quieter than the surrounding speech. The patient then re-initiates on line 6, offering a 'repaired' version of the turn (actually, (are) we happy with that). The prosodic features on the turns on lines 2, and 6, namely the change in emphasis on words "you" and "we" show the relationship between the two turns. The healthcare professional offers a positive evaluation to this news, then moves on to further describe the chosen treatment option.

4.2.7 Partner self-selects to initiate or insert a new action sequence

Across all twenty-eight consultations, the majority of partner turns were the result of self-selection in order to initiate or insert a new action into the conversation. This was by far the most prevalent method used for partner contributions, accounting for 90.7% of all partner turns. From 273 identified partner turns, 215 were the result of the partner self-selecting in this manner. In examining these forms of participation, these 215 turns were further organised according to the actions they served to accomplish within their sequential organisation. This led to a distribution of social actions by self-selection (Table 10).

Table 10: Initiating actions of self-selected partner turns

Action	**Repair**	**Request**	**Inform**	**Affiliative**
Total	123	27	61	4

4.2.8 **Affiliative turns**

A small collection was identified where turns were initiated by partners to offer some form of evaluative commentary, projecting both alignment and affiliation with the conversation sequence in progress. These self-selected contributions comprised a series of 4 turns inserted into sequences, with turns designed to project affiliation with the prior turns of the healthcare professional or the patient. Notably, these turns received no responses of sequential import, with three of the turns receiving no uptake, and the fourth receiving a form of minimal acknowledgement only.

In excerpt 6, the healthcare professional has been describing the extensiveness of the patient’s biopsy, pausing to offer an online commentary to account for the level of detail contained in their delivery to the patient.

Excerpt 6: The nitty gritty

```
1  HCP: Okay↑ so that's what was ↓positive↑ (.) >you know<
2       I'm ↑getting >to the< >nitty gritty< of this
3       [which to be ↑honest (.) was-]
4  PAR: [↑Ye::ah          ↓yeah yeah] (.) that's fine (.) but
5       (.) it's [bet- it's better to know whe-]=
6  PAT:          [I'm intrested don't worry    ]=
7  PAR: =to kno:w what you're [de:aling with isn't it↑]
8  HCP:                       [↑Yeah↓ (0.5) so what I ]
9       mean fr- (.)=
10 PAR: =>You can understand it a little bit<
11      (.)
12 HCP: from the left lateral (.) Okay↑(.)
```

The partner initiates in overlap with an affiliative turn that takes place across lines 4, 5, 7, and 10. The turn, along with the patient's turn which also projects alignment and affiliation, are both sequentially deleted as the healthcare professional initiates on line 8 with "Yeah, so what I mean". This initiation indicates that the turn has arisen from incipiency, and in this case, as a continuation of the turn across lines 1- 3 (Bolden, 2009). This turn is completed on line 12 with the turn on line 10 only serving to disrupt the healthcare professional's turn. This is apparent as the turn on line 12 is initiated with the re-completion of the same lexical item that was cut off on line 9. In this, the affiliative turns of the partner and the patient had no sequential impact as they were interactionally erased from the sequence.

In the same consultation as excerpt 6, a similar pattern is demonstrated in excerpt 7 where the healthcare professional is further describing the extensiveness of the biopsy, noting that they've taken a wide sample from the prostate.

Excerpt 7: You've looked at it very, very closely

```
1  HCP: In fact if ↑anyth↓i:ng↑ (.) the (.) good news:s
2       about this >is that< we've taking a wi:de sample
3       °from your prostate°.
4       (.)
5  PAT: [Ri:ght].
```

```
7  HCP:  [↑((Number)) ↓seven↓] (0.8) biopsies (.) ↓yeah?]
8  PAR:  [>You've looked adit ↑very very closely        ]
9        ↑haven't yeh.<=
10 PAT:  ↑((number)) ↓seven.=
11 HCP:  =and from >out of< tho:se we've only found ↑one↑ with
12       one millimet- ↑Each biopsy's u:sually between five
13       #t- to-# five millimetres to ↓ten.
14 PAT:  °right.°
```

The healthcare professional offers an elaboration on line seven, specifying the number of samples that were taken. In direct overlap, the partner offers their affiliative turn, noting “You’ve looked at it very, very closely”. Notably, they close the turn by tagging on the question, “Haven’t you?” which transforms the turn into a first pair part that both addresses the healthcare professional and projects a degree of accountability for them to provide a conditionally relevant second-part part of either an agreement or disagreement with this assessment. Critically, neither is produced as the healthcare professional continues their information delivery sequence absent of orientation to the affiliative turn. In the same manner as in excerpt 6, the healthcare professional’s turn across lines 11 – 13 are a direct continuation of the turn that was completed on line 7, with the partner and patient’s evaluative turns only serving to temporarily disrupt this information delivery.

The most prevalent actions of repair, inform, and request were subjected to a detailed, line-by-line analysis to better understand these action sequences. In this analysis, a pattern was identified in these actions where partners self-selected as a form of patient advocacy, offering contributions of interactional and clinical utility to the consultations.

4.2.9 **Initiating repair, an act of advocacy**

The concept of repair relates to what might be described as a problem solving, or trouble shooting system for social interaction. In such terms, repair in social interaction relates to a problem or trouble source that takes place in an unfolding interaction, with an initiation of repair placing proceedings on ‘hold’ to attend to the source of trouble, prior to resumption of the interaction (Kitzinger, 2013). Trouble sources include problems such as mispronunciations, trouble finding a word, the omission of key details in a turn. Notably, while the person producing the trouble source can initiate and repair their own trouble source at any point within a turn-at-talk (e.g. Schegloff, Jefferson and Sacks, 1977), repair can also be initiated by another interlocutor, where initiation typically takes place after the turn-at-talk reaches some form of transition point (Robinson, 2006a; Kitzinger, 2013). Notably, this form of repair projects an indication that the prior turn was either problematic or insufficient in some way within the unfolding sequential organisation. In this, these initiations place on hold the normative progression of the interaction in order to attend to this trouble source, with a solution enabling progressivity to resume. It is important to note that repair initiations are not necessarily argumentative or adversarial actions. Instead, repair initiations should be considered as actions that treat what has come before them as inadequate for the purposes of progressing the ongoing project. This form of repair featured prominently in partners' self-selected turns across all twenty-eight consultations, with the partner initiating repair almost exclusively after healthcare professional turns-at-talk. Across all 123 identified repair initiations, the prevailing pattern was of turns that treated the healthcare professionals' turn as insufficient in some way, either by way of omitting a key detail, or including some form of inaccuracy. By initiating repair, partners were able to demonstrate the extent to which they were attending to the consultation, while consistently working in service of receiving clarity of information while taking up the stance of the patient through repair initiations in service of patient advocacy.

The repair initiation in excerpt 8 takes place as the healthcare professional is outlining the next steps of placing the patient onto an active surveillance programme as the chosen treatment option.

Excerpt 8: He's never had an MRI

```
1  HCP:  An the things that wul happen a:re (0.3) regulrly >are<
2        gedding PSA:A ↓blood↓ ↑tests?
3        (0.4)
4  PAT:  °yep,°
5        (0.8)
6  HCP:  having a rectal exa:m
7        (1.0)
8  HCP:  and a:lso (.) at some sta:ge, (0.3) but not for about
9        eighteen months (0.3) >possibly< >two years<_ (0.4)
```

10 repeating thee MRI scans n biopsies:s.
11 0.5
12 PAR: Hees nev[eh had] an MRI
13 HCP: [°°okay°°]
14 (0.3)
15 HCP: >Oh< ohr- oh:r at least getting an [MRI] sca:n,
16 PAT: [>yeah<]

The healthcare professional formulates the steps in a three-part list of blood tests, rectal exam, and “repeating the MRI scans and biopsies”. It is on line 12 that the partner initiates repair, noting that the patient has never had an MRI. Notably, the healthcare professional turn on line 13 is substantially quieter and is hearable more as the initiation of a transition to the new sequence. This is further underlined by the way that the healthcare professional ‘steps back’ to reformulate the final part of their account, where they initiate with a change of state token on line 15, indicating receipt of new information, and a repair solution to the sequence “at least getting an MRI scan” (Heritage, 1984a). Unlike the partner’s affiliative turns, the healthcare professional acknowledges and addresses the repair initiation. In this repair initiation, the partner informs the healthcare professional of clinically relevant detail, while taking a stance to represent the patient and their interests in the consultation. After this repair sequence, the healthcare professional transitions to the new sequence, offering a summative evaluation of active surveillance.

The repair initiation in excerpt 9 also takes place during a sequence where the healthcare professional is outlining the process of active surveillance.

Excerpt 9: Not three months?

1 HCP: S:o uhm yeah wel- we’ll list you >fo that< (.) as well.
2 .hhh >bu in the< interim I’m gonna see you >in about<
3 six months with the blood test.
4 (0.8)
5 PAR: Not ↑three↑ months
6 (0.8)
7 HCP: I ↑think >we cn< do the first one (0.3) uhm (1.2) in
8 in:n (0.5) well >y’cd ↑have↑ it< >done in< three (.)
9 aswe:ll,(0.4) uh::m,
10 PAR: >↑Noh↑ isarih< s just tha he said (.)

11 [y-you you ((unclear))] h:e said every=
12 HCP: [>isat what ((name))-<]
13 PAR: =three
14 [mon:ns an (.) jus teh keep an e:ye on the- on thee]
15 PAT: [evry three month to be monitrin every three months bt]
16 PAR: the rate=
17 PAT: =>doe'nt matter< if you think six months youre the (.)
18 >the boss<

Across lines 1 – 3, the healthcare professional explains that the process will include a blood test that will take place in about six months. The final unit intonation projects a turn that has been performed to completion. The partner initiates repair after a gap of 0.8 seconds, which is long enough to project an incoming turn at talk that is not entirely in alignment with the prior (Pomerantz and Heritage, 2013). The partner's repair initiation on line 5 can be seen to treat the prior as insufficient insofar as it questions the validity of the timing of the blood test. In their turn "not three months?", the partner's turn design both initiates repair, while offering a candidate solution to the identified trouble source. After the initiation, there is a further gap of 0.8 seconds, that once again projects a turn incoming that is not going to be performed in alignment with the prior. The healthcare professional initiates their turn initially to offer some solution relating to the "first" blood test, before aborting the turn with a 1.2 second gap. They attempt to pick up from this turn once more, before a second abort, leaving a 0.5 second gap. From there, the healthcare professional initiates with a well-prefaced turn, further projecting a turn that is not in alignment with the prior, or at least, has a complicated relationship with it (Heritage, 2015). In the final part of the turn, the healthcare professional acknowledges that three months is a possibility, noting that it 'could' be done in three months 'as well'. The turn is fragmented, with delays, hesitance markers, and turn components that project reluctance, including the discourse particle "uhm" at the end of the turn. This projection is hearable enough that both the patient and partner offer an elaborate account as to why they expect the test to be conducted in three months, appealing to what another consultant has told them. The healthcare professional briefly orients to this information, while the patient and partner co-construct this account. The sequence closes with the patient in pursuit of a return to social solidarity, noting "you're the boss", drawing upon the common sense understanding of the doctor-patient relationship. As in excerpt 6, the partner's repair initiation is in direct advocacy for the patient and is of clinical import to the patient's healthcare provision. It also demonstrates the extent to which the partner has attended to the clinical process this far and is able to represent the patient's interests when it is required.

While partners' repair initiations could serve to highlight clinically important information, the ways that healthcare professionals responded to them could serve to project the impression that their repair initiation was not an essential action, insofar as the turn taking place after the initiation was an incipient action that was not contingent upon the prior turn (Bolden, 2009). In excerpt 10, the healthcare professional is summarising their findings in relation to tests results and the diagnosis for the patient.

Excerpt 10: What should it be?

```
1  HCP:  >So a< o:ne millimeter so- once again (0.3) going back
2        (.) >look at< some things (.) considering your prostate
3        is enla:rged okay?
4        (.)
5  HCP:  You've goh a ((number)) mill prostate,
6        (0.4)
7  HCP:  °Okay?°
8        (.)
9  HCP:  [↓So:o-↓]
10 PAR:  [  °Wha ] should it be.°=
11 HCP:  =So:o (0.3) fifte:en to thirty mills is what we would
12       normally start with (.) okay? >after< the age of thirty
13       slowly the prostate starts (.) °en° (.) larging n
14       getting bigger n bigger (.) >n as< it gets bigger oka:y
15       it's a problem.
```

They return to a measurement of the patient's prostate, noting that it is "enlarged" before elaborating with a specific measurement. After a gap of 0.4 seconds, they initiate again in pursuit of acknowledgement. Absent of this, the healthcare professional initiates once more on line 9 with a so-initial turn hearable as a turn to transition to a new sequence. It is on line 10 that the partner initiates repair with a turn that treats the information provided in lines 1 – 5 as inadequate as they ask, "what should it be?". In response, the healthcare professional reinitiates their turn with the same elongated so-initial turn, but notably pauses for 0.3 seconds before continuing the turn. The turn, while orienting directly to the partner's repair initiation, projects a turn arising from incipiency, and not as a product of the repair initiation (Bolden, 2009). As an alternative, a well-prefaced turn would have projected a response that arose from the repair initiator, projecting a response from the 'side' of the healthcare professional (Heritage, 2015). However, the initial delivery of information from lines 1 – 7 was hearable as a complete project, with the inclusion of the turn on line 7 as a pursuit of acknowledgement. Once again, the partner's initiation demonstrates their orientation to the clinical process, eliciting information that is of clinical import. It is however important to note that the turn on line 11 – 15 doesn't actually provide an answer to the partner's question, but instead, it is used as a platform to underline that a sixty-millilitre prostate is larger than a "normal" starting point of "fifteen to thirty mills". Nevertheless, this act of advocacy in repair initiation can be seen to draw information that was seemingly otherwise not forthcoming.

Partners acting in advocacy for the patient related to more than the provision of clinical information and could be enacted in pursuit of more practical matters. In excerpt 11, the repair initiation relates to the partner identifying an inadequacy of information delivered by the healthcare professional regarding the booking of an appointment.

Excerpt 11: What time have you booked?

1 HCP: ((name)) hoodwinked yo:r (0.3) >appointment< >an
2 ((name)) <booked you >anothe one< fuh this wee-
3 wednsday.
3 (0.4)
4 HCP: tihsee >somebody< bout radi therapy,
5 (0.4)
6 PAT: ↑oh ↓right,=
7 HCP: =[S:o ehm-]
8 PAR: [What wha] t:ime >ave you< booked t=
9 HCP: =Eh:m doctuh ((name)) ad an appointment ah quarter
10 tuh two:o (.) available,
11 (0.8)
12 Eh::m
13 (0.5)

```
14 HCP:     I don know >if ees goda<- (.) ahts is only one lef::t
(.)
15          [is that awk,]
16 PAR:     [#Wi-ehhuhih#] O:h >we aveto< cancel the who- no:o
17          yell ahv tuh [have it (.)  ] you gotta [have] it.
18 HCP:                  [t- oh bugger ]
19 PAT:                                            [hmmm]
```

The sequence opens with the healthcare professional offering an admission that an appointment has been booked without checking with the patient as to their availability. In the turn across lines 1 – 4, they explain that an appointment has been booked for “this Wednesday”. After a gap of 0.4 seconds, the patient offers acknowledgement with a turn that projects the receipt of new information (Heritage, 1984a). Following this, the healthcare professional initiates a turn on line 7 with an elongated so-initial unit, projecting an incoming topic transition. In overlap with this, the partner inserts a repair initiator that looks back at the prior turn, marking it as insufficient to warrant a topic transition. The turn, requesting a time is latched onto by the turn of the healthcare professional who initiates with an elongated “ehm” discourse particle. While the turn orients toward the repair initiator, it is also produced as an account as to why this particular time was booked, that is to say, it was the only appointment available. This response and embedded account receive no take up from the patient or partner. After a gap of 0.8 seconds, the healthcare professional initiates once again with a further elongated “ehm” discourse particle, which is left for a further 0.5 seconds without any take up by the patient and partner. This leads to the healthcare professional seemingly looking for alternative appointments, as the lack of immediate acknowledgement has evidently projected a problem with this time slot. In searching for alternatives, the healthcare professional confirms there are no other slots. After this, the trouble with the time slot becomes apparent as the couple evidently have a scheduling conflict, which they resolve to cancel. In this, the partner’s repair initiation served to facilitate matters of practical import to the consultation that would have otherwise led to later scheduling problems, namely a prior commitment interfering with the appointment time. This once again shows how partners orient to the clinical process, and how they can take up the stance of the patient to represent their interests during the consultation.

4.2.10 **Making information requests as an act of advocacy**

Across the twenty-eight consultations, there were twenty-seven examples of a partner self-selecting to request information from the healthcare professional. As initiations of new action sequences, these turns were shown to enable progressivity in the consultation, unlike repair initiations that were seen to place progressivity temporarily on hold. These turns neither treated the prior as insufficient or problematic, nor did they place conditions ahead of the production of a response. In this respect, these requests were the initiating sequences of new actions within the consultation. Notably, requests were exclusively observed as acts of patient advocacy insofar as they made requests to support and protect the patient's position. This included requesting information about testing, diagnosis, treatment, and logistics. Partners' requests were performed in four particular ways, varying by turn-design. Specifically, the partner made requests for the patient (e.g., "does he have to have hormone therapy?"), as the patient (e.g., "do you need a full bladder?"), and with the patient (e.g., What do we have to do now?).

In excerpt 12, the healthcare professional has been describing the process of taking part in a randomised control trial where the patient would be allocated to accept a standard, or an experimental treatment.

Excerpt 12: Speaking for – He doesn't get a choice?

HCP: >So< (.) clealy fiyo:u tuh acc:cept tha alloca:tion:n
(0.3) first >of all< (0.6) #ih# wenot (0.4) allocating
#r# ((Treatment A)) option:s, (0.5) so (.) if yo:hr
prefrence is fuh oneothe ((Treatment A)) options
↓then↓ (.) ↓the trial↓ >is not< fiyou
(0.8)
HCP: [Uh:h-] [#ye:ep#]
PAR: [So-] >can I< js (.) clarify [somethi]- y- said (.)
if #uh# ee goes intuh the tri:al (.) hes then allocated
either th- #th# (.) the ((name)) o:r ((Treatment B)),
HCP: Thats correct=
PAR: =>and he< doesn >geh< a choice about tha- (crect)
[(.) ri:ght]
HCP: =[soif ((Treat]ment B)) is something that >youare< v-

15 vehemently agains:t (.) again (.) the trial is not
16 >fuh< yo:u.

Until this point, the patient and partner have expressed interest in the experimental treatment as their preferred treatment choice. At each point that the experimental treatment is raised as a preferred treatment choice, the healthcare professional refers to the randomised control trial. As this sequence opens, the healthcare professional is once again describing the trial, noting reasons for not going into the trial. Across lines 1 – 5, they note that one of the standard treatments (Treatment A) is not one of the options in the trial. After a gap of 0.8 seconds, neither the patient nor the partner initiates any form of acknowledgement that would typically be forthcoming at this point. As the healthcare professional continues their turn, the partner makes their request. The so-initial turn projects a turn that is pursuing a pending interactional agenda (Bolden, 2009). In this sequence, the turn relates to the couple's earlier expressions of interest in the experimental treatment. On lines 8 – 10, the partner makes the request on behalf of the patient, requesting clarity on what happens if he does into the trial. Notably, the healthcare professional initiates their answer before a key part of the request is completed, relating to their choice of the experimental treatment. In orientation to this question, the healthcare professional initiates a reformulated reason to not enter the trial.

Excerpt 13 takes place towards the end of the same consultation, where two competing agendas under pursuit become transparent.

Excerpt 13: Speaking as - You can't have the experimental option?

1 HCP: Bu- yiknow↓ if yoh- if you rema:in interestid in
2 ((name)) an notin (Treatment B)) (0.9) thats importnt
3 fohme tikno:ow an I cn:n (0.8) >tell yuh thuh< next
4 (.) soddof eh:m
5 PAT: ↓Yeah↓
6 (0.7)
7 HCP: >↑Yiknow↓< whot >your< o:ptions are °ba:sicly°
8 [°°okay.°°]
9 PAR: [right] so if:f you don't go on thuh tri:al yeh
10 cant ahv thu ((name)) (.) tha[ts whut yeh sayin' y]eah,
11 HCP: [Uh:h we:ll Imnot (.)]

```
12       exactly sayin that, [I'm so]ddoh sayin=
13 PAR:                      [Oh (.)]
14 PAR:  ↑↑HAHAHAHA↑
15       (0.4)
16 HCP:  Uhm (.) inan i:deal world (.) >evebody< having (.)
17       ((name)) shouold >be in< this kindof tri:al.
18       (0.7)
19 HCP:  >But< (0.3) we >live in a< slightly (0.8) fuzee wo:rld
20       where (0.4) >we don't< >always< haveto:o apply:y.
21       (0.3)
22 HCP:  There ah basicly othe way of having ((name)) (0.4)
23       within >within< thee N H ES:S (0.5) which (.) uh:h
24 PAR:  Oh [I:I se:e]
25 HCP:     [Which ca]n be delivered (.) if that's yor prefrence
26 PAR:  I:I [↓see↓ wo- ]
27 HCP:      [but ahr st] AHR strong prefrence is is thit (0.4)
28       pe:eople considering ((name)) should (.) >ideally< bein
29       this >study<
```

With each expression of interest in the experimental treatment, the healthcare professional turns the conversation toward the trial. This sequence sees the healthcare professional acknowledge that the couple is interested in the experimental treatment and not in the standard option that may be allocated to them in the trial, but they neither accept this preference, nor do they make clear what their steps would be in selecting the experimental treatment. Instead, they offer a suboptimal formulation about how the couple should tell the healthcare professional what they prefer, so they can in turn let them know what are their options (Clayman and Raymond, 2021). It is across lines 8 – 9 that the partner makes a further request in advocacy for the patient, taking their perspective, and the conceptual form of "you", instead of referring to the actual patient as "he". In this turn, the partner is enacting advocacy while speaking "as" the patient. The so- initial turn further indicative of a turn that has pursued a pending agenda and is a clear pursuit for clarity relating to the couple's preferred treatment choice. This turn places a strong element of accountability upon the healthcare professional to clarify this matter. The response, though in overlap, starts with the discourse particle "Uhh" which is hearable as projecting an incoming turn, and a well- preface that projects a turn that is not in alignment with the prior (Heritage, 2015). It is on the account offered from lines 10 – 27 that the healthcare professional's agenda becomes more transparent where they return to the appeal of the trial, further suboptimal formulations about an "ideal world" and a "fuzzy world", closing the account with what is their "strong preference" for people considering the experimental treatment to be in the trial. In this, it is the advocacy of the partner that elucidates these effectively crossed purposes in the interaction, which are notably taking place in a consultation that is expected to be sensitive to the patient's preferences (NICE, 2014). Instead, the unfolding interactions illustrate a process where the healthcare professional is actively orienting away from an expressed preference of the couple, and is instead, orienting towards what they describe as their "strong preference".

Partners could make requests in service of patient advocacy using question designs that enabled them to project a particular stance relative to the cancer experience. In these instances, partners made requests that positioned them as speaking with the patient, using reference terms such as "we" and "us". In making these requests, advocacy was seen to be enacted while in a manner that projected the experience and impact of prostate cancer as a shared concern between the couple. In excerpt 14, the partner has expressed interest in a novel form of radiotherapy that is administered over five days instead of the usual twenty.

Excerpt 14: Speaking with - What now?

```
1  PAR:  >I'm< intre:sted in the uthe one (.) th- the five day
2        one >I< think that mi:ght be:e
3        (0.5)
4  HCP:  Yeah↓ [I meah- I::I_]
5  PAR:        [Its not so dr]awn o::ut is it (.)
6        [yono worimea:an ove]r ih_
7  HCP:  [Na:h I think its uh] its potenshly a very nice
8        option:n (.) [yiknow=]
9  PAR:               [Yeah↓  ]
10 HCP:  =>I cn< see no reason why you wouldn't be:e suitable
11       forrit, (0.5) but we'll >give you< some informa:tion
12       n:n [leh  ]ye have a word with ((name)) then:n [uh:hh]
13 PAR:      [yeah↓]
```

```
14 PAT:                                                  [yeah↓]
15 HCP:  ((theyl))>be able< to ta:lk >tuh you< about that in
16 PAR:  =Yeah↓ o:kay the:n=
17 HCP:  =more deet so very greatfl >fyeh consider it<
18 PAR:  So what duwe ahv tuh do no:w >duwe a:hv< tuh go ba:ck
19       tuthe [((names)) o::r]
20 HCP:        [Yeph ye:h YE:H] ehv the spend £some minits (.)
21       talkhin tuhmy cohhlleagues in ohne way or anoh-££=
22 PAR:  Aw:right,
```

The healthcare professional initiates with turns that are in alignment with this evaluation, only mitigating their response slightly with the term “potentially” on line 7. Upon elaboration, the healthcare professional provides information about the next steps in the process, noting the provision of some information, and a next step of speaking to another colleague. It is on line 18 that the partner makes the request on behalf of themself and the patient as a couple, asking what they “what do we have to do now?”. Notably, the healthcare professional initiates in overlap, where the initiate their turn with the word “you” three times, each with increasing volume and pitch. They then continue their turn with a smiling, then laughing voice, with a turn that is a reformulation of their previous explanation of what happens next. In this, they strengthen their turn using an appeal to a deontological authority, stating what they “have to” do, underlining this as an essential step in the process with the tag “one way or another”. The partner acknowledges this with a news receipt token as the sequence closes. In this example advocacy arises from the partner positioning the couple as a single unit within the consultation, with a request that supports this position. This form of requests stands distinct from the alternatives such as “so what does he have to do now?”, or the less specific, “so what do you have to do now?”. The partners chosen reference term can therefore be seen to accomplish a particular action, inserting the partner as a clear stakeholder in this cancer experience.

4.2.11 **Offering information as an act of advocacy**

Across the twenty-eight consultations, there were fifty-four instances of a partner self-selecting to offer information in ways that could simultaneously address the patient and the healthcare professional. In this sequence, the partner was observed to initiate their turn to volunteer information at points where no next speaker had been explicitly selected, initiating with turns that almost exclusively supported or represented the patient’s position. Accordingly, these informing sequences were observed as being accomplished in service of progressing the consultation, while advocating for the patient. In these turns, partners were seen to offer information that was of clinical import, while also forming an opportunity space for the patient to elaborate upon or collaborate with the partner’s initial informing.

In excerpt 15, the patient is describing the particulars of a physical impediment that has led to pre-existing medical concern that has been placed on hold as a result of their prostate cancer diagnosis.

Excerpt 15: And they’re giving a lot of pain

1 PAT: .hhh (.) Having f- wa:lking tuh favour that one, (.)
2 Ah think the >othe ones< now gone. <so I’ve got two
3 (0.5) dodgy ankles.
4 (.)
5 HCP: °mhm,°=
6 PAT: .hhh uh:m >which< (.) uhm (0.9) it some sta:ge hve got
7 >tuh be< done.
8 PAR: °an they >givin< a lot of pain°
9 PAT: and theyr >givin me a loddof< pain at the moment
10 (.) [Uh::hm]
11 HCP: [°yeah°]

The concern relates to a long-term problem with their ankles. Across lines 1 – 7, the patient describes the deterioration of their ankles, noting that something has to be done about them at some stage. This information is of both clinical and practical import for this consultation as it will influence the choice of treatment as well as having implications for getting to and from the hospital. It is on line 8 that the partner initiates their turn, offering information that, in the first instance, builds upon the patient’s information, while simultaneously opening up an opportunity space for the patient to continue as the turn orients toward the patient as a form of prompt or reminder. The partner’s turn design is notable. Their initiation takes place after the patient’s turn has become hearable as complete, with their turn ending with a marked downward final unit intonation on line 7. The partner initiates their turn at lower volume than the surrounding talk, projecting that the turn was directed towards the partner as an informative prompt. The turn begins with “and”, which projects a turn that is designed to build upon what has come prior. By initiating their turn in this manner, the partner is working with the patient to co-construct the information that they consider to be of clinical and practical import for the consultation. The turn also indicates to an extent, the epistemic status of the partner, who is effectively speaking for the patient at this point as they note “they’re giving a lot of pain”, instead of the alternative, “they are giving him a lot of pain”. This co-construction is further underlined as the patient initiates on line 9 to confirm and offer a more specific formulation, offering an almost verbatim version of the turn from their own perspective, elaborating with a degree of temporality, noting that they are experiencing this pain at the moment. In this sequence, unlike repair initiations, the partner has offered information that can be seen to have enabled progressivity in the consultation, providing information that was relevant for both the patient and the healthcare professional.

In offering newsworthy information during the consultation, partners were able to accomplish a dual action of providing clinically important information, while prompting the patient to collaborate by way of expanding upon the partner’s initial contribution. This is highlighted in excerpt 16 where the partner initiates a turn to offer information relating to their daughter who is visiting them.

Excerpt 16: Our daughter’s coming over

```
1  PAR: Our daughters a ((HCP)) (.) she’s >coming over frum<
2        ↑((place)) tonight so=
3        =[shell sit do:wn an £talk toim, ((cough))]
4  PAT:   [And ↑and I↑ wont↑ make any decisions >  ] ‘til I’ve<
5        spoken to ↓he:r↓ so:o,=
6        (0.4)
7  HCP:  ↑Okay↓ so in ↑terms↑ of (0.3) gle:ason scores and
8        [things,]
9  PAT:  [Yeah?  ]
10 PAR:  °mhm°
11 HCP:  Uh:m (.)       [its-  it’s a      ]three plus four?
12 PAT:            that [I undehstand yeah?]
```

The partner offers the newsworthy information across lines 1 – 3, describing what is going to happen and when. While the patient’s turn on line 4 occurs in overlap with a sizeable portion of the partner’s talk, it is evident that the patient initiated their turn at an identifiable transition point from line 2. The patient’s turn can hearable as a co-completion of the partner’s turn across lines 1 – 2. Between the partner and the patient, both turns provide a news update that is of clinical importance to the healthcare professional and the consultation insofar as the patient has stated that they will not make any decisions until they’ve spoken to their daughter. Although the prompting action in this excerpt is similar to that found in excerpt 15, it differs insofar as the informing turn in excerpt 16 can be seen to have a dual recipient design. The surface level orientation can be seen as a straight information delivery to the healthcare professional. However, the turn is demonstrably hearable as a prompting action oriented toward the patient, which is made evident by the way that the patient initiates their turn in collaboration, starting the turn with the conjunction “and”, projecting a turn that is building on what has come immediately prior. It is therefore noteworthy that the healthcare professional fails to acknowledge receipt of this news, and instead, after a gap of 0.4 seconds, moves to transition the conversation to a new topic.

The extent to which partners were able to offer information relating to the patient’s experience is further outlined in excerpt 17.

Excerpt 17: It’s not in the night, is it?

```
1  HCP:  And >I mean< ha:ve yo::u hah- ha- >↑how many< times >do
2         you< gedup normally >dig:o< (.) °for a ↓wee at night°.=
3  PAT:  ↑I’m qu:ite↑ >good ac-<=
4         =[I cn sleep right throu:gh].
5  PAR:   [↑>’s not ↓in the< ↓ni:ght] ↑>is it<_
6  HCP:  °Yeohkay.°=
7  PAT:  =Uh:h quite often I don’t (.) °g- (.) sleep through it
8         but° (.) >first thing in the morning< uh (.) °Ih-° I
9         manage tuh >quite af:f<(.) do a flo:w yikno:w.
```

In this sequence, the healthcare professional has been taking some form of medical history relating to medications that patient currently takes. Following on from this, the sequence begins with the healthcare professional enquiring about symptoms experienced by the patient, asking how many times they need to get up ‘for a wee’ during the night. Noticeable is the substantial reduction in volume as the healthcare professional finishes their turn with “for a wee at night", as they formulate their question using the somewhat child-like turn of "go for a wee" instead of a more clinical formulation relating to urinating. This formulation can be seen to be mirrored in the patient's response where they offer an evaluative response over lines 3 and 4, stating that they are "quite good" and that they "can sleep right through". Notably, the partner initiates on line 5 in overlap with much of this turn, offering a turn that not only aligns with the patient's position of "I'm quite good", but offers an elaboration that is of clinical import, insofar as the patient's urinary symptoms are not necessarily being experienced in the night. Once more, the partner's turn is oriented toward the patient, but designed to address both the patient and healthcare professional simultaneously. The healthcare professional acknowledges the receipt of this information on line 6, after which the patient offers a more elaborate account of their urinary symptoms from lines 7 – 9. In this sequence, the partners informing is performed more explicitly as a prompt to the patient, with the final part of the turn "is it", hearable as a pursuit of acknowledgement from the patient. Accordingly, the patient's turn from lines 7 – 9 can be seen as a more elaborate formulation of the initial formulation on lines 3 – 4, with the later account offering some indication as to the complexity of the patient's symptoms. Once again, the partner's turn offers some insight into their epistemic status insofar as they are able to offer insight into the patient's experience, initially in a manner indicative of speaking as the patient, only to transform the turn with the request for acknowledgement at the end of the turn. In tagging "is it" onto the end of the turn, the partner can be seen to soften their epistemic stance, while offering the patient the opportunity to endorse this evaluative claim.

The same pattern was observed in excerpt 18. This sequence takes place at the opening of the consultation as the healthcare professional has just finished their introductions.

Excerpt 18: Tired a lot, aren't you?

```
1  HCP:  How a:h y:ou first of a#ll#.
2        (0.6)
3  PAT:  How am I.
4        (0.8)
5  PAR:  ((tuts))
6        (0.6)
```

```
7  PAR:  Jo:vial is you probly ga:theh
8  PAT:  Uh:hm [(0.4) y:yeah uh::m?]
9  PAR:        [££Khi£ °Hmm hmm££° ]
10       (0.6)
11 PAT:  Ah dunno↑ ↓re:allee↑ (0.3) #uh::m#
12       (0.6)
13 PAT:  isard >tuh take< in:n I:I spose?
14 HCP:  Ye::ah↓ yeah .h [ha-]
15 PAR:                  [ti:]yerd ehlot aent °you°
16       (.)
17 HCP:  Right.=
18 PAT:  =E:h oh:yeah ph:hysicly:y (0.4) I goh (.) sortoh pain
19       round ee:r round ee:r (.) #ehm# #uh# (.) du bo°tt°om
20       th- eer (0.3) #uhh# aches:s, (0.8) a:fteh thu biopsee,
21       (0.7) uh::h HHhh wedder that’s:s ey:y ahdu- #ih# (0.4)
22       sotto didn ache befo:re buddit does no:w. s:o=
23 HCP:  Ri::ght.
```

In the initiating turn on line 1, the healthcare professional opens with a generalised query relating to the status of the patient. The prosody of this turn differs from how it is typically delivered, with the emphases being placed on “you” instead of “are” in “how are you?”. The gap of 0.6 seconds projects a turn that is not in alignment with the prior, which is confirmed by the patient’s response on line 3, as they initiate repair with their turn. It is then the partner who offers an account for this response, with an evaluation that is fitted to the particular context. From this turn, the patient elaborates across lines 8 - 13, noting their difficulty in coming to terms with their situation. The healthcare professional acknowledges this on line 14, before attempting to initiate some form of follow-up turn, that is hearable as the start of a question. However, the partner initiates their informing turn at the same time. Orienting to this, the healthcare professional drops out immediately in accordance with the systematics of turn-taking (Sacks, Schegloff and Jefferson, 1974). In their turn, the partner simultaneously informs the healthcare professional, while displaying orientation to the patient with their turn design (tired a lot, aren’t you?). In this sequence, the partner is both providing information that is of clinical import, while offering an explicit prompt for the patient to endorse the partners evaluation. As in the previous excerpts, this turn offers some insight into the epistemic privileges of the partner, as they are able to make a situated knowledge claim about the patient's experience, while offering an opportunity space for the patient to endorse this stance. In their next turn, the patient not only endorses the partner's information, but goes on to elaborate upon it, using the initial informing of fatigue to go on to describe further physical symptoms that have been experienced, noting that they may well be the result of a recent biopsy. Just like excerpts 15 and 14, the partner's informing turns were performed in service of progressing the consultation while acting to support and represent the patient's position. These turns demonstrate that these partners are regularly in a position to offer contributions to the consultation that are of clinical, practical, and social import as they provide insight into the patient's experience that may well have been overlooked.

4.2.12 **Exceptional cases: Non-advocating turns**

Across all twenty-eight consultations, there were three instances of self-selected partner turns that were not performed in service of patient advocacy. These instances were identified in two consultations. The common feature across these turns was that the patient was initiating to offer information about their own experiences and orientations. Two of these turns were sequentially deleted, receiving neither acknowledgement, nor take-up by the healthcare professional or the patient. However, the third turn led to a sequential misalignment that required interactional work to restore a semblance of social solidarity to the interaction.

In excerpt 19, the healthcare professional is describing some of the side effects of hormone therapy introducing the concept of 'hot flushes' to the patient.

Excerpt 19: I didn’t have them

1 HCP: Uh::m (1.3) °°yiknow°° (0.7) the ho- (0.3)
2 [ho’ flushes]
3 PAT: [ho’ flushes] uhn=
4 HCP: =which sounds very trivial but
5 [>actully< they th-] ih they’re significant they- this-
6 PAT: [wel- ah ↑ih:::h]
7 PAR: ((clears throat)) I didn’t av them fortunate-
8 ££ahehehehehehehe (.) he££=
9 HCP: =Uh::m (.) >you know< y- >you know< l- loss of libi:do
10 (.) lethargy (.) [low energy] (.) uh:m
11 PAT: [°mm::mm°]
12 HCP: Yiknow (.) they’re all significan.

The patient orients to this by way of a co-completion of the turn on line 3. The healthcare professional continues on line 5, underlining the ‘significance’ of these hot flushes. It is on lines 7 and 8 that the partner initiates with their turn which offers insight into their experience of having received hormones previously. In this, they note that they were fortunate to not experience these hot flushes. This receives neither take-up nor acknowledgement. This is evident as the healthcare professional’s turn is continuous across lines 1, 3, 4, 5, 9, 10, and 12, with turns produced by the partner and patient not having any genuine sequential impact.

The same pattern is evident in excerpt 20, which was taken from the same consultation as excerpt 19. In this sequence, the healthcare professional continues to outline the side effects of the available treatment choices, noting that radiotherapy can cause tiredness. Once again, the partner initiates to offer information relating to their own experience (been there, done that). Once again, this turn receives no take-up, and the healthcare professional continues their information delivery relating to the available treatment choices. Indeed, the healthcare professional’s turns across lines 1, 2, 5, and 6 can be read as a single turn, once again, only broken up by the patient and partner’s turns.

Excerpt 20: Been there done that

```
HCP: I mean I didn’t mention that thu- the ra:diotherapy can
     make people feel quite ti:red as well,
PAT: Yeah.=
PAR: =I know (.) [I’v been] there done ££that huhuhuhuhu££=
HCP:             [uh:hm   ]
HCP: =°okay >so that’s< (0.8)But yeh I mean froma- from a
     surgical recovery, (0.4) yeah we would want you
     >up n abou< o:n (.) day one day two:o.
```

The notable, and only exception is highlighted in excerpt 21. This sequence stands distinct from the previous two insofar as excerpts 19 and 20 feature turns that, while are not in service of patient advocacy, are still produced in alignment with the ongoing delivery project. That is to say, the partner is contributing in a manner that aligns with the topical and sequential context.

In excerpt 21, the patient has been working to describe how they believe that their prognosis is exceptional to the ‘norm’, as they contrast their situation with anecdotes of other people they know, who did not have the same choices as the patient.

Excerpt 21: I’m allowed to voice my opinion

```
PAR: So hearing that toda:y >is like< (.) hhhh go::d.=
HCP: =Were talkin abo:ut (.) a very different
     [°can:ceh°]
PAT: [oh ye:ah] [It’s a different thin don’t know- >dont<- ]
PAR:            [I kno:w (.) I- comple:tely different thing]
     (0.5)
PAR: I knO:W (.) I’m jus sAYin.
     (.)
     >I’m [allowed to< voice my- my-]
PAT:      [Mmm mm- mm- you know (.) ] we look on the bright
     si:de of £thing wiv ehrm£
     (.)
HCP: So=
PAR: =I’m allowed to voice my opinion.
     (.)
```

```
16 PAT:  °yeah I #kno:ow# I- [I kno:w that.]°
17 PAR:                      [sjust tha hor]rible wo::rd.
18       (.)
19       Ye think °sh::it°=
20 HCP:  =It’s a very- >a very< different beast.
```

As the patient’s story ends, the partner initiates with a post-story evaluation that is out of alignment with the sequential context. This turn effectively breaches the sequential mould. Instead of aligning with the purpose of the story (that the patient is rather fortunate), it instead expresses the partner’s anxieties at hearing the news of the diagnosis. What unfolds is the only observed, explicit misalignment sequence between a patient and a partner in the entire collection. Immediately after offering their evaluation, the healthcare professional latches onto the turn to offer a strong form of repair that treats the evaluation as inapposite, noting that they are talking about a ‘very different’ cancer. On line 3, the patient initiates to express a clear alignment with the healthcare professional, while on line four, the partner initiates just a moment after, and in overlap with much of the patient’s turn to offer a similarly aligned turn. It is in these two turns that the sequential misalignment is observed. Pausing briefly, the partner orients to the way the patient’s turn has aligned with the healthcare professional’s repair initiation. In this, the partner’s turn is somewhat louder than the surrounding talk as they offer both an account, and justification for the valence of their evaluation. As they initiate their turn in service of justifying their evaluation “I’m allowed to voice my opinion”, the patient initiates, offering some form of repair initiation, noting that “we look on the bright side of things” before notably trailing off. After a brief pause, the patient completes their justification turn on line 14. Once again after a brief pause, the patient initiates, this time, acknowledging the partner’s turn with a pitch and volume that is hearable as a de-escalation attempt, with both pitch and volume lowered substantially. This turn is notable as it represents the restoration of a social solidarity that was threatened across lines 4 and 5. The partner then initiates to offer a further account for their evaluation, noting “it’s just that awful word”. The sequence is closed as the healthcare professional offers a positive upshot, describing the patient’s cancer as a “very different beast”. In this, excerpt 21 is an exceptional example within this small collection of non-advocating, self-initiated, partner turns.

4.2.13 **Partner self-selects after patient selected as next speaker**

There were fifteen examples of a partner self-selecting to speak after the patient was selected as next speaker. While these sequences were relatively rare in terms of quantity, the practice of obtaining a turn-at-talk was considered to be worthy of a more in-depth analysis due to research indicating that this action can serve to breach the socially organised norms of turn-taking, while having potential implications relating to patient autonomy within the consultation (Sacks, Schegloff and Jefferson, 1974; Mazer *et al.*, 2014). Accordingly, this practice was selected for a systematic analysis which is presented in the following research paper.

4.3 Speaking Out of Turn: The Prosocial Effect of a Partner Speaking After a Patient has Been Addressed During Prostate Cancer Consultations

4.3.1 Highlights

- Partners were rarely addressed in consultations.
- Partners regularly self-selected to speak as the primary method of obtaining a turn-at-talk.
- The result of the partner self-selecting this way was consistently prosocial.
- Partners consistently oriented to the patient’s primary rights to respond to turns that selected them as the next speaker.

4.3.2 Keywords

Prostate Cancer, Partners, Spouses, Medical Communication, Conversation Analysis, Sequential Organisation, Turn-taking, Next Speaker Selection

4.4 Abstract

Concepts of patient-centredness and shared decision making have largely been interpreted in relation to the dyadic configuration of a patient and healthcare professional. Likewise, patient autonomy in healthcare has long been interpreted in relation to a patient's individual rights to self-determination. This study examines multi-party interactions where a partner responds to a turn-at-talk that addressed a patient during clinical consultations for people with localised prostate cancer. A conversation analysis of twenty-eight consultations demonstrated that this action sequence was prosocial and patient enabling. In these interactions, the partner displayed orientation to the patient's rights and obligations to take their turn as the selected next speaker, only initiating their turn after a substantial delay from the healthcare professional's turn-at-talk. As a consequence, the partner consistently opened an opportunity space that the patient took up to elaborate upon or collaborate with the partners' turn as they regularly took up a unified stance of "we" or "us", resisting the healthcare professional's consistently individualised turn designs. This research demonstrates the social and clinical utility of partners during these consultations, as they served as an important, yet underutilised interactional and informational resource for the healthcare professional and patient. This study offers evidence for a reconsideration of what it means to enact patient-centred care, suggesting a shift away from the Kantian liberal approach of patient autonomy, towards the understanding of the patient as inherently relational.

4.5 Introduction

Communication in medical care has been the subject of research relating to the structure, content, and social processes that unfold during clinical encounters between a patient and a healthcare professional. Research has described the clinical encounter to be a situated site of social action that necessitates an approach that encapsulates the lifeworld concerns of the patient alongside the biomedical concerns of the healthcare professional (Mishler, 1985). While initially considered as a site for paternalism, that imbues the healthcare professional with the epistemic and deontic authority to make decisions for a typically passive patient (Charles, Gafni and Whelan, 1997), research has underlined the ways that patients can act to assert agency through negotiation and resistance during the clinical encounter (Koenig, 2008, 2011; Stivers *et al.*, 2018; Toerien and Jackson, 2019). In this respect, the medical encounter has been regarded as a site where the patient and healthcare professional should act jointly as agents who work to negotiate diagnoses and treatment decisions (Peräkylä, 2006; Lindström and Weatherall, 2015). In the UK, this has helped to inform clinical practice with concepts of patient-centredness in medical care, and Shared Decision Making (Sinfield *et al.*, 2008; Coulter *et al.*, 2011). These concepts are idealised as a process that serves to ensure that the patient's autonomy is protected, while encouraging the patient to engage with the healthcare professional in the sharing of evidence and perspectives during the encounter (Landmark, Gulbrandsen and Svennevig, 2015; Elwyn, 2020). These policies are underpinned by the understanding of the patient as having a right to individual determination, who has the right to make decisions about their medical care (Beauchamp and Childress, 2019). Patient-centredness and SDM have informed clinical practice across several medical contexts including neurology and oncology (Cohen and Britten, 2003; Toerien *et al.*, 2018; Toerien and Jackson, 2019). However, there is research that indicates that the ideals of SDM might be difficult to enact, even in contexts where healthcare professionals openly advocate for SDM and patient-centredness (Lipstein, Dodds and Britto, 2014; Driever, Stiggelbout and Brand, 2020).

The concepts of patient-centredness and SDM are largely interpreted in relation to a configuration of medical encounter comprising a dyad of patient and healthcare professional. This is noteworthy as research has shown that patients regularly attend their medical encounters with a co-present companion (Beisecker *et al.*, 1996; Eggly *et al.*, 2006; Laidsaar-powell *et al.*, 2013). While companions can include friends, relatives, and carers, in the context of oncology, and in particular prostate cancer, patients tend to be accompanied by a romantic partner such as their spouse (Stewart, Roberts and Brindle, 2021). When considering the extent to which prostate cancer can affect patients and their partners, this should not be unexpected. The experience of prostate cancer and its treatment have been shown to have substantial physical and psychological morbidities for both the patient and their partner that have a marked impact upon their relationship (Bullen and Tod, 2013; Wootten *et al.*, 2014). It is therefore unsurprising to note that patients largely expect their partners to be involved throughout the cancer experience as they navigate the difficulties of living with the consequences of prostate cancer and its treatment

(Beisecker *et al.*, 1996; Davison *et al.*, 2002; Zeliadt and Penson, 2011; Klafke *et al.*, 2014).

In the context of prostate cancer, there has been limited research undertaken to examine partner involvement during clinical consultations, with the majority of studies relying on retrospective accounts to understand the roles of partners during the encounter, the extent to which partners are involved by percentage of discourse space, and the factors that might relate to patient and partner satisfaction with the consultation (Stewart, Roberts and Brindle, 2021). To date, research has yet to examine the communicative and social practices as they unfold within a prostate cancer consultation comprising a healthcare professional, a patient, and their co-present partner. Accordingly, this study offers an examination into the ways that partners come to contribute to clinical consultations for localised prostate cancer, and particularly, the consequences of their contributions. In doing so, this study first attends to the distribution of partner turns-at-talk across the consultations, before providing a detailed analysis of a turn-taking practice where the partner responds to a healthcare professional turn that explicitly addresses the patient. This form of partner contribution has been selected as research has considered to be problematic in both clinical and everyday settings. For example, a study into companion involvement during advanced cancer consultations reconceptualised this practice as ‘pseudo surrogacy’, describing how a companion speaking for or as a patient might negatively impact the patient’s autonomy due to the companion speaking as if the patient were not able to speak for themselves (Mazer *et al.*, 2014). By contrast, research on speaker selection in paediatric encounters demonstrated that, when parents self-select to speak after the child has been selected as next speaker, they do so after a substantial delay, orienting to the child’s primary rights and obligations to respond (Stivers, 2001). Likewise research into everyday interaction has described a socially organised preference for a selected speaker to respond to a question, along with a ‘second order’ preference that prioritises receiving a response compared to no response, even when it has not been provided by the selected next speaker (Stivers and Robinson, 2006). Combined, these findings show that, while there is a preference for the selected speaker to take the next turn, the act of self-selecting to speak after someone else has been selected as next speaker should not automatically be considered as problematic without a close examination of the turn-by-turn actions that comprise such interactional sequences. In examining the practice of a partner speaking after the patient was selected as the next speaker, this research serves to elucidate the interactional consequences of these interactions within the context of localised prostate cancer.

4.6 Analysis

In accordance with the fundamental principles of CA, initial analytical work proceeded absent of focused analytical goals (Hoey and Kendrick, 2017). This process comprised repeat listening to the recordings, while noting key observations. An initial observation was noted relating to the turn-taking practices across all twenty-eight consultations. It was apparent that partners were rarely selected as the next speaker (Lerner, 2003). This initial observation was examined in greater detail through an analysis that centred upon the CA concept of next speaker selection (Sacks, Schegloff and Jefferson, 1974). This concept comprises turn allocation as a technique used to allocate the next turn to a particular interlocutor, and recipient design, which is the ways that a turn-at-talk displays orientation and sensitivity to a particular interlocutor (Sacks, Schegloff and Jefferson, 1974; Lerner, 2003). There are three ways in which the next turn can be allocated: The current speaker can select the next, the next speaker can select themselves, or the current speaker may continue. The primary method for a speaker initiating a turn-at-talk is by way of having been selected as the next speaker. There are several ways in which this action can be accomplished, such as directing gaze to the selected next speaker, or using an explicit address term (Lerner, 2003). Additionally, speaker selection can be considered as tacit, only identifiable through an examination of the sequential context of a given turn-at-talk. Through an examination of questions and responses during multi-party interactions, speakers overwhelmingly selected the next speaker, underlining the primacy of this method of next speaker selection (Stivers, 2010). Likewise, research into questions and responses has shown that, in multi-party interactions, there is a socially organised preference for the selected next speaker to respond, alongside a ‘second-order’ preference for the receipt of a response compared to no response, even if this response is not provided by the selected next speaker (Stivers and Robinson, 2006).

4.7 Results

4.7.1 Partner contributions by speaker selection

The analysis required all partner turns to be organised in relation to the principles of next speaker selection (Table 11). In the initial examination of partners' turns-at-talk, 237 partner turns were identified across all twenty-eight consultations. Partners overwhelmingly obtained their turn through the process of self-selection, either by initiating or inserting a new action, or by self-selecting to speak after the healthcare professional had selected the patient as the next speaker. Partners were selected as next speaker three times by the healthcare professional, and four times by the patient. The relative paucity of these turns meant that a systematic analysis of these methods of speaker selection was not possible.

Table 11: Distribution of partner contributions by speaker selection

	Self-Selection, Initiating or inserting Action	Self-selecting after patient selected	Responding to HCP selecting partner	Responding to patient selecting partner
Total	215	15	3	4
Percentage	90.7%	6.3%	1.3%	1.7%

4.7.2 Partner self-selects after patient selected as next speaker

Fifteen interaction sequences were identified where a partner self-selected to speak after the patient was selected as next speaker. In all of these examples, the healthcare professional had completed their turn using a form of question with explicit orientation toward the patient. The notable feature of all fifteen examples was that partners initiated their turn after a substantial delay from an identifiable transition point of the healthcare professional's turn-at-talk, projecting orientation to the patient's primary rights and obligations to take their turn as the selected next speaker (Stivers, 2001). In some cases, the partner initiated after the patient had initiated their turn, elaborating upon, or to collaborating with the patient in the construction of a joint response to the healthcare professional. Notably, the process of the partner taking a turn after the patient was selected was, in the sequential organisation, exclusively a prosocial, collaborative exercise that maintained social solidarity between the patient and partner who regularly took up the discourse space afforded during these exchanges to take on a unified stance as a couple, referring to their experience in collective terms such as “we” and “us”.

In excerpt 22, the healthcare professional is attempting to outline the sexual impact of treating prostate cancer.

Excerpt 22: Have you seen the surgeons?

```
1  HCP: A::nd (0.5) #uh# du:hm #up# (0.5) did (0.4) #wuhh#
2       >have you seen the surgins tdeh- are they- (.) eh::m
3       would they s:say thed they ken spare a nu:rve or
4       anything like thad?
5       (2.3)
6  PAR: .hh we’ve ony had one meeting with mister ((name)), s:o
7       we,-
8  PAT: Weh he told us:s [the re]sults.
9  PAR:                  [just  ]
10 HCP: >Oh ↑okay< °jus tha results then°
```

This sequence takes place after a lapse in the conversation, with the healthcare professional initiating this sequence to request further information. In doing so, they ask two distinct polar questions within a single turn; one to establish if patient had seen the surgeons, and one to ask if the surgeons said that they can “spare a nerve or anything”. This turn is designed with explicit orientation to the patient. Nerve sparing in surgery is intended to minimise loss of erectile function. The asking of two polar questions, the hesitance markers, and self-repair make the turn hearable as fragmented. After a considerable gap of 2.3 seconds, the partner initiates on line 8, while initiating repair relative to an apparent problem with the two questions asked. The trouble source is elucidated by the patient who picks up the turn on line 9, noting that “he told us the results”. The healthcare professional orients to this turn with a turn that indicates receipt of new information with the production of the change of state token “oh”, before reaffirming the patient’s informing (Heritage, 1984a). This sequence shows how a partner self-selecting after the patient was selected as next speaker was both a prosocial, and subsequently, a collaborative action. This action was not only informative for the healthcare professional, but it also enabled the co-construction of their response. This was a common feature across all examples when a partner self-selected after the patient was addressed by the healthcare professional.

The action of partners self-selecting after the patient was selected, regularly resulted in a collaborative action between the patient and partner, yet this collaboration was not always acknowledged by the healthcare professional. In excerpt 23, the healthcare professional is opening the consultation.

Excerpt 23: In shock

```
HCP:  Howeh you. (.) >alright<?
HCP:             [((mouse click twice))]
PAT:  Eh:h (.)  [£↓wehhl↓ (.) hah [hahha:hhah]
PAR:                              [↑In↑ shock]=
PAR:  =[HAHAHAHA]=
PAT:   [.hhh hah]
PAR:  =[Ahs great-      ]
HCP:   [((mouse clicks)) ]
HCP:   [Ri:igh then      ] let me jus:sah ((clicks))(.) bring
      up your no:tes (.) sorrih, (.) ((clicks)) °caught >me
      on< >th' hop,<°
```

Their initial turn in this sequence is produced as a question along with a candidate response (How are you, alright?). Within the clinical context, this question, and the production of this particular candidate response is unusual. The patient responds in a manner that treats the question as inapposite, initiating with “Err, well” followed by laughter, indicating a response that departs from the normative expectations of the prior turn (Pomerantz and Heritage, 2013; Heritage, 2015). The response is produced with a smiling voice, and an embedded laughter particle. The partner latches onto the laughter, and elaborates upon the patient’s response, noting that they are “in shock”. This is also performed with a smiling voice and is followed with laughter that joins with the patient’s laughter in chorus. Before the laughter dissipates, the healthcare professional initiates with “Right then”, and moves straight to talk about the patient’s notes. During the patient and partner turns, the healthcare professional is heard to click a mouse. They continue to do so as they initiate this transitional turn that sequentially deletes both the question they asked, and a co-produced response that provided an important ‘status indicator’ of the co-present couple. Instead, the turn directs the conversation away from the patient and partner’s first contributions to the consultation, transitioning to the ‘business side’. This action projects a situation where the lifeworld-driven issue of this ‘shock’ is to all intents and purposes, unattended.

In excerpt 24, the patient has provided some specific information relating to their biopsy experience.

Excerpt 24: Did you have a powdery thing?

```
1   HCP:  You >y’know< last ti:me you had the biopsee
2         [>y’ st]arted< the:e (.) [>antibiotics< the ]night=
3   PAT:  [Ye:ah.]                 [two hou:ers before]
4   HCP:  = befo:re.
5   PAT:  >No I< didn °it° ws two ho:urs (.) #uh# cus I had a
6         powderee thing?
7   HCP:  Oh d’yuav po:wdree thing.
8   PAR:  N-[yeh-]
9   HCP:    [oh  ]why ws thah (.) >dyou ↑know.<
10        (.)
11  HCP:  dyou [know why tha wuh- ]
12  PAR:       [.hhhhh   is becus ]he said soming tudo with the:h
13        [straining uv the (.) muscle (group)   ]?
14  PAT:  [Av I- (.) hhh        hhev I goh tendon]i:tis (.) uh:h
15        >istha< I didn ackshee av [tendonitis] but ah do have
16  HCP:                            [arr ohkay ].
17  PAT:  brittle (.) tendons,
```

They highlight the exceptional circumstances of their antibiotics noting that they had to have a ‘powdery thing’. The healthcare professional then initiates in response to this information, with their request for confirmation hearable as a repair initiator insofar as it places a hold on the progression of the conversation until this matter is resolved (Kitzinger, 2013). The partner initiates a turn on line 8 that appears to be an attempted response to the healthcare professional’s request, before immediately aborting the turn. As they initiate, the healthcare professional pursues further before the partner’s turn is hearable as confirmation. In doing so, the healthcare professional produces three distinct interrogative turns, asking “why was that?”, “do you know?” and then “do you know why that was”. The partner initiates their turn in overlap with the third question, offering a response that is fitted directly to the first interrogative produced by the healthcare professional. At first glance, the overlap may seem like the partner has not oriented to the patient’s primary rights and obligations as the selected next speaker, however the timing between the first question “oh why was that?” and the partner initiating demonstrates a clear gap within which the patient could have initiated to respond, despite the healthcare professional reformulating the question twice more. As with the previous examples, the patient, who did not initially respond to either the healthcare professional’s repair initiator, or the request for an account relating to the ‘powdery thing’, initiates to collaborate with the partner. In this, they offer an account across lines 14 to 17 that is fitted to the partners response, leading to an acknowledgement from the healthcare professional on line 16.

The ways that partners initiated their response to turns that selected the patient could be seen to serve as a form of advocacy that, instead of inhibiting patient contributions, served as an enabling action, providing an opportunity space for the patient to contribute as shown in excerpt 25. In this sequence, the healthcare professional is working to minimise the patient’s concerns about surgery-related side effects.

Excerpt 25: No idea

```
1  HCP:  .hhh an then the:e (.) the (.) the c:continence (.)
2        what’s you:ur (0.6) undestanding >about< how long you’d
3        be leaking urine.
4        (.)
5  PAT:  Uh- >I woud’ve-< I thought abit three ↑months
6        (0.4)
7  HCP:  °Tha’s right° [So (.)] >on average< (.) three months.=
8  PAT:                [Mmmm. ]
9  PAT:  =Mmmm.
10 HCP:  #By# #uh:h# >yiknow< half the men >will be< dried up by
11       then an the other half=
12 PAT:  =yeah.=
```

13 HCP: =>is a< bit longer.
14 (0.3)
15 PAT: Hm:m=
16 HCP: =An what's your (.) imagination of how >many people<
17 would still be leaking at one ye:ar.
18 (1.1)
19 PAT: Uh:h#ih#m#=
20 PAR: No idea £hhh£=
21 PAT: =>No uhn< #huh#- (0.3) I >wouldn've< >thought< any:y
21 (.)
22 HCP: So i-it's lo:w i:is probably (.) uh o:ne in ten wearing
23 pa:d,

In this sequence, the healthcare professional asks two questions that can be described as examination questions inasmuch as the healthcare professional is asking questions to which they themselves know the answer. It is on lines 16 – 17 that the healthcare professional asks the patient what is their "imagination of how many people would still be leaking at one year". Critically, the turn design, and the lexical item "imagination" presupposes that the patient's response will be inaccurate and is projected to be produced only for the purpose of correction. The 1.1 second gap after the question before the partner initiates with a response, shows that the patient's primary rights and obligations as selected next were acknowledged by the partner. Moreover, the patient latches onto the laughter particles of the partner to offer a turn that aligns with the partner's response before going on to offer a response to the question in a manner that is fitted to the sequence, noting that they "wouldn't have thought any" would be leaking after a year. Like all identified sequences, the partner's initiation after the patient was selected as next speaker not only displayed orientation to the norms of turn-taking but provided opportunity space for the patient to contribute along with the partner, co-delivering accounts and information as a couple.

The ways that partners self-select after the patient was selected as next speaker was shown to enable patient contributions with as little as a single lexical item being produced by the partner as shown in excerpt 26.

Excerpt 26: Brachytherapy is the one we prefer isn't it?

1 HCP: Ok#a:y# .hhh >fine< .hh >so- so< what d'you understand

```
2         about yo:ur (.) prostate can:cer and about the v-
3         options fuh tre:a’m’n:t.
4         (0.5)
5   PAR:  °W:well°=
6   PAT:  =Well so fa:r (1.0) >I aven< actully:y- #ohh ih#- the
7         ones I- I’ve >read ohl<- all the (.) paperwork or we’ve
8         read all the paperwork n:d sortof gone >through it< n:n
9         (.) picked it apa:rt n (.) god [knows what] el-
10 HCP:                                 [ye::ah    ]
11 PAT:   .hh >so far< I ca:an’t see a good positive.
12        (.)
13 HCP:   .HHhh
14        (0.6)
15 PAR:   °mmm° Braca the:rapy is the one we prefe:r °i’n it°.
16        (1.2)
17 HCP:   Do [you euh-]
18 PAT:      [We’ve lo]oked at thu:h th- operation:n to remo:ve
it
19        and I:I thought we- uh- a:t first I thought >well that<
20        probly a good ide:a,
21        (0.6)
22 PAT:   Anen I:I read th- the litri’re n I though- f:flipping
23        el:l y’godda be avin a la:ugh is worse [thn (.)] if you
24        ave thu:h,
25 HCP:                                          [ye:ah. ]
26        (0.6)
27 PAT:   thuh actu:l (.) #uh:m# therapy yiknow (.) like [thu:h]
28        thuh br[a- brack, ]
29 HCP:                                                  [yeah ]
30 PAR:          [ra:diothe-]
31 HCP:   >Yeah< (.) brachy[ther:apy  ]
32 PAT:                    [Yeah which] the:y stick (.) fi- (.)
33        >wiggle uh< (.)
34 HCP:   Ye:ah=
```

Here, the healthcare professional initiates a sequence to elicit information from the patient across lines 1 – 3. After a relatively short gap, the partner begins a turn with “well” as an apparent preface to a longer turn-at-talk. Well-prefacing has been shown to project an incoming turn that is not in alignment with the prior, or has a complex relation to it (Heritage, 2015). Latching onto this, the patient initiates their own well-prefaced turn, producing an account that is not entirely in alignment with the healthcare professional’s question, as the patient narrative departs somewhat from the initial pragmatic design of the healthcare professional’s question. Instead of indicating some form of preference, the patient evaluates negatively, all the available options. As the patient completes their evaluation, the partner re-initiates to offer a form of supportive elaboration that picks up from the patient’s turn with “mmm” on line 15, followed by an expression of preference on behalf of them both. The partner completes the turn with the tag “isn’t it?”, which presents this preference to the patient to endorse or otherwise reject. After a 1.2 second gap, the healthcare professional initiates, only to drop out when the patient initiates their turn. The patient then, from the perspective of the couple (we’ve looked at) provides a more elaborate account of their understanding, underlining the complexity of their considerations, as projected by the initial well-prefaced turns on lines 5 and 6.

Partners’ self-selected initiations after the patient was selected as next-speaker could also take place after the patient had initiated their turn, with their turns serving as collaborative expansion units to the patient’s turn-at-talk. Nevertheless, these turns were observed to accomplish the same action of orienting to the patient’s primary rights and obligations as the selected next speaker, while serving to enable further contributions from the patient as a collaborative act. This was shown in excerpt 27 where the healthcare professional initiates a sequence in order to outline the sexual impact of prostate cancer treatment.

Excerpt 27: We have discussed it

```
1  HCP: Thee- uhm- (1.0) the::e (0.8) othe’ down side is- (.)
2       #a#changes >t’ yo’< sexual function,
3       (0.5)
4  HCP: >Ah’ y’< sexu’y active >at th’ moment?<
5       (0.6)
6  PAT: W- >we ~a:are~< (.) >but ah ↓mean↓< (.) Ahm ↑seventy↓
7       comin’ [t’ sev]enty.
```

```
8  HCP:        [↓yeah↓]
9        (0.6)
10 PAT:  (not to) [((unclear due to overlap from HCP))]
11 HCP:           [Well uh- I- (.) so I think tha’ it-] (.)=
12       =[so it’s noh-]
12 PAT:   [so it’s som]e’ing we’[ve discuss]ed- .hhh ih=
13 PAR:                         [the impo- ]
14       (.)
15 PAR:  =we have discussed it [as something]=
16 PAT:                        [i- in depth]
17 HCP:                        [↓ye:ah↓    ]
18 PAR:  =for for’y seven years (.) and (y’- well °about°) I
19       [(w:ould have) t’ say,]
20 PAT:  [°y’ ‘ow wo’ ah mean° ]
21 HCP:  [↓ye:ah↓]
22       (.)
23 PAR:  [~>very ] very<~=
24 PAT:  [°↓God↓°]
25 PAR: =°fort[unate~]°
```

The question posed on line 4 is designed with explicit orientation to the patient. The patient initiates their response after a delay, and offers a mitigating account, indicative of a dispreferred response (Pomerantz and Heritage, 2013). Such responses are considered to run contrary to the normative expectations of the initiating question. As they continue their account, the patient produces hearable trouble sources with hitches and re-initiations which are made more problematic as the healthcare professional initiates a turn that takes place in overlap with much of the patient’s talk on line 10. As the patient continues their turn on line 12, the partner initiates, with their turns operating in collaboration with the patient’s turns from lines 13 – 25. This collaborative effort is elucidated when looking at lines 15 and 16 where the patient offers a persuasive elaboration as to the extent to which the couple has discussed the going concern (in depth). Despite the regular occurrence of overlapping talk in this sequence, the partner’s contributions only serve to enable the patient to contribute to the conversation while underlining the patient’s and partner’s stance as a couple in this exchange.

4.8 **Discussion**

This research examines the sequential organisation of an everyday turn-taking practice, situated within the context of localised prostate cancer consultations. It attends to a situated social practice where a partner initiates their turn-at-talk after the patient has been selected as the next speaker by a healthcare professional. The use of CA, with an analytical focus on the concept of next speaker selection enabled a detailed analysis into the ways that these interactions unfolded when a partner initiated their turn following a turn-at-talk that was delivered with explicit orientation toward the patient. The analysis demonstrated that these interaction sequences unfolded in a consistently prosocial manner, with partners taking their tun after a substantial delay, displaying orientation to the patient's primary rights to respond to the turn that selected them as the next speaker (e.g. Stivers, 2001). This was made evident by the timing between the transition point of healthcare professionals' turns and partners' initiations, where a sufficiently hearable gap was observed in every case in this collection (Stivers and Robinson, 2006). These hearable gaps could be as little as 500 milliseconds. Moreover, despite the patient appearing to initially pass on their option to take their turn as the selected next speaker, the act of the partner initiating after the patient's interactional move of passing consistently served as an opportunity space for the patient to elaborate upon or collaborate with the partners turn-at-talk. Notably, patients and partners almost invariably co-produced the subsequent turns-at talk, often taking a unified stance of 'we' or 'us', despite the healthcare professionals turns orienting exclusively toward the patient as an individual. This sequential organisation was present throughout the collected examples.

This research compares well to work in other clinical contexts where the process of next speaker selection has been examined. Research in the context of the seizure clinic has shown how companions regularly oriented to the patient's primary rights as the selected next speaker, prior to initiating their turn-at-talk (Doehring, 2019). Within the same context, research has demonstrated that, far from impeding patient participation, companions served as a facilitative resource to both the patient and the doctor (Robson, Drew and Reuber, 2013). The ways that partners initiated after the patient had evidently passed on their rights as selected next speaker also follows a similar pattern to that identified by research where companions in the seizure clinic could initiate to contribute when patients exhibited interactional troubles or resistance (Robson, Drew and Reuber, 2016). Likewise, research in the context of paediatric primary care has shown that parents orient to their child's primary rights as the selected next speaker prior to presenting the child's concern (Stivers, 2001). The finding that partner contributions opened an opportunity space for patients to contribute by way of elaborations or collaborations also bears some similarity to research that has shown how parent contributions in paediatric settings served to encourage the child patient to contribute (Cahill and Papageorgiou, 2007). Instead of being an impediment, these findings demonstrate that the person accompanying the patient can be drawn upon as an informational and interactional resource for both the patient and the healthcare professional.

The findings from this study stand in contrast to previous research in the context of oncology that has considered the ways that partners can speak for or as the patient may have negative implications for the patient's autonomy (Mazer *et al.*, 2014). While this study offered detailed descriptions of the ways that partners can perform their concept of 'pseudo-surrogacy', it did not attend to, nor report on critically important components of these interactions such as the timing of turns, emphases, prosody, non-word utterances, and the sequential organisation of these moments. A close inspection of these interactional features enabled this research to show the consistently pro-social and collaborative nature of these exchanges, indicating that the act of the partner initiating after the patient was selected as next speaker was an enabling, not inhibiting action during the consultation.

The data from this study suggest that partners can offer the conditionally relevant response to a healthcare professional's initiating turn, after the addressed patient's response has become hearable as absent through substantial delay, or by repeated initiations by the healthcare professional (e.g., excerpt 24). This practice compares well to research into everyday social interaction that has outlined the regularities of next speaker selection, and how participants orient to a socially organised preference for the selected speaker to take up their rights as the selected next speaker, while orienting to the second-order preference of obtaining a response versus no response (Sacks, Schegloff and Jefferson, 1974; Stivers and Robinson, 2006). Following the partner's conditionally relevant next turn, the patient invariably initiated to elaborate or collaborate in a series of turns that included co-production of turns, co-completions, anticipatory completions, and choral production of turns where participants produce the same or similar turn-at-talk in overlap (Lerner, 2002). While some research has considered this format of talk akin to ‘interrupting’ (e.g. Cahill and Papageorgiou, 2007), the findings from this research indicate that these overlaps and co-produced turns-at-talk accomplished exclusively prosocial actions; a finding supported by research into overlapping speech (Lerner, 1989; Drew, 2016).

The findings from this study suggest that, even when addressed as an individual, patients can act in a manner that is hearable as having passed on their initial rights as selected next speaker, while following up on their partner’s contribution, regularly forming a unified stance in alignment with them. This unified stance was evident in both the turn design and sequential organisation of the patient’s and partner’s turns, including person references, co-production, and co-completions of turns-at-talk.

These sequences are indicative of the patient and partner acting as the ‘cancer couple’ as conceptualised by earlier research. (Soloway *et al.*, 2005; Bullen and Tod, 2013). These actions speak to the expressed preferences of patients and partners, for partners to be involved in oncology settings, particularly in relation to making treatment decisions (Davison *et al.*, 2002). Indeed, research evidence indicates that partner involvement is largely valued by patients in oncology settings.

A review of research into romantic partner involvement during oncology consultations has underlined the important roles that partners could enact during oncology consultations, as they can advocate for, provide practical, informational, and emotional support to the patient (Stewart, Roberts and Brindle, 2021). In the context of prostate cancer, alongside several other genitourinary cancers, this is unsurprising as the experience of these cancers, and the impact of treating them are rarely confined to the patient alone. In the context of prostate cancer, the decision to treat has particularly powerful and complex implications for people with whom the patient shares an intimate relationship, as they navigate together, the psychosocial and sexual impact of this condition and its treatment (Nanton *et al.*, 2010; Bullen and Tod, 2013). It is therefore surprising that there are apparent incongruities between the understanding of prostate cancer as a shared experience between couples, and the ways that this experience is communicated during consultations when a couple is in attendance.

The prosocial findings of this study must be juxtaposed against the initial understanding that, across all twenty-eight consultations, there were only three instances of a healthcare professional selecting the partner as the next speaker, with none of these examples having any bearing on the decision-making process.

Based on the data collected for this study, it is evident that partners' contributions can serve to enable the patient to provide the healthcare professional with information that was not initially forthcoming, encouraging progressivity in the interaction, and acting as a valuable interactional resource. In considering this incongruity, some explanations might be found in policies relating to patient-centredness and shared decision making (SDM).

As a clinical model, SDM is idealised as a practice where healthcare professionals and patients reach decisions together through the sharing of evidence and preferences (Elwyn *et al.*, 2010; Coulter *et al.*, 2011). SDM is designed to encourage a collaborative form of engagement between the patient and the healthcare professional, with the intention of promoting individual patient autonomy in the decision-making process (Elwyn, 2020). Likewise, the emphasis upon patient-centred communication is intended to promote patient involvement through SDM (Landmark, Gulbrandsen and Svennevig, 2015). It is therefore possible that there exists a tension between the configuration of the consultation where a couple is present, and clinical ideals that are entrenched within an individualist approach to patient autonomy.

Despite the findings in this study demonstrating the social and clinical utility of partner contributions, healthcare professionals exclusively addressed the patient as an individual, standing distinctly separate from their co-present partner. While this approach may align with a patient-centred approach to medical care, it can also be indicative of enacting an individualised version of autonomy as conceptualised by Immanuel Kant, where individual decisions are considered to be the result of solo cognitions that take place outside of social influences (Kant, 1996). Indeed, the clinical model of patient autonomy places heavy emphasis upon the patient's right to individual determination, while actively working to isolate them from external influences (Beauchamp and Childress, 2019). By contrast, the ways that the patient and the partner regularly took up a unified stance as a couple could be seen as indicating that their autonomy within this setting was inherently relational as their responses consistently resisted the individualised turn design of the healthcare professional, to present a presentation of their 'selves' as relational (Goffman, 1990b; Keller, 1997). In this respect, the ways that patients and partners acted in collaboration serves to underline the understanding that decision-making is never a solo cognitive process, but that it is instead, a fundamentally social process that takes place across multiple time-points, and is inextricably connected to social relations and practices (Rapley, 2008; Elwyn, 2020).

In sum, this research offers evidence for a need to reconsider what it means to enact patient-centred care, especially when the patient attends the consultation as part of a couple. As decision-making and patient autonomy can be considered to be relational, and inherently social, there is value in reframing the patient as equally social, inextricably connected to a complex network of social relations and influences that in turn, inform their everyday decision-making (Struhkamp, 2005). One way that this might be accomplished within the context of prostate cancer, would be to both sanction and address partners as an integral part of the consultation process, akin to the process observed in the seizure clinic (Robson, Drew and Reuber, 2013; Doehring, 2019). As these studies have demonstrated, the formal sanction of a partner does not impact upon the duration or structure of the encounter, but it does provide a valuable interactional resource for both the patient and the healthcare professional. Partners are likely to remain as unratified participants in this setting unless healthcare professionals proactively engage with patients and their partners as a couple. Absent of this form of participant ratification, partners will most likely continue to have to work to insert their contributions into the consultation while continuously having to resist the dyadic structure of the unfolding interactions within the encounter.

4.9 Conclusion

This study examined one of the ways that partners contribute to clinical consultations in the context of localised prostate cancer. In these consultations, the ways that the partner provided a conditionally relevant next turn where the patient had evidently passed on their rights as the selected next speaker was consistently prosocial, with the partners initiation consistently serving as an opportunity space for the patient to follow up with elaborative and collaborative contributions. In these follow up contributions, patients regularly took up a unified stance with the partner as a couple, resisting the healthcare professional's individualised formulations of the patient. This finding shows that, far from impeding the patient, these initiations can serve as an enabling force that enhances the relational autonomy of the patient and partner as a couple. This study argues for a reframing of the patient as inextricably situated within their social relations, as well as an examination of what it means to enact patient-centredness in the prostate cancer clinic.

Funding

The lead author was funded and supported by the South Coast Doctoral Training Partnership of the Economic and Social Research Council, Ref: ES/J500161/1.

Declaration of competing interest

None.

CRediT author statement

Simon John Stewart (Conceptualisation, Methodology, Formal analysis, Investigation, Data Curation, Writing – Original Draft, Writing – Review & Editing, Visualisation, Funding acquisition; Lisa Roberts (Validation, Supervision, Formal analysis (support), Writing – Review & Editing (support)); Lucy Brindle (Validation, Resources, Supervision, Formal analysis (support), Writing – Review & Editing (support), Funding acquisition, Conceptualisation)

Acknowledgements

The lead author would like to thank their mentor, Dr Merran Toerien for their ongoing support, encouragement, and insight into the turn-taking system, the TrueNTH study that funded the data collection and the original study team. They would also like to thank the participants for their invaluable contribution to this study.

4.10 **Chapter discussion**

This chapter started with an illustration of a common-sense, taken for granted, turn of phrase that ‘everyone knows’, “speak when you’re spoken to”. As defined by the Cambridge English Dictionary, the phrase is “said to a child to tell the child not to speak if no one speaks to them first” (Cambridge.org, 2020). As much as this phrase can be considered as largely outmoded, its relationship with the socially organised regularities of taking part in social interaction can be seen to persist. Harvey Sacks and colleagues described the regularities inherent to taking part in everyday social interaction, noting the importance of sanctioned participation, and the process of next speaker selection (Sacks, Schegloff and Jefferson, 1974; Sacks, 1992). In this respect “speak when spoken to” relates to the primary method of obtaining a turn-at-talk where the speaker of the prior turn actively selects the next speaker, and moreover, grants exclusive, yet evidently, time-limited rights for the selected next speaker to respond. This time limit is in itself highly organised as a situated preference, in which the floor can be seen to ‘open up’ should the selected next speaker’s turn become hearable as absent (Stivers and Robinson, 2006). That this absence can become hearable in as little as 700 milliseconds, speaks to the extent to which everyday social interaction is organised. The regularities of turn-taking are so well organised, that the introduction of as little as 750 milliseconds of latency during online video interactions can frustrate this otherwise well-ordered turn-taking system (Seuren *et al.*, 2021).

This research in this chapter examined the turn-taking practices enacted during localised prostate cancer consultations comprising a healthcare professional, a patient, and their co-present partner. The research demonstrated the paucity of interaction that is explicitly oriented toward the partner, while underlining the utility and prosocial nature of exchanges where a partner takes a turn, whether self-selecting to initiate a new action, or self-selecting after the patient was selected as the next speaker. While the findings may seem to run contrary to the socially organised preference for the selected next speaker to respond (Stivers and Robinson, 2006), and the common-sense idiom “speak when you’re spoken to”, a detailed analysis of these moments illustrated that a form of social order was maintained. When taking their turn, partners only did so when it became ‘hearable’ that the patient had passed on their exclusive rights to take their turn as the selected next speaker. In this respect, the partner should not be considered as speaking out of turn, but instead, they should be considered has having taken a turn after the patient's turn, which can be characterised as a distinct interactional move of 'passing' on their turn. That the sequences in this research invariably proceeded without negative sanction for the partner demonstrates that, like many common-sense ways of knowing, the idiom "speak when spoken to" is somewhat reductive, and not situation-invariant, but is instead, highly dependent on the situated understanding of whether the unaddressed party has allowed a small, yet crucial amount of time for the selected speaker to pass upon their rights as the selected next speaker. In essence, these exclusive rights might be considered as a time-limited 'first-refusal' to take the next turn, after which, the floor is 'open' to self-selection without the threat of negative sanction.

Chapter 5 Expressing Preferences

5.1 Chapter introduction

The previous chapter offered an overview of the turn-taking practices across the entirety of prostate cancer consultations comprising a healthcare professional, a patient, and their partner across all phases of consultation openings, results and diagnosis, treatment discussions, next steps, and closing. In addition to showing the prosocial impact of partner contributions, the research shows that partners are largely unaddressed by healthcare professionals across the entirety of the consultations. The three instances in which the healthcare professional does address the partner directly have no bearing upon the treatment decision-making process, with these moments being situated largely outside of the 'business side' of the consultation.

The collected examples in this study, along with previous research into shared decision-making demonstrate well that the decision to treat localised prostate cancer is never a solo activity, and that it is distributed across multiple time-points and social relations (Rapley, 2008; Elwyn, 2020). Localised prostate cancer is also a medical condition in which the treatment decision should depend more upon expressed preferences in the enactment of shared decision-making (Simmons, Hetrick and Jorm, 2010; NICE, 2014; Whitehead, 2015). Indeed, the presented examples in this study show how these couples have approached and discussed their situation prior to attending the clinical consultation ("*We've* discussed it", "Brachytherapy's the one *we* prefer isn't it?"). In this respect, an examination of the conversational practices enacted relative to treatment choices within these consultations is warranted. Accordingly, this chapter attends to the interactional consequences that unfold when a patient or a partner expresses a preference relative to the available treatment choices during this preference sensitive setting.

5.2 Sequential Misalignment and Conflict Management: Patient and Partner Preferences During Localised Prostate Cancer Consultations

5.2.1 Highlights

- During consultations patients, and their partners regularly express treatment-related preferences.
- When healthcare professionals disalign from these expressions, it can cause a shift toward an adversarial configuration of interaction.
- This sequential misalignment can result in patients and partners silencing themselves, indicative of conflict management.

5.2.2 Keywords

Prostate Cancer, Partners, Spouses, Medical Communication, Conversation Analysis, Sequential Organisation, Conflict, Treatment Decision Making

Word count excluding references and tables: 5321 (+191 Abstract)

5.3 Abstract

This study examines the sequential organisation of treatment-related preferences expressed by patients and their co-present romantic partners during clinical consultations for people with localised prostate cancer. A conversation analysis of 28 diagnostic and treatment consultations was carried out with data collected from four clinical sites across England. When healthcare professionals' responses disaligned with expressions of preference, it caused a sequential pattern of discordance, shifting the interaction toward an adversarial configuration. This sequential misalignment led to patients and partners silencing themselves. Two deviant cases were identified that did not contain this sequential misalignment. These findings highlight the immediate consequences of expressions of preference being resisted, rejected, and dismissed in a context that should be sensitive to such expressions. The adversarial configuration of these moments contaminated the interactions during a time where cooperation is desirable. The deviant case analysis offers an alternative to the salient pattern observed across the collection. This research offers a detailed comparison between misaligned sequences, and two deviant cases where social solidarity is maintained. Instead of disaligning from expressions of preference, healthcare professionals should acknowledge these as valid contributions within a preference-sensitive consultation.

5.4 Introduction

In healthcare settings, patients typically seek medical attention to gain an explanation and solution for an illness they are experiencing. During clinical consultations, the explanation and potential solution are usually discussed during concurrent phases (Robinson, 2003; Stivers, 2006). Research into these phases has shown how healthcare professionals can communicate diagnoses and make treatment recommendations in ways that project varying degrees of medical authority (Peräkylä, 2006; Stivers *et al.*, 2018). For example, the ways that diagnoses are presented has been shown to draw upon authoritarian concepts (Byrne and Long, 1976; Heath, 1992). Likewise, in making treatment recommendations, research has indicated that the most common form of treatment recommendation is the authoritative use of a pronouncement, such as “I’m going to start you on X” (Stivers *et al.*, 2018).

Research into the interactional processes of treatment recommendations has served to elucidate how patients orient toward such authoritative actions. This research has shown how patients producing minimal responses to authoritative deliveries can be indicative of resistance (Heath, 1992; Koenig, 2011; Stivers *et al.*, 2018). These studies indicate that this resistance should be treated as an important interactional resource that enables patients to assert agency and engage in active participation during the consultation. (Koenig, 2011). The medical encounter has also been regarded as a site where both the patient and healthcare professional should be treated as agents in the negotiation of diagnoses and treatment decisions (Peräkylä, 2006; Lindström and Weatherall, 2015). This relates well to the concept of Shared Decision Making (SDM). As a clinical model, SDM is designed to encourage healthcare professionals and patients to share information, achieve consensus, and to promote informed, and shared decisions (Charles, Gafni and Whelan, 1997; Elwyn *et al.*, 2012).

SDM is conceptualised as a middle ground between concepts of paternalism which imbues the healthcare professional with the epistemic and deontic authority to make decisions for a typically passive patient (Charles, Gafni and Whelan, 1997), and consumerism where the patient is afforded a greater degree of agency relating to treatment choices (Bishop and Yardley, 2004; Oliffe *et al.*, 2011). As an ideal, SDM means that the expressed preferences of the patient should be acknowledged and actively considered. This concept has informed healthcare policies across several medical contexts, including neurology and oncology (Cohen and Britten, 2003; Toerien *et al.*, 2018; Toerien and Jackson, 2019). However, research indicates that the ideals of SDM are rarely enacted, even in contexts where healthcare professionals advocate for SDM (Lipstein, Dodds and Britto, 2014; Driever, Stiggelbout and Brand, 2020). In the context of gastroenterology and rheumatology, Lipstein and colleagues observed limited use of SDM noting minimal elicitation of preferences, treatment goals, and patient knowledge. Likewise, Driever and colleagues noted that, while most primary care physicians in their research advocated for SDM, they often reverted to a paternalistic delivery during primary care consultations.

Low and intermediate risk, localised prostate cancer is a noteworthy medical context for two reasons. Firstly, the research to date indicates that there is no clear benefit in selecting one treatment option over any other (Hamdy *et al.*, 2016). In the UK, this has informed a policy of preference-sensitive treatment decision-making during clinical consultations (NICE, 2014). Secondly, the experience of prostate cancer has been shown to affect both patients and their romantic partners, as its treatment-related side-effects have profound implications for what has been described as the ‘cancer couple’ (Soloway *et al.*, 2005; Bullen and Tod, 2013). Side-effects such as incontinence, impotence, and fear of cancer progression can all lead to the cancer couple experiencing physical and psychological morbidities that inevitably impact upon their relationship (Bullen and Tod, 2013; Wootten *et al.*, 2014). Accordingly, patients largely expect their romantic partners to be involved throughout the cancer experience (Beisecker *et al.*, 1996; Davison *et al.*, 2002; Zeliadt *et al.*, 2011; Stewart, Roberts and Brindle, 2021). It can therefore be reasonably expected that this is a context in which the cancer couple’s expressed treatment-related preferences should be privileged.

To date, research into expressed treatment-related preferences, has taken place mainly in contexts where there are biomedical and lifeworld justifications for a healthcare professional to privilege their own expertise over that of the patient (Koenig, 2011; Lindström and Weatherall, 2015). Nevertheless, in these cases, healthcare professionals were still found to orient toward the patient’s right to accept or refuse treatment recommendations. Additionally, research has examined the ways that parent companions may orient to healthcare professionals’ recommendations, indicating that they can resist recommendations as an interactive resource for negotiation on behalf of a child patient (Stivers, 2005; Toerien and Jackson, 2019). To date, research has yet to examine the communication practices relating to a patient's and romantic partner's treatment-related preferences as expressed during a consultation situated within a context where preference-sensitive treatment decision-making might be expected. Accordingly, this research examines the ways that treatment-related preferences are expressed by patients and their co-present romantic partners during clinical consultations for localised prostate cancer. This study offers an analysis into the sequential organisation of these interactions by examining the ways that healthcare professionals organise their talk around treatment preferences, how patients and partners express their preferences, and in turn, how healthcare professionals respond to these expressions.

5.5 Analysis

In accordance with the fundamental principles of CA, initial analyses proceeded absent of focussed analytic goals (Hoey and Kendrick, 2017). This involved repeat-listening to the recordings, with notes made about key observations in the data. One observation was that patients and partners regularly expressed preferences relating to decisions about treatment, with or without invitation from the healthcare professional such as the production of a patient view elicitor (PVE) (Toerien *et al.*, 2018). All sequences containing such expressions were collected for a more detailed, line-by-line analysis. The analysis considered how the configuration of these sequences informed contribution opportunities for the patient and their partner, attending to details such as turn design (Drew, 2013), and sequential organisation (Stivers, 2012). The analysis produced an illustration of how healthcare professionals oriented to patients' and partners' expressions of treatment preferences.

5.6 Results

5.6.1 Sample

Twenty-eight prostate cancer diagnostic and treatment choice consultations were analysed where a patient attended with their partner. Patients were diagnosed with low or intermediate risk, localised prostate cancer. Consultations involved the healthcare professional outlining several available treatment options. In accordance with NICE guidelines, healthcare professionals are expected to present these treatment choices while being sensitive to expressed preferences and orientations (NICE, 2014).

5.6.2 Disaligning with expressions of preference

Sixteen sequences were identified where patients and partners expressed treatment-related preferences. In the analysis, the ways that healthcare professionals oriented to these expressions of preference was found to disalign with the ongoing activity in a manner that reconfigured the interaction from cooperative to oppositional (Whalen, Zimmerman and Whalen, 1988; Heritage, 2011). This sequential misalignment became apparent as healthcare professionals moved to dismiss expressions of preference, sought to educate patients and partners, and organise the interaction as a series of turns that could serve to either oppose or sequentially delete expressions of preference. The concept of sequential deletion relates to a turn that takes place absent of orientation toward the prior turn, as if the prior was not produced at all (Lerner, 1989).

For each excerpt, HCP: indicates the healthcare professional, PAT: indicates the patient, and PAR: indicates the partner.

5.6.3 Disaligning, with patient-initiated preferences

This sequential misalignment takes place over a protracted sequence in excerpt 28.

Excerpt 28: What's your imagination?

```
1  PAT:  Yeah (.) 'eah [°>bu- bu-<]
2  HCP:                 [Wha- wha- ] what >soddo< things are
3        attractive to yo:u in choosing a treatment,
4        (.)
5  PAT:  Weuh↓ (.) #Ah# Ah wa- I wasn't keen on thee eh:m (0.5)
6        eh removal.
7        (0.5)
8  HCP:  Mhm,=
9  PAT:  =Th- that's uh:m (1.0) first'v all >an' en'< I b- wa'dn
10       keen on tha- o- option,
11       (0.7)
```

```
12 PAT:  [Uh:m      ]
13 HCP:  [>What wa-<] What was driving that decision o:ut of
14       interest.
15 PAT:  We:ll uh- thee:e thee ongoin:n uhm (.) #ihh# havin' a
16       cathete:h 'n uh:h nappies 'n all that foruh- fo' months
17       'n' (0.3) yiknow=
18 HCP:  =So:o so let's >just make< su:re >that your<
19       understanding is (.) #uh# >correct< on that >so the<
20       catheteh stays in foruh (.) ten:n ↓days?=
21 PAT:  =Righ [ye:ah]
22 HCP:        [.hhhh] >Then it's< removed [s:so ] the's no
23       catheter a:fter=
24 PAT:                                    [mmhm↓]
25 HCP:  =tha:at,
26       (0.4)
27 PAT:  °no°=
28 HCP:  =.hhh (.) Uh:hm (.) an:n s:so that's (.) yiknow sh:hort
29       period time,
30       (.)
31 HCP:  .hhh an then the:e (.) the (.) the c:continence (.)
32       what's you:ur (0.6) undestanding >about< how long you'd
33       be leaking urine.
34       (.)
35 PAT:  Uh- >I woud've-< I thought abit three ↑months
36       (0.4)
37 HCP:  °Tha's right° [So (.)] >on average< (.) three months.=
38 PAT:                [Mmmm. ]
39 PAT:  =Mmmm.
40 HCP:  #By# #uh:h# >yiknow↓< h:alf the men >will be< dried up
41       by then an the other half=
42 PAT:  =yeah.=
43 HCP:  =>is a< bit longer.
44       (0.3)
45 PAT:  Hm:m=
46 HCP:  =An what's your (.) imagination of how >many people<
47       would still be leaking at one ye:ar.
```

```
48        (1.1)
49 PAT:   Uh:h#ih#m#=
50 PAR:   No idea £hhh£=
51 PAT:   =>No uhn< #huh# (0.3) I >wouldn’ve< >thought< any:y
52        (.)
53 HCP:   So i-it’s lo:w i:is probably[ (.)] uh o:ne in ten
54        wearing pa:d
55 PAT:                               [Hmm ]
56        (.)
57 HCP:   Ana handful (0.3) s:o that’s many (.) swf- safety:y
58        [o:r  ] just a fe- few=
59 PAT:   [yeah.]
60 HCP:   =drips here n the:re >nothing<
61        (.)
62 PAT:   °Yeah.°=
```

At line 2, the healthcare professional initiates a patient view elicitor (PVE). The patient’s responses from lines 5 – 9 are performed with a well-preface, hitches, and re-initiations, all indicative of a turn performed against the normative expectations of the request (Pomerantz and Heritage, 2013). After expressing their preference there is a gap long enough for the patient to initiate a further turn on line 12. At the same time, the healthcare professional initiates a turn on line 13. This turn treats the patient’s expression as insufficient in some way and is a repair initiator insofar as it is an explicit request for an elaborative account (Kitzinger, 2013). The repair initiator impedes progressivity of the consultation, but does not alter the configuration from cooperative to adversarial (Heritage, 2011). However, the sequence is then transformed into a series of healthcare professional turns that either oppose or reject what has come before them. The sequential misalignment is not one-sided. The patient initiates their turn on line 14 with a well-preface, projecting both a formulation from ‘my side’, and a departure from the normative expectations as constructed by the repair initiator (Heritage, 2015).

The healthcare professional, instead of acknowledging this account, initiates a problematising sequence, beginning on line 18. This sequence is overtly designed to educate the patient as the healthcare professional signals their intent to make sure the patient’s understanding is “correct”. This is where the sequential misalignment becomes explicit. From lines 19 – 47, the healthcare professional launches a sequence of corrections and examination questions. During this sequence, the healthcare professional is not acting to understand the patient’s preference but is instead performing an education sequence designed to problematise it. The first education action takes place on lines 18 – 29, where the healthcare professional rhetorically describes the duration of catheter use as a ‘short period’. Next, the healthcare professional asks the first examination question on lines 31 – 33, asking the patient for their understanding of how long they will leak urine. This information was explicitly provided prior to this sequence. The patient’s response is hearable as distressed as they abort and re-initiate their turn, answering with the information provisioned earlier. The patient orients to the organisation of this sequence, downgrading their answer to what they “thought” it was. After a notable gap, the healthcare professional provides a more elaborate version of the answer from lines 37 – 43, with only minimum acknowledgement that the patient answered correctly on line 36. The third action makes transparent the adversarial nature of this exchange. On lines 46 – 47, the healthcare professional asks “what’s your imagination of how many people would still be leaking at one year?”. The turn design, and the lexical item “imagination” presupposes that the patient’s response will be inaccurate and is expected to be produced only for the purpose of correction, as signalled by the sequence initiator on line 18. The 1.1 second gap after this question is noteworthy as it is followed by an extended discourse particle “uhm” on line 49, to which the partner orients as a clear trouble source as they provide the repair solution in support of the patient on line 50 with “no idea”. The laughter particle produced after this is noteworthy as, taken in combination with the patient’s turn, and the 1.1 second gap, it indicates that the question was considered as inapposite within the organisation of this interaction (Potter and Hepburn, 2010).

The patient then attempts to answer on line 51 with a further downgraded response, performed in orientation to the sequential organisation of the healthcare professional turns, as every response in this sequence has been some form of upgrade upon the previous. The healthcare professional concludes that “one in ten” will still be leaking, and around “one or two in a hundred” might need surgery, described rhetorically as “low” and a “handful” respectively. It is therefore of critical importance to note how the patient orients to these assessments, as their contributions are reduced to negligible; with the patient reducing their responses to near silence in orientation to a protracted sequence of disalignment from an expressed preference.

In Excerpt 29, the expression of preference takes place after the healthcare professional pronounces what they describe as the ‘best option’.

Excerpt 29: That’s the one I didn’t want

```
1   HCP:  So we've discussed it >in one of our< meetings, and
2         everyones agreed re:ally that the bes:t (.) option >for
3         you< would be something we ca:ll active surveillance,=
4   PAT:  =°Oh n:o° £aHAHHAH£ [>no I-<] £ca:hn't£ s:s-that's the=
5   HCP:                      [S::o   ]
6         =one I didn' want.
7   HCP:  ↓N::aw↓ s:so I mean↑ (.) active surveillance is like PS
8         A surveillance which is↑ >what youv< basically been on
9         (0.4) for the last (.) ye:ar or two
10        (0.3)
11  HCP:  ((lip smack)) okay?
12        (0.3)
13  HCP:  Bec’se we have been watching your PSA:A, haven't we.
14  PAT:  Mmmm.
```

The healthcare professional’s turn is designed to project a high level of paternal entitlement based upon the epistemic and deontic authority of “everyone” from the meeting, taking a unilateral stance of “us” relative to the patient. The patient latches onto this recommendation to resist it. The laughter particles, turn design, and the re-initiation during the turn project an expression that is being performed in opposition to the high entitlement of the recommendation. The sequential misalignment occurs on line 7. Prior to this turn, the healthcare professional attempted to initiate their next turn, only to then reorient toward the patient’s resistance. In doing so, the initiating lexical item of “Naaw” on line 7 disaligns with the patient’s resistance, evidenced by the ways that the healthcare professional performs a persuasive elaboration across lines 7 – 9. There is no uptake by either the patient or partner, which prompts the healthcare professional to pursue a further response on line 11. After a brief gap, the healthcare professional elaborates further still, with an evaluation and an explicit request for acknowledgement. The minimal response token on line 14 “mmm” demonstrates that the patient and partner have silenced themselves in this exchange (Koenig, 2011). By not providing conditionally relevant next turns, their silence can be seen as an interactional move to keep their disagreement ‘beneath the surface’ (Toerien and Jackson, 2019).

The critical aspect of the observed sequential misalignment is the ways that healthcare professionals disaligned from expressed treatment-related preferences. The importance of this relates to the ways that healthcare professionals inadvertently established an oppositional relationship with patients and partners during a time where it would be of benefit to all parties to maintain a constructive and cooperative structure to the consultation. This is of significance as clinical interactions are typically organised around the normative relationship between a doctor and a patient, in which the doctor takes up the epistemic rights and privileges of the ‘expert’ (otherwise known as a K+ status) relative to the patient who typically expects advice and guidance from the doctor (otherwise known as K- status) (Heritage, 2012; Lindström and Weatherall, 2015). Accordingly, the discordance with expressed preferences is arguably counter-productive within the context where healthcare professionals should acknowledge and actively consider these preferences (NICE, 2014).

5.6.4 **Disaligning with partner-initiated preferences**

Sequential misalignments were more pronounced in partner-initiated expressions of preference. In Excerpt 30, the healthcare professional has been outlining treatment choices.

Excerpt 30: The cancer's the main thing

```
1  HCP: [S:O-    ]
2  PAR: [>As far<] as I'm concerned the sexual side (.) I
3       mean:nthe cancer's the main thing=
4  PAT: =It is[:s.] °it is°]
5  HCP:       [yeah. (.) Bu]ddin [TERMS OF]
6  PAR:                          [From the] othe' si[de th-]
7  HCP:                                             [BUDDIN]
8       TERMS OF (.) thee (.) phhackage of the two treatments,
9       (0.6) Uhm (1.3) Yiknow (0.7) is depends whethe' on:e
10      seems >to be< more attractive to you than another.
11      (0.7)
12 HCP: [Uh::m]
13 PAR: [Hhhh ]
```

The opening line is hearable as a transition to a new project within the consultation. As the healthcare professional initiates their turn, the partner self-selects in overlap, expressing their own preference for a curative intervention over the preservation of their sexual relationship. Notably, the patient initiates their turn on line 4, latching onto the partner's expression with the supportive expansion, "it is". Instead of acknowledging, accepting this at face value, for example, with a news receipt, the healthcare professional initiates in overlap with the patient, taking a stance of disalignment relative to the co-constructed expression of the partner and patient. The partner then initiates an elaboration on line 6. The turn is hearable as not completed as the healthcare professional re-initiates their turn from line 5 by way of an interjacent overlap. They initiate with their voice raised above the surrounding talk, with the partner dropping out. The healthcare professional orients briefly to the way that they have taken the floor from an active turn-in-progress, but the configuration of the interaction has been transformed by the manner in which the partner's expression is treated as inapposite by the healthcare professional. The 0.7 of silence combined by an audible outbreath performed by the partner indicate they have silenced themselves where a conditionally relevant next turn was warranted, its absence indicative of the same interactional move of conflict avoidance or minimising.

Sequential misalignment with the partner's expressed preference is evident in Excerpt 31.

Excerpt 31: Obviously you must have an opinion

```
1  HCP:  Ra:rely [(.) one particular] treatment,
2  PAT:          [((clears throat)) ]
3        (0.4)
4  HCP:  =the treatment that you should have (.) kay? (.) >there
5        a< number of options >for you< to consider >so< re:ally
6        (0.4) toda:y is more about (.) giving you (0.7) >the<
7        diagnosis, (.) >telling you< about the diagno>sis< a:nd
8        (.) then giving yo:u (.) some information (0.4) °okay°,
9        >so th't< >you c'n then< go awa:y,(0.3) reflect on that
10       information, (0.4) star' to absorb it (0.3) =and then
11       come ↑ba:ck (1.2) M:ore informed (.) >tuh then< (0.6)
12       talk (.) >a bit< more about (.) wha' you think (0.5)
13       >w'be the  best< treatment for yor- (0.3) #your
14       >disease< (.) =>and we< can guide you through that
15       (.) >with the< help of myself, (0.7) >uthe membis
16       uthe< team (.) >dealing< ((name[ na::ame)) `n' pro- ]
17 PAR:                                [>b'd obviously< y:ou]
18       must h:ave (0.3) an opinion,
19       (0.7)
20 HCP:  ↑↑Yeah we D:O↑↑ HAVE OPINIONS (.)=
21       =BU- (.) [BU-  (.)  BU-   (.)    BUT   ] IN YO:UR CASE,
22 PAR:          >[£with more experience thn us£]<=
23       (0.3)
24 HCP:  in your case (.) ther:re a:a number uv options.
25       (0.6)
26 HCP:  Okay?
27       (0.5)
28 HCP:  No:w (0.6) if yo:u (.) >if you< have very aggressive
29       prostate cancuh,
```

As the healthcare professional introduces the treatment choices, the partner self-initiates with a turn on lines 16 and 17 to express a preference for some form of expert guidance relating to treatment. While the partner's turn was hearable as incomplete on line 17, the gap of 0.7 provides affordance for the healthcare professional to respond to this expression. It is therefore on line 19 that the interaction shifts toward an adversarial configuration, with the turn on line 19 hearable as disaligning with the partner’s expression. The pitch of the turn-initial “yeah we do” is significantly higher, with the turn escalating in both volume and pace. As they initiate the next unit of their turn a total of four times, this turn actively inhibits the partner’s attempted elaborative account for their expression on line 21. The healthcare professional continues at the same high volume on line 22, after which they take a micropause before reinitiating the turn, noting “in your case, there are a number of options”. The 0.6 second silence demonstrates that the partner has silenced themselves where a conditionally relevant acknowledgment was warranted. Notably, the healthcare professional orients to this, producing a response pursuit on line 25, which receives no take-up.

As shown in excerpt 32, the same pattern is observed later in the same consultation.

Excerpt 32: There must be a favourite

```
1  HCP:  [That's all the in]formation]=
2        =[I'll >give] you< ] [information pack ] (.) as well=
3  PAR:  [But als-  ]
4  PAT:                       [((clears throat))]
5  PAR: W:we will be goveren- (0.4) ~£bec'z yo(h)u're
6       exp(h)e:rience£~
7  HCP: ↑#Buddi#↑ [I thin-]
8  PAR:           [By::y  ] (.) You'r=
9       =o[pinion (.) is >to wha-< (.) ↑you kn↓ow?]
10 PAT:   [Yeah but wh't you're sayin' is we have ] a choice.
11 HCP: Yes >↑you do have a↑< choice >an I thin'< (.)
12 PAR: >Bu[t there must be a fa:v'rit-< ]
13 HCP:  ↑[Well lets- lets >puddit-< lets] pud- lets >puddit-<
14      hhlets- lets puddithh >this wa:y<.
15      (.)
16 HCP: >Y' know< (.) Thir are (1.0) a surgical treatment here
17      >will be remove< the whole prostate (.) and >we get a<
18      negative ma:rgin (0.5) a:and (.) your PSA drops tuh (.)
19      unrecordable.
20      (0.4)
```

21 HCP: It's very clear cut.
22 (.)
23 HPC: >okay?<
24 (0.5)
25 HCP: Pthologist says (0.5) >that we’ve goddit< a:ll, (.) yoh
26 PSA: refects that,

At the start of this excerpt, the healthcare professional has moved to close the sequence. The partner renews their expression of preference for a recommendation on line 3, 5, 7, and 8 with an affiliative appeal to the healthcare professional’s status as the expert. Within this sequence, the patient initiates a tun on line 10, seeking clarification that they have a choice. It is of sequential import that the healthcare professional orients to this turn, but not the partners at this point. After the partner’s turn receives no uptake, the partner pursues further on line 12, asserting that there ‘must be a favourite’. Crucially, the healthcare professional initiates their turn on line 13, a micropause after the partner’s turn. The turn disaligns with the partner’s assertion, as it is initiated five times, with each initiation audibly more exasperated than the last, with the initiations hearable as distressed with emphasised out-breaths. Once again, the silences on lines 20, 22, and 24 demonstrate the partner silencing themselves in orientation to the approach of the healthcare professional who has shifted the configuration of the exchange, inhibiting the expression of preference through sequential misalignment as the partner pursues a recommendation from lines 5 - 12.

Disalignment from expressed preferences could also be performed by sequential deletion. In Excerpt 33, the healthcare professional notes that ahead of any curative treatment decision, the patient will be monitored.

Excerpt 33: So, there’s no harm, sorry there is harm

```
1  HCP:  Uh:m (.) an:nd (0.8) >in the< mean time we >gonna be<
2        monitoring you an a:ble to give you othe’(0.7) [non:n-]
3  PAT:                                                 [Ye::s ]
4        (.)
5  PAR:  Ahs- That’s what we want=
6  PAT:  =[Ye::s- ]
7  HCP:   [yiknow↓]
8        (.)
9  PAT:  [ye:ah- °yeh°-      ]
10 HCP:  [So #i#- SO #i#- S:O] I think there’s ↑no↑ harm (0.7)
11       >Well< (0.3) >sorry< >ther is< harm ↓treating↓ you,
12       (.)
13 PAR:  °Mmm.°
14       (0.6)
15 HCP:  Uh- (0.3) >but the< ha:rm is something tht we cn
16       expres:s.
17       (0.6)
18 HCP:  In percentages n >so on<[n you] can appreciate [that.]<
19 PAR:                                                 [Yes. ]
20 PAT:                                                 [Mhm. ]
```

It is on line 5 that the partner self-selects to express a joint preference for active surveillance, stating “that’s what we want”. The expression is endorsed by the patient on line 6. In overlap, the healthcare professional initiates a triple so-initiated turn that is hearable in its sequential deletion of the partner’s expression, with the extensive use of “so” projecting a turn that has been initiated as arising from incipiency, absent of orientation to the prior (Bolden, 2009). Moreover, the healthcare professional moves to disalign with this expression by returning to the concept of curative treatment, while failing to orient to a co-produced expression of preference. Instead, the healthcare professional produces a pairing of bad news and good news. This can be seen as utilising the pairing phenomenon to make salient reasons to select a curative treatment (Leydon, 2008).

5.6.5 **Deviant cases**

Two deviant cases were identified in which the sequential organisation differed remarkably. Both deviant cases featured the same healthcare professional whose consultations are distinct insofar as the purpose is to discuss one particular treatment rather than the entire suite of available choices.

Excerpt 34: Brachytherapy’s the one we prefer, isn’t it?

```
1  HCP: Ok#a:y# .hhh >fine< .hh >so- so< what d’you understand
2       about yo:ur (.) prostate can:cer and about the v-
3       options fuh tre:a’m’n:t.
4       (.)
5  PAR: °W:well°=
6  PAT: =Well so fa:r (1.0) >I aven< actully:y- #ohh ih#- the
7       ones  I- I’ve >read ol<- all the (.) paperwork or we’ve
8       read all  the paperwork nd sortof gone >through it< n:n
9       (.) picked it apa:rt n (.) god [knows what] el-
10 HCP:                                [ye::ah    ]
11 PAT: .hh >so far< I ca:an’t see a good positive.
12      (.)
13 HCP: .HHhh
44      (0.6)
15 PAR: °mmm° Braca the:rapy is the one we prefe:r °i’n it°.
16      (1.2)
17 HCP: Do [you euh-]
18 PAT:    [We’ve lo]oked at thu:h th- operation: to remo:ve it
19      and I:I thought we- uh- a:t first I thought >well that<
20      probly a good ide:a,
21      (0.6)
22 PAT: Anen I:I read th- the litri’re n I though- f:flipping
23      el:l  y’godda be avin a laugh is worse [thn (.)] if you
24      ave thu:h,
25 HCP:                                        [ye:ah. ]
26      (0.6)
27 PAT: thuh actu:l (.) #uh:m# therapy yiknow (.) like [thu:h]
28      thuh br[a- brack, ]
```

```
29 HCP:                                                [yeah ]
30 PAR:          [ra:diothe-]
31 HCP:   >Yeah< (.) brachy[ther:apy  ]
32 PAT:                    [Yeah which] the:y stick (.) fi- (.)
33        >wiggle uh< (.)
34 HCP:   Ye:ah=
35 PAT:   =needl[es in o:r >suh-think< an:n, ]
36 HCP:         [needles into your prostate  ]
37 PAT:   >anen< fippi:n (.) [whackit] with som:e (.) pellets or
38        >some’ing<.
39 HCP:                      [ye:ah. ]
40        (.)
41 HCP:   Yih- #y-# y:yeah yeah ↑wha- so- so- what- what-↑ did
42        mister ((name)) ex:plain to abo:ut w:wha=
43        =[what w’s found on the s:can n the- (.) the bi]opsy
44 PAT:    [Hes::::::::::::::::::::s (.)      euhhhh ]
```

In Excerpt 34, the healthcare professional initiates this sequence with a topic transition on line 2, followed by an open format patient view elicitor (PVE). The turn design of the PVE solicits neither preference nor decision, but instead, it makes a request for the patient to inform the healthcare professional of their own understanding.

This strategy enables the patient to launch a storytelling sequence from second position (Mandelbaum, 2012). The well-prefaced turns in lines 6 and 7 indicate the ways that both patient and partner oriented to this request, with the well-preface projecting a response requiring an extended turn-at-talk, while simultaneously indicating a departure from the normative expectations projected by the healthcare professional’s turn (Heritage, 2015). This is a critical difference when compared to the absence of a PVE, or an approach in which the turn is designed to mobilise a shorter question-answer sequence as a tightly structured adjacency pair (Drew, 2013). The design of the patient’s turn initiation in line 7 indicates the production of a dispreferred response, as it is performed with delay, hitches, and self-repair (Pomerantz and Heritage, 2013). The inclusion of the well-preface and the lexical item “actually” further project this dispreferred response. In its entirety, the turn on lines 6-9 is hearable as an account that foregrounds the evaluation of the treatment options on line 11. The configuration of this sequence is underlined by the healthcare professional whose turn at line 10 can be heard to serve as affiliative while encouraging progressivity. Although the evaluation in turn 11 projects resistance toward the selection of any treatment option, the healthcare professional does not move to address this resistance, and instead they pass up on their opportunity to speak. The partner then self-initiates a turn that offers a form of supportive elaboration, which notably selects the patient to speak next. The resulting gap after this turn is sufficiently long for the healthcare professional to initiate a turn. They drop-out when the patient initiates their turn. From lines 18 – 38, The patient then elaborates upon their evaluation. During this sequence, the healthcare professional both acknowledges receipt of turns and supports story progression through affiliative continuers in lines 25, 29, 31, 34, 36, and 39, encouraging progressivity, while demonstrating alignment with the teller’s project (Stivers and Robinson, 2006). The critical distinction takes place at the end of this sequence. Once it is hearable and apparent that the patient, in conjunction with their partner, has completed their account, the healthcare acknowledges this contribution, and in this moment, treats it as sufficient to warrant a topic transition.

Excerpt 35 illustrates a similar pattern, featuring the same healthcare professional in a different case.

Excerpt 35: Radiology was the best for me

```
1  HCP: °°right (.) oka:y°° (.) °f:fine° hhh ↑Uhm >So- So< ↑
2       What >do you< understand about your (.) prostate
3       ↓cancer↓ and about the- (.) options for treatment↓=
4  PAT: =I re- (.) I ↑listened↑ >to the ma:n< (.) >That I< sa:w
5       (0.7) ↓ladies↓ colleague on (.)
6  HCP: On >mi- o- [Monday< ] (.) Yes:s
7  PAT:            [Monday]
8       (.)
9  PAT: I’d ↑already ↑heard >some of it< (.) I’d (0.4) Of
10      course I (.) >live in a< block where ↓>there are<↓ a
11      lot of sick £people as well£
12      (.)
12 HCP: O:h ↑>okay<↓=
13 PAT: =>And I’d-< (.) end up doing shopping >for things< and
```

```
14       >↑everybody< tells me their ↑prob↓lems=
15 HCP:  =Ri:ght=
16 PAT:  =So I’ve ↑heard different (.) stories different things.
17       (.)
18 HCP:  Ye:ah↓
19 PAT:  I looked at >all the< (.) options I h:had anyway↑
20       (.)
21 HCP:  #Yeah↓#=
22 PAT:  =Then (.) ↑((name))↑ told me on ↓Monday↓ (.) °>the
23       options<° >and I< worked out (.) really what >was< best
24       for m:e↑
25       (.)
26 HCP:  Ye:ah↑
27 PAT:  What would ↓work↓ for ↑me↑=
28       =[(.) With lookin’ after th:e ((relative))]
29 HCP:   [Yes (.)           Ye:s:s (.)              ] °yes°.
29 PAT:  U:hm (0.4) My way of life which would suit me (.) >the
30       best< and it ↑seemed [>to be<] that radiology ↓was >the
31       best↓<
32       (.)
33 HCP:                       [Ye:ah↓]
34 PAT:  >For me<=
35 HCP:  =Right (.) Yeah (.) yeah good (.)    [↑Okay↓    ]
36 PAT:                                       [°you know°]
37 HCP:  So- ↑So (.) They- >so there’s< ↑two↑ different ways
38       actually of havi- having (.) radiotherapy ↓tre:atment↓=
39 PAT:  =Yeah↓
```

Like the previous excerpt, the healthcare professional produces a topic transition before initiating the next sequence with an open format PVE (lines 1-3). Likewise, the patient launches a story from second position in lines 4 – 34. During this story, the healthcare professional orients to their responsibilities as a story recipient, producing responses that both acknowledge turns while enabling story progression, including a repair initiation on line 6 that serves to facilitate progression. (Mandelbaum, 2012). The story culminates in the patient offering an account ahead of their expression of preference. The expression is acknowledged by the healthcare professional on lines 35, after which the healthcare professional initiates topic closure on line 37 before initiating topic transition.

When compared to the pattern observed across all other collected cases, the differences are substantial. The healthcare professional explores preferences without introducing any element of sequential misalignment. They bracket this activity from the previous, cede the floor to the patient, and invite them to take an extended turn at talk. While the elicitation of ‘understanding’ leads to an expression of preference in both cases, this preference is elicited neither implicitly nor explicitly. Instead, in both instances, the story culminates in an expression of preference. Critically, after the exploration of, and production of this preference, the healthcare professional acknowledges this preference, closes the sequence, and moves onto the next project in the consultation, proceeding in alignment with the expressed preference. These interactions do not contain the sequential misalignment that is present in all of the other cases in this collection (Heritage, 2011).

5.7 Discussion

This research examines the sequential organisation of treatment-related preferences expressed by patients and partners during consultations for localised prostate cancer; a condition with profound implications for the cancer couple, in a consultation where healthcare professionals are expected to be sensitive to treatment-related preferences (Soloway *et al.*, 2005; Bullen and Tod, 2013; NICE, 2014). The analysis of these consultations illustrates a contradiction in the sequential organisation relating to the ways that healthcare professionals orient to expressions of preference. While healthcare professionals disaligned from patient-initiated expressions (Excerpts 28 and 29), they disaligned from partner-initiated preferences in particularly robust terms (Excerpts 30 – 33). Moreover, it is noteworthy that, in the deviant case where the partner expresses a joint preference, this turn is sequentially deleted, albeit without the sequential misalignment observed in the main analysis (Excerpt 34). It is arguable that the approach of the healthcare professionals in all but two of these consultations is problematic for the purpose of exploring treatment preferences. In disaligning from patients’ and partners’ expressed preferences, where preference-sensitivity is expected, the healthcare professional is drawing upon the typical epistemic gradient between a doctor and a patient and the normative expectations that inform relations between this pairing of a doctor with an inherent K+ status relative to the patient's and their partner's K- status (Sacks, 1972; Ruane and Ramcharan, 2006; Schegloff, 2007). These actions suggest that healthcare professionals are privileging their own epistemic status at a time where treatment preferences should be considered and negotiated in a manner that affords all parties a position as resourceful agents within the encounter (Peräkylä, 2006; Lindström and Weatherall, 2015). Accordingly, responses that serve to disalign from preferences, serve to construct an interactional situation that draws upon the concept of paternalism (Charles, Gafni and Whelan, 1997; Driever, Stiggelbout and Brand, 2020).

Turning to partner-initiated expressions of preference for expert guidance, the healthcare professional takes up a contrasting stance relative to that taken toward expressions for or against treatment options. Unlike these moments, where the healthcare professional takes up a strong K+ epistemic stance, disaligning from preferences, they adopt a contradictory stance. In excerpts 30 – 32, when the partners expressions imply or explicitly assert an expectation of expert guidance, healthcare professionals were seen to actively disalign from these expectations, as they drew upon the concept of patient choice. These sequential misalignments are doubly hearable through patient and partner silences where conditionally relevant responses were warranted, and healthcare professional pursuits for acknowledgement. The act of disaligning from expressed preferences for expert guidance can therefore be seen to draw upon the concept of consumerism as a polar opposite to paternalism. (Bishop and Yardley, 2004). In short, when patients or partners express a treatment-related preference, it can result in the sequential misalignment, yet when they pursue expert guidance in accordance with the normative expectations of a medical encounter, it can lead to the same sequential misalignment.

The importance of these findings is best illustrated through comparison with the deviant case analysis. The most salient difference is that, in these exceptional sequences, the healthcare professional acts to be informed, instead of acting to inform. The patient's views are solicited through communication practices that encourage the production of a narrative account, with expressions of preference for and against treatment choices treated as equally valid, despite these expressions of preference against treatment choices posing a threat to consultation progressivity (Stivers and Robinson, 2006).

Previous research has examined the importance of partner involvement in prostate cancer treatment decision-making, with patients overwhelmingly expressing a preference for their partners to have an active or collaborative role in treatment-related decisions (Davison *et al.*, 2002). Likewise, the contributions of partners are typically expected and valued by patients across multiple clinical settings as they facilitate information provision and decision-making (Shin *et al.*, 2013; Wolff *et al.*, 2017). Accordingly, it is reasonable to expect a partner's expressed preferences to be acknowledged and accepted, particularly when endorsed by the patient. Other studies have examined the conflict inherent in the ideals of SDM, describing tension between healthcare professionals' established expertise and the affordance of patient autonomy (Bishop and Yardley, 2004). However, this study relied upon data from nine focus groups comprising only patients as participants who offered shared, constructed accounts of their experiences. This means that their accounts will undoubtedly have been moderated as it is likely that each participant in a focus group will want to present a particular impression within this setting (Goffman, 1990a). Related studies indicate that patients want to be informed by healthcare professionals, but do not necessarily want to make decisions based solely upon healthcare professional's information (Beaver *et al.*, 2005). As such, it has been argued that resistance to healthcare professional information provision should be accepted as an interactional resource that projects autonomy (Stivers, 2005; Koenig, 2011; Lindström and Weatherall, 2015). This study highlights the ways that patient and partner expressions of preference treated as dispreferred, 'blocking' actions that impede the progress of the healthcare professionals' information delivery (Stivers and Robinson, 2006). This is underlined by the ways that healthcare professionals inserted repair initiations after expressions of preference, as well as how they treated expressed preferences as inapposite through disalignment from them (Sacks, 1992; Stivers and Robinson, 2006).

The importance of these findings relates to both the clinical context of prostate cancer, and broader structures of social action. The clinical encounter is understood to be a site of social action, encapsulating the biomedical and lifeworld concerns of the patient (Mishler, 1985). Moreover, it is evident that it is a setting, like many in everyday interaction, in which there is an expected preference for the maintenance of social solidarity, and the minimisation of conflict (Heritage and Clayman, 2010). Accordingly, the sequential misalignments highlighted by this analysis are arguably dysfunctional within both their sequential and situational context as they represent a configuration of conflict and therefore, a threat to ongoing social solidarity (Heritage, 2011). This is evident in the ways that patients and partners were observed to silence themselves, following the sequential misalignment, with such silences 'hearable' as an interactional move to avoid escalation of conflict, and instead keep it 'below the surface' (Heritage, 1984b, p. 265; Toerien and Jackson, 2019).

While this study demonstrates the immediate consequences of these sequential misalignments, it cannot speak to the broader implications relating to patient outcomes, such as satisfaction with the encounter, or satisfaction with the treatment decision (Cohen and Britten, 2003). However, these findings do offer a detailed comparison between a dysfunctional practice, and a contrasting practice. Such data can be valuable for making salient the social practices in clinical communication, which can in turn, inform clinical communication skills training.

5.8 Conclusion

People with prostate cancer have indicated that they expect and value the active and collaborative contributions from their partner throughout the cancer experience, and in particular, relating to treatment decision-making (Davison *et al.*, 2002; Shin *et al.*, 2013; Klafke *et al.*, 2014). In these consultations, patients and partners regularly expressed treatment-related preferences which, in the context of a preference sensitive consultation, should be acknowledged and incorporated as a valid component of treatment decision-making. In this collection, healthcare professionals treated expressed preferences of patients and their partners as blocking actions to their information delivery that subsequently required address prior to the progression of the consultation (Stivers and Robinson, 2006). Moreover, the healthcare professionals' orientations to these expressions caused sequential misalignments and a shift toward an adversarial configuration of interaction as they actively disaligned from expressions of preference. This pattern contrasts with the deviant cases in which the healthcare professional inverts this configuration, treating expressions of preference as valid while maintaining progressivity of the consultation. Unless healthcare professionals adopt the configuration as illustrated in these exceptional cases, there will always be an underlying tension present in the unfolding of these interactions.

Funding

The lead author was funded and supported by the South Coast Doctoral Training Partnership of the Economic and Social Research Council, Ref: ES/J500161/1.

Declaration of competing interest

None

CRediT author statement

Simon John Stewart (Conceptualisation, Methodology, Formal analysis, Investigation, Data Curation, Writing – Original Draft, Writing – Review & Editing, Visualisation, Funding acquisition; Lisa Roberts (Validation, Supervision, Formal analysis (support), Writing – Review & Editing (support)); Lucy Brindle (Validation, Resources, Supervision, Formal analysis (support), Writing – Review & Editing (support), Funding acquisition, Conceptualisation)

Acknowledgements

The lead author would like to thank the members of CA Data Sessions South for their insight during the development of this work, the TrueNTH study that funded the data collection and the original study team. They would also like to thank the participants for their invaluable contribution to this study.

5.9 Chapter discussion

The research in this chapter examined the ways that healthcare professionals oriented to expressions of preferences from patients and partners within a consultation that is expected to be sensitive to these expressed preferences. In the analysis, the research shows that expressions for or against multiple treatment choices that included preferences against surgery, preferences against active surveillance, and preferences for active surveillance, the healthcare professional did not proceed in alignment with these expressions, but instead, actively resisted them with proceeding talk misaligned to these expressions. In these moments, it can be argued that the healthcare professional had missed an opportunity to orient to and demonstrate sensitivity to a clearly expressed preference. By contrast, when patients and partners expressed a desire to be guided by way of expert direction, this was also resisted, with proceeding talk also misaligned from these expressions. As such, these moments were arguably additional missed opportunities to orient toward, and display sensitivity to a clearly expressed preference, albeit in a different direction. Without healthcare professionals adopting approaches that serve to foster expressions of preferences as illustrated in these exceptional cases, tensions in the clinic are likely to persist, along with interactional difficulties and missed opportunities for shared decisions that could, in turn, adversely impact upon patients' outcomes and experiences of healthcare.

Prior research has indicated that there is a desire and expectation for partners to be involved across the prostate cancer journey, including clinical consultations, and treatment decision-making (Beisecker *et al.*, 1996; Stewart, Roberts and Brindle, 2021). With this in mind, along with an understanding of the profound impact that prostate cancer has for couples (Galbraith *et al.*, 2005; Sanders *et al.*, 2006; Bullen and Tod, 2013), it is reasonable to expect healthcare professionals to not only acknowledge a couples' expressed preferences, but to incorporate them into the decision-making process. To date, there are no participatory frameworks that formally acknowledge or recognise the ways that localised prostate cancer and the decision to treat it has implications for couples, with frameworks of shared decision making and models of autonomy all designed based upon the ontological assumption of a patient as an individual entity (Keller, 1997; Struhkamp, 2005; Rapley, 2008).

Accordingly, the next chapter examines an aspect of prostate cancer that has a profound and lasting impact upon couples, offering an analysis into the ways that the sexual impact of prostate cancer is communicated to couples during these consultations.

Chapter 6 Communicating the Sexual Impact

6.1 Chapter Introduction

"Let's talk about sex" – Song (Salt 'n' Pepa)

Released in 1990, the song "let's talk about sex" spoke to a growing need to bring sex and sexuality into the public discourse as a viable conversational topic. Some thirty years later, it might be argued that attitudes toward sex have shifted in this general direction. Nonetheless, as a topic, it is still approached with a degree of reservation and caution. This is particularly evident when examining approaches to sex and sexuality within clinical settings where, as a product of societal understandings, and interactional processes, topics around sex are still considered as 'taboo' (Addis and Mahalik, 2003; Chow *et al.*, 2018). Research has indicated that, during consultations such as those in oncology settings, healthcare professionals and patients share a degree of reluctance to discuss sex and sexuality (O'Brien *et al.*, 2011; Ussher *et al.*, 2013). Following outpatient consultations for gynaecological cancers, patients, their partners, and healthcare professionals described the difficulties they had in discussing sexual concerns within a context that had unavoidable implications for the couple's sex life (Iavazzo *et al.*, 2015). This difficulty has also been described in the context of prostate cancer where research has described the difficulties in discussing sex with couples during the consultations due to difficulties in understanding and attending to the diverse needs and coping strategies of these couples (Huber *et al.*, 2016). The result is that sex and sexuality is a topic that is not routinely discussed with couples in oncology settings (Stewart, Roberts and Brindle, 2021).

It can be argued however, that there is a form of disconnect between the societal understanding of sex and sexuality as taboo, the need to discuss sex in clinical settings, and the expectations of healthcare professionals and couples. Research into the unmet psychological and sexual needs of prostate cancer patients with their partners outlined how patients and their partners expressed regret in their reluctance to discuss the difficulties the faced, particularly in relation to their sex lives (O'Brien *et al.*, 2011). In this study that interviewed 35 patients and 18 partners, respondents described their embarrassment at the prospect of raising their psychosexual concerns, worrying that the clinician would consider them ‘too old’ for such matters. The study however made it clear that this is something that couples very much want to discuss. In this, patients and their partners can be seen to be drawing on outmoded tropes of sex and aging in their apparent belief that the topic would be inapposite within this clinical setting. Likewise, related research has demonstrated how this societal understanding of sex and sexuality is creating barriers for healthcare professionals (Ussher *et al.*, 2013). While they agreed that sex and sexuality should be routinely discussed as a matter of clinical import, they also drew upon tropes of sex and ageing to argue that they are reluctant to discuss sex during consultations as it may offend or embarrass couples, further stating that it is inappropriate to discuss with patients they described as ‘older’. In sum, it is evident that some couples want to talk about sex during these consultations. It is also evident that healthcare professionals believe that this is an important element in the provision of medical care within this setting. However, the topic is insufficiently addressed due to couples’ and healthcare professionals’ continued orientation to an unspoken, yet highly informing social understanding of sex and aging as taboo. This underlines the importance of guarding against stereotypes and ageist assumptions relating to sex and ageing.

A range of genitourinary cancers, including prostate cancer are well-known to have profound implications for couples, particularly for their sexual relationship (Davison *et al.*, 2002; Giarelli, McCorkle and Monturo, 2003; Bullen and Tod, 2013). In the context of prostate cancer, the sexual impact for couples is particularly complex with physical, psychological, and social factors relating to the difficulties they experience. The physical impact of prostate cancer upon most patients who opt for a radical, curative treatment include difficulties in obtaining and maintaining an erection, problems with reduced libido (a desire to have sex), as well as ejaculation and fertility concerns (Ganz, 2001; Ussher *et al.*, 2013; PCUK, 2018a, 2018c). While some of these effects can be temporary, with symptoms of side effects subsiding in around 6-12 months, they can also be long-lasting, and in some cases, permanent (NHS UK, no date; Ganz, 2001). As sexuality is considered to be embedded within contemporary constructions of gender identity, difficulties in the enactment of such gender roles within a relationship can lead to feelings of isolation, and a degree of psychological distress for couples as they try to come to terms with the unavoidable changes to their sexual relationship (Addis and Mahalik, 2003; Bullen and Tod, 2013). The sexual impact of prostate cancer can also be understood as particularly complex due to situated social constructions of sex and gender, particularly for those people who identify with contemporary concepts of masculinity where the ability to perform sexually, such as obtaining and maintaining an erection is closely related to the heteronormative ideals masculine identity (Bullen and Tod, 2013). Moreover, seeking help for such concerns is regularly constructed in accordance with contemporary masculine ideologies as some kind of ‘weakness’ (Addis and Mahalik, 2003). As much as this affects the patient, the impact upon the partner is equally marked. Research has shown the extent to which partners of people with prostate and other genitourinary cancers have reported experiencing both psychological and physical morbidities as a result of a cancer diagnosis, and related treatment (Wootten *et al.*, 2014). It is however important to recognise that these findings were produced from data collected by way of focus groups comprising only partners of people with prostate cancer, which will have led to an inevitable bias in the ways that these participants gave accounts for their experiences and actions (Garfinkel, 1967; Goffman, 1990a).

Combined, this research indicates that there are prevailing social structures that are inhibiting the extent to which sex is discussed during prostate cancer consultations. Despite being an undeniably important aspect in the majority of romantic relationships, and the topic considered to be important by both healthcare professionals and couples alike, the need to discuss the sexual impact and ways to ameliorate this impact is regularly reported as unmet (O’Brien *et al.*, 2011; Ussher *et al.*, 2013). With most studies placing emphasis on participants’ retrospective accounts for their experience in the consultation, there is a lack of research into the ways that sex is actually discussed within the consultations, and in particular, the ways that conversational and social actions are employed to organise the topic within the consultation. Accordingly, the exploratory analysis in this chapter presents an examination into the ways that the sexual impact of prostate cancer and its treatment choices is communicated to couples during treatment and diagnostic consultations.

6.2 **Analysis**

Initial observations related to the ways that the sexual impact of prostate cancer and its treatment options were discussed among the healthcare professional, patient, and partner, along with the sequential organisation of these multi-party interactions. A collection of eighteen sequences from the twenty-eight consultations was compiled to examine the ways that the sexual impact of prostate cancer and prostate cancer treatment was discussed, including how this impact was initially formulated, how these formulations afforded opportunity spaces for patient and partner contributions, and how the healthcare professional responded in turn to these contributions. Once the sequences were collected, a detailed line-by-line analysis was performed on this entire collection. The analysis examined the turn design, turn-taking practices, and sequential organisation of these interactions. The analysis considered whether the topic was signposted in any way, and how healthcare professional turns were designed for particular recipients. The analysis offers an illustration of how the sexual impact of prostate cancer was raised and discussed.

In these consultations, all patients had a diagnosis of low or intermediate risk, localised prostate cancer. The sequences relating to the sexual impact were exclusively initiated by healthcare professionals during talk that was adjacent to, or within sequences where they had outlined treatment choices. This practice relates to NICE guidelines that state that information should be provided relating to the availability of treatment choices and their side effects for the making of shared and informed decisions about treatment choices (NICE, 2014). The topic was raised in eighteen of the twenty-eight consultations, with thirty-two distinct sequences identified across these eighteen consultations. During the initial analysis of these thirty-two sequences, two distinct sequential patterns were observed: In one pattern, healthcare professionals were observed to introduce the sexual impact of prostate cancer by first foregrounding the topic using the polar question “are you sexually active” which served as an entry point to the topic. In the other pattern, they introduced without this question by way of a more generic topic transition, with varying degrees of demarcation from the prior sequence. Accordingly, the collection of thirty-two sequences was organised into two separate collections; those that took place after the polar question, and those took place without the polar question.

6.2.1 **“Are you sexually active?”**

The polar question “are you sexually active” was used in seven consultations. It was typically delivered at the mid-point of an extended period of healthcare professional talk that was delivered to outline the available treatment choices and their associated side-effects. It is important to note that across all twenty-eight consultations, the sexual impact was not signposted as a potential or upcoming topic of discussion at any earlier stage of the consultation such as the agenda setting phase (Robinson, Tate and Heritage, 2016). This meant that the initiation of the polar question “are you sexually active?” was consistently the first time that this topic was raised in these consultations. This is of sequential import for the organisation of these consultations, and the topic itself.

The polar question takes place around the mid-point of excerpt 36.

Excerpt 36: And my next question is…

```
PAR: Bu:ud >on a< comical side. say you grew br:east.
     (.)
HCP: °yeah°
PAT: >An then< you stopped the hormone treatmen,=
HCP: =°>yeah<°
     (.)
PAT: D’they go a↓wa:y?
     (0.4)
HCP: Uh:m (1.2) N:not elot.
     (.)
PAT: ↑Hihh↓
PAR: °Gos:h you°=
HCP: =Uh:h >little ↓bit.-<=
PAR: =££>You’ve already< [goht-££]
HCP:                     [BAT    ] ↑↑N:NO=↑↑
PAR:  [££Hahih££ ££Hah big che]ss muscles££
HCP: =[BUD- BUD- BUD- BUD AH:H]
HCP: ((Cough)) (sniffle))=
PAR: =££Hih££=
HCP: >Buddit<- ih- >deynot< (.) #ei:i# >usjalee< >they nod<-
     (1.1) °mm° big (.) bud (.) you can:n (0.5) .hhhh bud
     yo:u- c- bud:d #ih# (0.6) THESE treatmnts can preven
     (0.3) people from:m (.) #deloping#
     (1.0)
```

25 PAT: °Hmm.°
26 (1.6)
27 HCP: A:n:nd (.) the other (0.3) two:o options- #uihh# .hh
28 #uhm# (0.8) m:y >next question is< (.) a:h you >still
29 °sexually #active#<°
30 (0.5)
31 PAT: °Mmm°
32 (0.8)
33 HCP: So:o (1.2) so dattis uh- >one thing< to consider as
34 #well?#
35 (2.2)
36 HCP: To maintain >a sexual< function:↑ the tablets ar:re (.)
37 bettir.
38 (0.5)
39 HCP: >Soh wi the< injections: (0.4) Ah:h it'll (.) >have an
40 effect< on yr li°bido°.
41 (0.3)
42 PAT: °↓right?°
43 (2.9)
44 HCP: °okay?°=
45 PAT: =°Mhm?°

In this sequence, the patient has taken the initiative to query the potential impact of hormone treatment in relation to the development of breast tissue. The healthcare professional attends to the patient's query, orienting to the preconditions offered on lines 1 and 4, prior to the production of the query on line 7 (do they go away?). As a polar question, this is designed structurally with a preference for an affirming response (Pomerantz and Heritage, 2013). This preference organisation is further underlined by the social understanding that growth of tissue in men is in the main, an undesirable outcome. This organisation is only further demonstrated by the healthcare professional's response where the pauses and hesitance markers indicate an incoming response that is not in alignment with the constructed preference organisation of the polar question. In turn, the healthcare professional initiates a sequence at line 13 that is designed to "walk back" the initial response with a series of upgraded alternative assessments (e.g. Leydon, 2008). What unfolds is of sequential import as the partner initiates an evaluative response across lines

12, 14, and 16, noting that the patient already has ‘big chest muscles’, the implication being that any breast growth will be especially pronounced.

As the partner initiates this turn, the healthcare professional persists with their sequence of upgraded assessments, turning to the partners contribution with an explicit rejection of it that takes place across the entirety of the partners turn at talk. This overlapping talk is produced at significantly higher volume on line 15, and this volume continues across line 17 as the healthcare professional initiates their turn a total of six times in contest to the partner’s evaluation.

Upon resuming their sequence, the healthcare professional completes their reformulation of their assessment, while outlining treatments that can prevent the situation altogether. It becomes clear however, that the configuration of the interaction has been altered, which is noticeable due to the absence of a conditionally relevant responses from the patient and partner, such as a form of acknowledgement to the healthcare professional’s evaluation. (e.g. Toerien and Jackson, 2019).

After presenting this reformulated assessment, the patient responds minimally with a barely hearable “hmm”, after which there is another 1.6 seconds of silence. These gaps are hearable enough to note that the progressivity of the interaction has been somewhat derailed (Stivers and Robinson, 2006).

The polar question is produced across lines 27 and 28. The healthcare professional’s turn is designed to transition the topic to the ‘other two options’, before they abort this turn entirely, re-initiating with a turn that offers an element of meta-commentary “my next question is”. This turn constructs a degree of separation between the healthcare professional and the question itself, as the healthcare professional takes a stance relative to the question before they ask it. By introducing it in such a formulaic manner, it projects an element of hesitancy to introducing the question in a near-apologetic manner, indicative of something they ‘have to’ ask. The design of the polar question offers a clearer indication as it is delivered with an embedded tag “are you still sexually active”. The design of this question is of critical importance as the use of the word “still”, and the way that “sexually active” is delivered at a significantly lower volume than the surrounding talk indicates the valence of the question. The design of the core question grammatically favours an affirmative response (e.g. Pomerantz and Heritage, 2013), but the embedded tag and delivery strategy at minimum, attenuates this with a cross-cutting social preference relating to the topic of sex and sexuality as an inappropriate, or taboo topic for ‘older couples’ (Ussher *et al.*, 2013).

What unfolds offers an indication as to the consequences of the healthcare professional’s interjacent talk. The patient initiates with a minimal confirmation after a gap of 0.5 seconds, with their response understood as an affirmative. A further 0.8 seconds elapses before the healthcare professional follows with an elongated so-initiated turn, before a further 1.2 seconds of silence, and a further so- initiated turn informing the patient that this is “one thing to consider as well?”. After a further 2.2 seconds, there is no form of uptake from either the patient or partner. This was an opportunity space where some form of acknowledgement is conditionally relevant, with the absence of patient and partner talk indicative of self-silencing in service of minimising disagreement or conflict (Toerien and Jackson, 2019). In absence of uptake, the healthcare professional offers elaborations in lines 36, 39, and 40, with talk of maintaining “a sexual function” and descriptions of impact upon the patient’s libido, constructing further, a distance between this issue and the co-present couple. The entirety of this talk is focused upon the physical and biomedical experience of the patient, with none of the experience delivered in orientation to the co-present couple. There is notably no uptake between these evaluative statements. When the patient does finally initiate their turn, it is produced as a continuer, “right?”, denoted by the upward intonation and the noticeably reduced volume of the turn. Instead of continuing, there is a gap of 2.9 seconds that is hearable as absent of any other activities. After this lengthy gap, the healthcare professional takes a turn that is hearable as an attempt to secure some form of acknowledgement. The patient produces the most minimal form of acknowledgement with “mhm?”, with the upward intonation projecting an acknowledgement that does not fully endorse the healthcare professional’s talk, while keeping an explicit disagreement ‘beneath the surface’.

As the topic is closed, it is apparent that the ways that the healthcare professional’s actions led to the inhibition of the partner’s contributions, and the ways that they constructed the sexual impact sequence led to the patient and partner effectively silencing themselves. Moreover, the topic was designed exclusively in terms of individual impact for the patient and their ‘sexual function’, effectively erasing the partner from an experience that has clear and major implications for them as well as the patient as a couple (Giarelli, McCorkle and Monturo, 2003; Bullen and Tod, 2013).

In excerpt 37, the polar question is produced after the healthcare professional has been outlining the available treatment choices.

Excerpt 37: Accounting for yes

```
1  HCP:  Thee- uhm- (1.0) the::e (0.8) othe’ down side is- (.)
2        #a#changes >t’ yo’< sexual function,
3        (0.5)
4  HCP:  >Ah’ y’< sexu’y active >at th’ moment?<
5        (0.6)
6  PAT:  W- >we ~a:are~< (.) >but ah ↓mean↓< (.) Ahm ↑seventy↓-
7        comin’ [t’ sev]enty.
8  HCP:         [↓yeah↓]
9        (0.6)
10 PAT:  (not to) [((unclear due to overlap from HCP))]
11 HCP:           [Well uh- I- (.) so I think tha’ it-] (.)=
12       =[so it’s noh]-
12 PAT:   [so it’s som]e’ing we’[ve discuss]ed- .hhh ih=
14 PAR:                         [the impo- ]
15       (.)
16 PAR:  =we have discussed it [as something  ]=
17 PAT:                        [i- in  ]depth ]
18 HCP:                        [↓ye:ah↓]
19 PAR:  =for for’y seven years (.) and (y’- well °about°) I
20       [(w:ould have) t’ say,]
21 PAT:  [°y’ ‘ow wo’ ah mean° ]
22 HCP:  [↓ye:ah↓]
23       (.)
24 PAR:  [~>very ] very<~=
25 PAT:  [°↓God↓°]
26 PAR:  =~fort[unate]~
27 HCP:        [SO:O ](.) >Ah mean< I think that with surgry (.)
28       cer’ny, (0.7) immejitlee (0.6) things #ll#- (.) >if you
29       w’ comparing< radiotherapy >’n’ su:rgry< (0.5) thee (.)
```

```
30        >affect on yoh continence< n >sexual function< is more
31        ma:rked with surgry, (0.3) hhh >an then< things- (.)
32        >ten' tuh< sta:bili:se.
```

Before they initiate this sequence, there is a hearable gap in the healthcare professional's talk. When they do initiate, their turn follows an aborted initiation, a hesitance marker "uhm", and two substantial pauses of 1 and 0.8 seconds before introducing the shift in the conversation to 'downsides' as 'changes to your sexual function'. This precursor is performed with a series of hesitance markers such as "uhm", noticeable gaps, elongations on words indicative of trouble sources, and rush throughs, which all project the turn as 'doing taboo'. The turn design also frames the upcoming information as exclusively the concern of the patient and their individual 'function'. After a further 0.5 seconds, the healthcare professional produces the polar question. In this instance, the healthcare professional tags the question with "at the moment" introducing an unnecessary temporal element to the question. They also perform the question in a series of rushed and elided lexical items. In delivery, the question is performed in the same format as in excerpt 36. This is demonstrated by the manner in which it is received. The grammatical preference of the question is at least inhibited by the tag, the precursor, and the prosody of the turn-at-talk.

The patient's response provides a further indication, as it takes place after a gap of 0.6 seconds, with the affirming response embedded within an extensive and co-produced, explanatory, and mitigating account. During this account, the patient and partner try to explain the extent to which they have discussed the matter, and to underline that they have been fortunate thus far. This account, performed between lines 6 and 26, is important as it resists the individualised turn design of the healthcare professional, as the couple offers a detailed account using explicitly relational terms (we are…, we have discussed it…). It is therefore important to note the way that the healthcare professional initiates their turn on line 11. They initiate once again in full overlap, attempting to resume their turn-at-talk with four attempted turn initiations, including two attempted so- prefaced turns, indicative of an attempt to advance an agenda that was already in process (Bolden, 2009). This is of critical importance as it indicates that the couple's account has been sequentially deleted. This is further underlined when the healthcare professional resumes their turn-at-talk on line 27, initiating their turn with a strongly emphasised so-initiated turn, followed by two further initial units “I mean”, and “I think”, further demonstrating an attempt to advance an agenda that was already in progress. When looking at the turn from lines 27 to 32, it is noteworthy that it does not orient at all to what has just been said, and more critically, it fails to describe in any way the sexual impact of treatment, reducing the concept of sex to the abstract concepts of “sexual function” and “things” (Lines 28, 30, and 31).

The polar question was not always introduced with the form of foreshadowing observed in excerpts 36 and 37. In excerpt 38, the question is introduced absent of any form of transition attempt, and instead, the healthcare professional, after a short pause, initiates the question in its core format, “are you sexually active?”. The organisation and the prosody of the question delivery is of sequential import.

Excerpt 38: I bloody well hope so!

```
1   HCP:  D- [ye:es↓ yes (.) ↑ye:es↓ yes (.) °yes°]
2   PAT:     [Yiknow- y’know wot >uh mean↓< (.) ↓so:o yiknow you
3         >gotta<- (.) it’s gotta] be:e (.) worthwhi:le
4         (0.3)
5   HCP:  ↑Yes [(0.7) yes (0.5) #°the°# (.) ↓quality↓-]
6   PAT:       [(c- I- fe) (.) #uh yeah# (.) goin’ fru] (.)
7         >whatever id is< y’ goin’ #through#=
8   HCP:  =Yes (.) yes [ezacly] (0.3) ye:ah.
9   PAT:               [#uhrh#]
10        (0.4)
11  HCP:  Yeah- .hhhh °>ah you< sexually #actif::f#°
12        (1.0)
13  PAR:  £He£ [£s:supposed >tuh b:e,£< ]
14  PAT:       [Ah >bloody well< ope s:o]
15        (.)
16  HCP:  ↑Mmm↑=
17  PAT:  =Ah [HEH HAH HAHAH hahaha↑         ]
18  PAR:      [Heh heh (°£no it[s ok yeah£°-)]]
19  HCP:                       [>Yeah< s:o-   ] so- so- (.) so o’
20        course that can be affected b:y any o’ the treatmnts
21        [fu pr]ostate #can:cer#
```

```
22 PAT:  [#Mm#↓]
```

Absent of any kind of foreshadowing, and the delivery of the question in a whispered tone is hearable as ‘doing taboo’. The question is followed by a 1 second gap that serves as an indication that the question was received as somewhat unexpected. It is important to note that once again, during this gap, there were no other hearable activities taking place. After this gap, the patient and partner initiate almost in direct overlap, with the partner’s turn taking place just ahead of the patient’s turn. The partner initiates their turn with a clear laughter particle, with their response produced in direct orientation to the design of the question, noting “he’s supposed to be”. The patient’s turn takes place in overlap as they note “I bloody well hope so”. After this, the patient and partner initiate a choral laughter. Combined, the two responses and the laughter provide a highly upgraded response when compared to the typed responses of yes or no, projecting a response that challenges the premise of the question, with the answer inferred to have been self-evident (Heritage, 1984a). After this turn, the partner initiates a turn on line 18 that trails off as the healthcare professional initiates their next turn.

It is important to note that the healthcare professional’s turn is initiated as an interjacent overlap that occurs away from any discernible indication that the partner’s turn was coming to a close. That is to say, there was no hearable projection of a transition relevance place (Clayman, 2013). In this overlap, the healthcare professional initiates their turn 5 times, including four so-initiations that indicate an attempt to resume an agenda already underway (Bolden, 2009). From there, the healthcare professional reduces the complex sexual impact of prostate cancer and treatments to “of course, that can be affected by any of the treatments”. The turn design is once again of sequential import. The initial “of course” indicates that this informing should be self-evident (Heritage, 1984a), projecting a situation in which this, yet-to-be-described impact is inevitable. Moreover, the entirety of the couples’ sexual relationship is reduced to a single lexical item once more “that”. From this short, yet vague description, the healthcare professional closes the topic and moves to the next project in relation to outlining treatment options.

This sequence, like those in excerpts 36 and 37 indicates that the polar question “are you sexually active” functions less in service of eliciting information, but more as a conversational springboard for the healthcare to deliver a relatively rigid informing of the sexual impact that follows in the same format irrespective of the couple’s responses.

So far, the examples outlined have related to affirmative responses to the polar question “are you sexually active”. These examples have offered an indication of how the sequential organisation of the question and its question design serve to project a particular form of preference organisation to which all participants orient. In this respect, the responses in these extracts are responded with minimal tokens, delays, accounts, mitigations, and challenges to the premise of the question. All of these indicate that an affirmative response in this context is socially organised as the dispreferred action (Pomerantz and Heritage, 2013). Excerpt 39 offers a further indication as to the organisation of these sequences when the response is “no”, that is to say, the couple is not sexually active.

Excerpt 39: No

```
HCP:  =(.) hh risk (.) S:o (.) again what ↑we've↑ #mentioned#
      about th:e uhm~ (.) >soreness< in your back °passage
      or- o:r >bowels< (.) hh Uhm >a little bit< ↓diff↓rent,°
      (.)
HCP:  °↑Are you↑sexually ↓#actiff#.°=
PAT:  =N:o.
      (0.4)
HCP:  £>Rhi:ght<£ >hhh Okay↓< .hhh >So we< ↑just↑ >have t'<
      mention >tha< on the fo:rm as well that it >can #u:h#<-
      °can affec° that uhm (.) tha- side of thing:s°.
      (0.7)
HCP:  U:hm (.) an then wi- >with a:ll< radiotherapy there's a
      ↑ti:ny (.) ti:ny ↓risk↑ of causing (.) anothe cance i:n
      the area we give the tre:atmn:t #t:o#.
```

In this sequence, which was the only example of a negative response, the polar question is produced in the same delivery format as in excerpt 38, which is to say that it is produced absent of any kind of precursor or foreshadowing. The hushed, whispering tone, once again indicative of a question design that is ‘doing taboo’. However, the patient’s response is distinct in three ways. First, it is initiated in slight overlap with the final unit of the healthcare professional’s question. Second, it is a straight, typed response interjection of “no”, and third, it is produced clearly, with a downward final-unit intonation, absent of any kind of account. These are all hallmarks of a response that is produced in alignment with a social preference organisation of a polar question (Enfield *et al.*, 2019). It is what follows that further elucidates this socially organised preference. In this sequence, after the patient responds, the healthcare professional initiates their turn after a brief pause, doing so with a ‘smiling voice’, and pronounced laughter particles as they acknowledge the patient’s response. Once again, the healthcare professional initiates their next turn-at-talk with a so-preface before offering an explanatory account of why they asked the question, noting that they “have to mention that on the form”. They go on to note how “it” can affect “that side of things”, in a description that is no more detailed than the one offered in excerpt 38.

Noteworthy are the prosodic features of the turn on lines 8-10 which include rushed elements, elided units, hesitance markers, and parts of the turn that are significantly quieter than the surrounding speech. These all speak to the social organisation of the topic as taboo (Soloway *et al.*, 2005). After this, the healthcare professional transitions to the next topic, despite receiving no verbal acknowledgement from either the patient or partner where an acknowledgement was warranted.

6.2.2 **Sexual function: Individualised interactions, biomedical focus**

For the majority of sequences, the sexual impact of prostate cancer and its treatments was introduced in a series of unilateral information deliveries, and without the production of the polar question. In order to produce a systematic and consistent analysis of these interactions, only the sequences in which the sexual impact was raised for the first time were used for this analysis. These sequences were selected as they represent the point when the topic was introduced to the consultation. In this collection of eleven sequences, a notable pattern of interactional ‘moves’ was identified, all relating to the healthcare professional’s approach to communicating the sexual impact of prostate cancer and its treatment. The sequential organisation of these moments, the healthcare professional’s turn design, and recipient orientations led to interactions that minimised opportunity spaces for patient and partner contributions more so than sequences that contained the polar question. Moreover the topic was discussed exclusively in individualised, biomedical terms, with no orientation toward the experience of sex and sexuality as shared between the couple (e.g. Giarelli, McCorkle and Monturo, 2003).

In excerpt 40, the sexual impact sequence takes place around the middle of the consultation. The healthcare professional has been outlining the treatment choices while underlining the advantages of Active Surveillance. This excerpt is noteworthy as the healthcare professional has taken the unusual step to advice the patient against any radical form of treatment such as surgery or radiotherapy and has instead indicated that the best course of action would be for the patient to undergo a period of Active Surveillance. They have delivered most of their talk as a unilateral body of informing talk. During this time, the patient’s and partner’s contributions are restricted to minimal acknowledgement tokens and continuers.

Excerpt 40: and all of that

```
1  PAT: °°mhm°°=
2  HCP: =But we will kheep a close eye >on it< (.) anif it
3       stats tuh- °dn° (.) change its spots (.) look like it
4       might be- gunna d:o something, (0.6) then (.) we can
5       still treat it, (0.6) with (.) curative intent (.) >in
6       ohde to get< >ridofit< completely,(0.9) u:hm (.)
7       without costing you anythink in terms of:f (0.3) cure
8       rates (.) n that type ahthing.
9       (1.1)
10 HCP: You might say >welin< ‘at case why d’nt you g’in (.) b-
11      bloomin get riddofit no:w,(0.9) Well the reason (.) foh
12      tha:at ↓i:s↑ th’t the tre:atments that we’ve #go’# #ah#
13      (.) can have quite significant (.) s- [s:ide] effects.
14 PAT:                                       [°Mmm°]
15      °°yeh°°=
16 HCP: =They can:n make yeh- (.) wa:tehworks wo:rse,
17 PAT: °°mhm°°=
18 HCP: =You cn be ca:used >to be< le:eaky of urine, o:r jus:s
19      (.) goin very frequentle::y, (0.3) .hhh you cn (.) get
20      >prob<lems with >sexual< function,
21 PAT: °°imp’tnce [yeeh?°° ((°°unclear°°)  ]
22 HCP:            [Uh:hn and >all of< that], (.) >and you can<
```

```
23       d:o (.) you can not have >any oh tho:se< problems if we
24       just watch you, (.) and we kno:w tha' in:n this- in
25       tho:se >people< we w:atch only abou' a qu:arter ever
26       com:e to needing anything done
27       (1.0)
28 HCP:  S:o ↑three↑ q:uaters >neveh< do
29       (0.8)
30 PAT:  °°ths°° °good 'en [innit°      ]
31 HCP:                    [(lip smack)] So that's a::hr (.)
32       that's our current thought, >thee uh< the game plan?
33       (.)a:n hope>ully< y:ou cn, (.) .hhh >n the wo:rst< pa:r
34       fyou o:urse thd you:r sat there with it.
```

This sequence opens with the healthcare professional offering an element of safeguarding and reassurances in relation to the option of active surveillance. They retain the conversational floor with continued use of upward final unit intonations that make their turns hearable as incomplete, projecting the intention to continue. When this turn-at-talk is finally hearable as complete on line 8, as indicated by the downward final unit intonation, there is a 1.1 second gap where some form of acknowledgement was conditionally relevant. It is in the next turn-at-talk that the healthcare professional's unilateral approach becomes explicit. At this point, it would have been reasonable for the healthcare professional to pursue some form of acknowledgement from the patient or the partner. Instead, they adopt the patient's voice, becoming the animator of the patient, despite them being present to speak for themselves. In this, they produce a question across lines 10 to 11 that the patient was afforded no opportunity to ask. After a gap of 0.9 seconds, the healthcare professional responds as if the patient had asked the question, including the initiation of the turn with a well-preface, indicative of a formulation from their perspective (Heritage, 2015). This perspective switching underlines the unilateral configuration of this interaction, as the healthcare professional has taken an epistemic stance that is so high, that they need not wait for the patient to ask a question. In responding to their own question, the healthcare professional moves to introduce the side effects of treatment, prompting two minimal response tokens from the patient. The healthcare professional latches onto the second unit, initiating a turn-at-talk in which the side-effects are outlined, once again with continued use of upward intonations at the end of each turn construction unit. During this turn, the healthcare professional makes their one and only reference to the sexual impact, performing the turn with delays, pauses, hitches, and rush throughs, which all speak to the preference organisation of the topic. In this reference, the only description produced is “problems with sexual function”, with no further attempt to elaborate upon what this really means for the couple. Instead, the patient offers an acknowledgement and indication of their understanding with a turn on line 21 that is practically whispered (impotence, yeah?). The healthcare professional then re-initiates in overlap with this turn, rounding off their three-part list with “and all of that” (waterworks, sexual function, all of that). They continue with the same format of delivery, offering positive upshots in relation to active surveillance. After this, the patient offers an affiliative response, noting “that’s good isn’t it?”. Once again, the healthcare professional initiates in overlap with this talk. In doing so, they fail to orient to what is a clear and unambiguous first pair part that makes the healthcare professional accountable to acknowledge by way of producing a conditionally relevant response. Instead, they move to a form of ‘summing up’ talk, once again taking up the patient’s voice, pronouncing what is the “worse part” for them. From there, the healthcare professional moves to transition to the next phase in the consultation.

The sequential organisation, turn-taking, and preference organisation from this sequence can be seen to exclude any possibility of taking up the topic from a relational perspective, and moreover, inhibits any form of patient and partner participation at all, while providing less than a bare minimum amount of information relating to the sexual impact of prostate cancer treatment, reducing it to “waterworks, sexual function, and all of that”.

Excerpt 41 highlights a protracted example an of how the healthcare professional’s unilateral presentation about the sexual impact of prostate cancer can proceed absent of orientation, and at times, in explicit opposition to the expressed of priorities of the couple.

Excerpt 41: Maximising ‘erectile function’

```
1  PAT:  Y:eah s=
2  HCP:  Bu' (.) in the:ory (.) >h:havin< ha:alf the prostate
3        treated, (0.6) ((lip smack)) does [>give ]you< s:ome
4        si:de effects,
5  PAT:                                    [°less°]
```

```
6   PAT:  °right°=
7   HCP:  Bu gives you (.) °les:s of:ten (0.3) an:n (.) can
8         prse:rve like (.) erecti:le function betteh°
9         (.)
10  PAT:  °yes:s°
11        (.)
12  HCP:  Thn:n >soma thee otheh< >so when yeh< yo:ung eh:m=
13  PAT:          [°yeh°]
14  HCP:  = we've [gotta] try n work out (.) .hh (.) with you:u=
15  PAT:  =°W:whats (.) s[posed the:h° ]
16  HCP:                 [n what- >see ] what your fe:elins a:re
17        >as well< >cus you< might (.) yiknow [>I had a guy]<
18        (.) #a# few=
19  PAT:                                      [#y-# yeah↓  ]
20  HCP:  =months ago whose- (.) .hh not (.) s:s- si- similar but
21        (.) >he 'ad< s:similar family his:story (0.3) but e:e
22        deci:de ee want to u:hh (.) h:help (0.5) future
23        rese:earch, (.) anee went down the (0.3) experimental
24        rout:te_
25        (0.5)
26  PAT:  ri:ight.
27  HCP:  A:n:n whereas >if I'd< another gap- chap- a young- like
28        yeself >ooh went< (.) >I just< (.) wannit (.) >finished
29        with< ah want the worry gone, (0.7) I wan' (.) de tried
n
30        tested °treatmnts°, (0.5) [°an ah-°] >so you've-< (0.5)
31        we'll help=
32  PAT:                             [°mmm.°  ]
33  HCP:  =suppo:rt you whicheveh wa:y you wan:t the go re:ally
34        well give you gui:idance an' (0.3)=
35  HCP:  =[infoma:tion (.)   bu-          bu-     ]
36  PAT:   [Y:eah that's >what °I understand yeah°<]
37        (0.5)
38  HCP:  H::help >give you all< >the info< you need about the
39        treatments, >the side< effeks:s, (0.5) °n what they
40        me:ean >so that< yo:u cn ma:ke an info:rmed, (0.4)
```

41 decision on which one (.) teh [go for]if ye >see whora
42 mean< so=
43 PAT: [°yeah.°]
44 HCP: =it- (0.3) #its# (.) >its problee< slightly harder when
45 ye younger in a wa:y orit might be e:asier >it just<
46 depends on whats:s, [(0.8) w's really impo:r]tnt teh
47 wor:r out=
48 PAT: [Ye::ah Ah men- (.) Ah-]=
49 PAT: =Children aren't (.) a worry I mean=
50 PAT: =[I don't min:d-]
51 HCP: [Ye:ah ah >wuz gonna] ask yeh (the:n)<=
52 PAT: =I:I don't mind th-
53 [uh:h (.) that I'm gonna be (.) steril:l]=
54 PAR: [°n:o yeh yeh°]
55 PAT: =but obvis:y (.) I wanna (0.3) hih if: (.) possibl:e=
56 PAT: =[an- an-] uh- t' be able 'o still (.) carry on=
57 HCP: [YE:AH]
58 PAT: ='avin a sex li:fe, buh (.) [you know, (.) uh::m]
59 HCP: [yeah (.) yeah (.) yea::h]
60 (0.6)
61 HCP: >Anats it< (.)[anats] wha' we wana try n< maximise (.)
62 make=
63 PAT: [yeah↓]
64 HCP: =[sure](.) the outcome of:f the treatment (.) >can be<=
65 PAT: [ye:ah]
66 HCP: =maximi:sed >so< (.) .hhhh we know (.) how (.) the
67 effects wha- (.) su:rgery >can ave< °on erecti:ile
68 function:n n=
69 HCP: =[what] (.) radiotherapy can.°
70 PAT: [°yeah°]
71 (0.5)
72 HCP: °>some o' the< hemi glan treatments they suggest (0.7)
73 cn be:e (0.3) less destru- destr-° (0.3) damaging to
74 erecti:le function (0.6) °bud some people oo come out
75 o thee: (.) hemigland treatmnts (.) have >problems with
76 erections:s<°,

```
77 PAT:  °hmm.°
78 HCP:  °equally as [bad°  ]
79 PAT:              [°nyeh°]
80       (0.6)
81 PAT:  [Righ-  ]
82 HCP:  [It a:ll] depends o:w (.) your body:y,
83 PAT:  °how you take it°=
84 HCP:  =°ta- comes out aftewards you know .hh ye-° YIKNOW .hh
85       while >yer onit< >you know thee< em (.) ((tuts)) (0.4)
86       the:e chah- thee (.) ehm (0.5) sota chil- children side
87       ofit- .hhh >we can< spe:rm ban:k (0.5) if you really
88       wanted to=
89 PAT:  =°°nah°°=
90 HCP:  =So ava think (0.3) don't >ave to< s- [say n- tuhda:y]
91 PAT:                                          [N:o (.)     ]=
92 PAT:  =I- I can't (.) °(see can- when)°
93 PAR:  °Well [no:o°]
94 PAT:        [Wan- ] wan- something yeah] no
95       [yeah]
96 HCP:  [No (.)] >Buttif is SOMEthin' yeh want< we've got that
97       (.) °o:ption available is not that difficult tuh set up
98       (.) is really e:asy so (.) if you-° some point (0.5)
99       before:re any of yeh treatmnts:s (0.3) you think >no I
100      think I [should]<
101 PAT:         [yes   ]=
102      (.)
103 HCP: °Ah cn settid up really easily n quickly for yer o:kay°
104      buddid's gotta be befo£hh£ ££HHAH HAH££
105 PAT: Yeah [obviously        ye:ah ]
106 HCP:      [££OF ANYTHING >S:O DYOU] SEE WHADDA MEAN££< ~cus
107      a:ll~ the treatmnts will have ehm (.) ((tut) atem- avan
108      affect on:n (.) yiknow on tha'.
```

Additionally, this excerpt demonstrates the ways that the healthcare professional's exclusive focus on 'maximising' the patient's ability to obtain and maintain an erection frames the topic in a manner that can be seen to erase any conditionally relevant discussion relating to the couple's sexual relationship, despite the patient expressing a clear preference for a continuation of their sex life.

As the sequence opens, the healthcare professional introduces the concept of 'erectile function' in a turn that is substantially quieter than the surrounding talk. During this talk, the patient's contributions are mainly delivered as continuers in service of enabling progression of the healthcare professional's extended turn-at-talk (Mandelbaum, 2012). Across lines 12 to 31, the healthcare professional offers two anecdotes about one actual patient, and then one hypothetical patient. The healthcare professional uses these anecdotes to return to the patient's situation, offering implications for what might be 'important' to a 'younger patient'. This formulation categorises this patient as the exception to the typically 'older patient', while drawing upon stereotypes related to sex and ageing to justify this stance.

The critical part of this sequence takes place when the patient states explicitly across lines 49 – 58 that having children is not a concern, they do not mind the idea of being sterile, but that a continuation of their sex life is in fact, important to them. During this sequence, the healthcare professional works to resume their turn-at-talk a total of four times at lines 51, 57, 59. And 61. Upon resumption, the healthcare professional continues their project across lines 62 – 76, talking about 'maximising erectile function'. With each mention of erectile function, the turns-at-talk are produced with hitches, pauses, hesitance markers, and re-initiations which are all hearable as 'doing taboo'. Within this part of the sequence, the healthcare professional's exclusive focus on erections excludes any genuine opportunity to discuss the topic in relational terms for the co-present couple. However, it is the next part of the sequence in which the talk becomes explicitly oppositional, further erasing the partner from an element of sex and sexuality that has inescapable implications for the partner; the decision to have children.

In this sequence, the patient made an explicit comment regarding fertility, stating directly that they did not mind being sterile. Despite this preference being stated in plain, unambiguous terms, the healthcare professional returns to this topic of fertility a further four times. They renew the pursuit of this project across lines 84 – 90, during which time, the patient can be heard to whisper "nah", followed by a definitive and elongated "no" on line 91 which occurs at the end of the healthcare professional’s appeal for the patient to “have a think”. The partner and patient then co-contribute at this stage, as they attempt to underline that this is not what they want. Critically, after this, the healthcare professional continues by outlining the ease at which sperm-banking can be ‘set up’, offering a ‘humorous’ summation of the project across lines 103 and 104. Not only does this insistence on talk of fertility resist the explicit preferences of the patient and partner, but it erases the fact that the decision to have children is something that is entirely a matter for this couple to decide. In this sequence, no consideration is expressed in relation to the partner who would presumably be responsible for carrying and birthing this hypothetical child. Combined with talk that focuses exclusively on the patient’s ability to obtain and maintain an erection, the approaches to the topic of sex and sexuality can be seen to inhibit the experience of the couple. This absence of sex talk in relational terms was observed across all collected examples, indicating that this is a structural feature of these encounters.

The emphasis on erectile function is exemplified in excerpt 42, where this sexual impact is communicated as a unilateral informing, with the impact described as an inevitable fact that should only be expected ‘going forward’.

Excerpt 42: Erections

```
1  HCP:  Uh:m (1.1) >an then< (.) again (0.8) soddof
2        o:verlapping alod >o the< treatments bt.
3        (0.7)
4        °erections.°
5        (0.5)
6  PAT:  °mhm°=
7  HCP:  =mkay (.) .hhh uh:hm they may well be affected.
8        (0.6)
9  HCP:  Yo::ur (0.3) dis↑e:a↓se↑ looks like, (0.6) it m:ay be
10       >reasonable< >to do< a ne:hv spare, (0.7) °Okay?°
11       [So the]=
12 PAT:  [°mm°  ]
13 HCP:  =ne:rves thet- (0.6) >help with:h< (0.3) °erections° >n
14       [to a<]=
15 PAT:  [°mm° ]
16 HCP:  =degree contin↓ance, (0.3) uhm pten:tially (.) .hhh UHM
```

```
17        they round the ou:tsi:ide of the prostate.
18 PAT:   °yeah.°
19        (0.8)
20 HCP:   ((lip smack)) No:w (1.8) alot ofit (0.5) r:really does
21        depend on:n (.) h:how things are once ye get in:n, an-
22        an- >people< are s:so variable in [terms] of (.) their
23        tissue planes n all=
24        PAT:                               [°mm° ]
25 HCP:   =kinduv stuff:f s:so .HHHHH (0.8) #yikno# I- I would s-
26        s:sortof s- s:say TENtatively a ner:r spare will probly
27        be:e (0.3) a reasonable (0.3) th↓ing, (1.1) based on
28        paper,
29 PAT:   Yes
30        (0.9)
31 HCP:   Uh:hm (0.4) an that may well help towa:rds °erections°
32        bt, (0.4) >yiknow< sometimes #that# (0.3) y- y:iknow
33        >even if< we tr:y an do a nerve spare it may not be:e,
34        (1.4) °yiknow°.
35        (0.6)
36 PAT:   °°yeh°° >same again< [££hmmhmm££ (.) hmm   ]
37 HCP:                        [The same (.) yeah and]- .hhh I- I
38        WOULD A:LMOST (1.2) go fo:rward thinking thet (.) you:r
39        erections will be affected in (.) to uh:h degree:e,
40        (0.7)
41 HCP:   °okay?° (.) >n if< they get badly affected therar
42        things thet we can d:o?
```

The healthcare professional initiates this sequence in the same format as in excerpt 41 with pauses, hitches, and hesitation markers, before introducing the topic for the first time in the consultation on line 4 with the single lexical item “erections”. The downward intonation and the prosodic features of this turn indicates it has been designed to stand independently. After a gap of 0.5 seconds, the patient produces a quiet acknowledgement, onto which, the healthcare professional latches their next turn-at-talk. Once more, the turn that raises erections is produced at a substantially lower volume than the surrounding talk, once more demonstrating the production of this talk as ‘doing taboo’. Upon resumption, the healthcare professional continues to outline the implications for the patient’s erections during an extended turn-at-talk that in its delivery and design, affords the patient the opportunity to produce nothing more than minimal response tokens in service of enabling the healthcare professional to continue talking.

During this extended turn-at-talk that takes place across lines 7 – 42, the healthcare professional’s delivery takes the form of a storytelling sequence, with each healthcare professional turn hearable as building upon the last, with none of them hearable as completing the story (Mandelbaum, 2012). Notably, in line 36, the patient attempts to produce a more elaborate turn that is evidently designed to project alignment with the healthcare professional’s informing. However, the healthcare professional picks up this turn, completing the patient’s turn for them, and at the same time, re-taking the conversational floor, while sequentially deleting the patent’s attempt to contribute (Lerner, 1989). In this turn, the healthcare professional raises their voice significantly, enabling them to re-take the floor, and underline the inevitability of the patient’s erections being affected ‘to a degree’. The healthcare professional closes the sequence with a positive ‘upshot’ before transitioning to the next phase of the consultation.

As with all of these consultations, the sexual impact is communicated in a manner that inhibits contributions from the couple, it is communicated in a manner of ‘doing taboo’, and is described in vague, biomedical terms, with an exclusive focus upon the physiological function of the penis. As the topic is consistently communicated absent of any orientation toward sex as primarily a relational activity, the organisation of this topic can be seen to erase any genuine opportunity for a couple to contribute to communicate their priorities and orientations relating to a topic that is of undeniable importance to them both in their relationship.

6.3 Chapter Discussion

The exploratory analysis in this chapter has offered some insight into the ways that the sexual impact of prostate cancer and its treatments has been communicated to couples during diagnostic and treatment consultations. The experience of prostate cancer, along with its related treatment is known to have profound effects relating to sex and sexuality (Matthew, 2016). The physiological impact is typically directed to the patient, such as their ability to obtain and maintain an erection, their ability to ejaculate, and their ability to conceive a child through sexual intercourse. It is however likely that these will lead to psychological distress for the patient and their partner, and their relationship (Wootten *et al.*, 2014; Walker *et al.*, 2017).

This relates to previous research that has noted that sex is infrequently discussed in clinical settings (Forbat *et al.*, 2012). Additionally, the analysis demonstrated the ways that healthcare professionals positioned the topic afforded limited opportunities for couples, and in particular, partners to contribute to the topic as they typically communicated the impact in a series of unilateral informing sequences. Instead of approaching the topic in terms of a sexual relationship, the ways that healthcare professionals focused on pathophysiology constructed the topic as entrenched within the domain of medical expertise. This approach arguably contributed to the lack of patient and in particular, partner contributions. This compares well to research that has indicated that there is little opportunity afforded for the discussion of the specifics of how prostate cancer affects sex and sexuality (Forbat *et al.*, 2012; Stewart, Roberts and Brindle, 2021). While the sexual impact of prostate cancer was introduced in some of these consultations by way of the polar question "are you sexually active?", the ways that the sexual impact was communicated to couples was effectively the same in consultations that contained this question, and those that did not.

Healthcare professionals consistently introduced the topics with turns-at-talk enacted in a manner consistent with performing a dispreferred action (Pomerantz, 2010; Pomerantz and Heritage, 2013). Across all collected examples, healthcare professionals introduced the topic with turns-at-talk interlaced with hitches, pauses, gaps, reduced volume, and inapposite topic transitions (e.g., excerpt 42). Additionally, during their limited descriptions, the sexual impact was described using vague, non-specific, and euphemistic terms such as "sexual function", "that", and "that side of things". This relates to the continued understand of sex and sexuality in this particular context as a social taboo (Soloway *et al.*, 2005; Ussher *et al.*, 2013; Chow *et al.*, 2018). Indeed, the taboo illustrated in excerpt 41 as the healthcare professional is addressing what they describe is a 'younger patient', noting that the decisions relating to the sexual impact are harder because they are "younger". This compares well with research that has highlighted the prevailing, outmoded assumptions relating to sex and aging where it is still assumed that the topic is inapposite for patients considered to be ‘older’ (Ussher *et al.*, 2013). Far from inapposite, research has shown that sexuality and intimacy are critical quality of life indicators for older couples (Galbraith *et al.*, 2005, 2008; Sanders *et al.*, 2006).

This analysis adds additional insight into the ways that the sexual impact is communicated to couples during prostate cancer consultations. Specifically, the constraints that the healthcare professional imposes upon the scope of talk relating to the sexual impact of prostate cancer can be seen to construct a context that situates the topic as the exclusive concern for the patient. As the impact is described only in relation to the patient’s erectile and reproductive function, these sequences are designed to exclusively address the patient, and by extension, designed to exclude the partner. This design is readily apparent even when patients resist this individualised format of delivery (e.g., excerpts 36 and 37). In excerpt 36, the healthcare professional’s approach can be seen to be active in the inhibition of the partner’s contribution, and in excerpt 37, despite the patient and partner co-producing an account to resist the individualised framing of the topic, the healthcare professional continues to deliver the same information in a turn that mentions ‘your continence and sexual function”, with none of the information designed to address the patient and partner as a couple.

In addition to an exclusive focus upon the physiological effect of prostate cancer upon the patient, this analysis demonstrated that the sexual impact was described exclusively in biomedical terms for the patient with no space afforded for the inevitable knock-on psychological, emotional, and social effects (e.g. Matthew, 2016). A pervasive focus upon biomedical concerns at the expense of social or lifeworld issues have long been understood as research has described an ongoing tension between these concerns within clinical settings (Mishler, 1985, 1986; Oliffe *et al.*, 2011). This research offers evidence that this tension currently persists in the context of localised prostate cancer, while demonstrating how this approach is erasing the lifeworld concerns of couples from an area that has critical quality of life concerns for them both (Galbraith *et al.*, 2005; Matthew, 2016). Accordingly, this research offers supporting evidence to research that has indicated that sex and sexuality continues to be a regularly unmet need among couples (Thewes *et al.*, 2004; O’Brien *et al.*, 2010, 2011; Ussher *et al.*, 2013; McClelland, Holland and Griggs, 2015).

6.4 Limitations and future research directions

As a pilot study, this analysis has offered an illustration about how the sexual impact of prostate cancer has been communicated to couples during clinical consultations. This work is limited by the lack of available data within the currently available corpus, as the sexual impact was absent in ten of the twenty-eight consultations. Nevertheless, this analysis does offer a valuable entry point into future research directions. Future research could expand upon and enhance these findings through a larger collection of instances where the polar question “are you sexually active” is posed in multiple clinical settings, to understand how it is used across multiple clinical settings.

6.5 Clinical implications

This research has examined the ways that the sexual impact of prostate cancer has been communicated to couples during diagnostic and treatment consultations. In doing so, the analysis has demonstrated how the healthcare professional’s approach to this topic could be seen to reproduce outmoded concepts of sex and sexuality as a societal taboo, particularly, the apparent taboos relating to sex and ageing. In the ways that the topic was introduced and outlined, these sequences were shown to produce next to no opportunity spaces for the couple to contribute in relation to a topic that is of profound importance to them both. The exclusive focus on the individualised, biomedical aspect of sex, namely the ability of the patient to use their penis, the sequences were seen to actively construct a situation that inhibited opportunities to approach the situation in relational terms. In this respect, this research offers additional evidence for a need to talk about sex in real terms, in ways that able to meet the real needs of couples, and critically, without approaching the topic based on outmoded assumptions about sex and ageing (Gott, Hinchliff and Galena, 2004; O’Brien *et al.*, 2011)

The findings from this study suggest that there is a general reluctance to introduce the topic of sex and sexuality to these consultations which resonates with contemporary constructions of sex and ageing (O’Brien *et al.*, 2011; Ussher *et al.*, 2013). These findings indicate that there is a need to re-think this practice and look to formulations that proactively normalise the concept of sex and sexuality in older adults, challenging the prevailing stereotypes. Moreover, such an approach should be able to introduce the topic to lone patients and couples in a manner that affords them agency to underline what is important to them. Unless healthcare professionals adjust their approach, this will continue to be an unmet need in this setting.

6.6 **Conclusion**

More than thirty years have passed since the record “let’s talk about sex” was released. Although it can be argued that attitudes toward sex have since shifted, it is evident from these consultations that work remains. In this respect, the findings from this chapter could be drawn upon in to inform clinical communication skills training packages where they might serve as a useful starting point to highlight the limitations of how the topic is currently being delivered. Based upon findings from previous research into talking about sex after an experience of cancer, couples and healthcare professionals agree that this is an important topic that has clear quality of life implications (Galbraith *et al.*, 2005; O’Brien *et al.*, 2011; Ussher *et al.*, 2013) Alongside the findings in this research, there is a demonstrable need to normalise the discussion of sex and sexuality so that it can be communicated to couples in relational, lifeworld terms, enabling couples to genuinely understand the sexual impact of prostate cancer.

Chapter 7 Discussion and Conclusion

7.1 Chapter Introduction

"No man is an island, entire of itself." – John Donne

In a series of essays from the 17th century, poet John Donne wrote this now famous phrase, using land as an analogy for people. The phrase itself is understood to express the idea that nobody can be truly self-sufficient, or isolated from their social world. Instead, Donne puts forward the notion that people and their worlds are inextricably interconnected as everyone relies on others to some extent. Be it a neighbour, a friend, a family member, or a spouse, Donne's writing argues for the interconnectedness of all that people do, from everyday social relations to the life-altering decisions that we make. This understanding is of substantial thematic relevance for the main findings in this thesis.

The overarching objective of this thesis was to systematically analyse a corpus of multi-party interactions situated within localised prostate cancer consultations comprising a healthcare professional, a patient, and their romantic partner. The initial research question related to the ways that partners contribute to the consultation, how they come to contribute, and how the structural configuration of the consultation might relate to these contributions. Using conversation analysis, this research examined the consultations across three chapters, with each analytical chapter having progressively increasing degrees of relevance for the co-present partner. The first analytical chapter examined the conversational processes relating to partner contributions across the entirety of the consultations. In the broadest sense, this analysis was informed by previous research indicating that partner involvement during oncology consultations tends to be expected and valued, but that the extent to which partners are involved is considered to be low (Davison *et al.*, 2002; Laidsaar-Powell, Butow, Bu, Fisher, *et al.*, 2016; Stewart, Roberts and Brindle, 2021). This was an important analytical step, designed to establish a broad, participatory framework relating to partners' turns-at-talk during these consultations (Sacks, Schegloff and Jefferson, 1974; Lerner, 2003). The next analytical chapter examined the sequential organisation and impact of couples' expressed preferences relating to treatment choices. The ways that prostate cancer and its related treatments can affect couples is well understood, and as such, it was considered as reasonable to expect any discussions relating to treatment to have an increased degree of relevance for couples attending the consultation (Boehmer and Clark, 2001; Giarelli, McCorkle and Monturo, 2003; Galbraith *et al.*, 2005, 2008). The final analytical chapter then examined the ways that the sexual impact of prostate cancer was communicated to the couples present in the consultations. The experience of prostate cancer and its treatments can have substantial impact upon the patient's sexual and reproductive functions. This includes, but is not limited to, their ability to obtain and maintain an erection, their ability to conceive children through sexual intercourse, and more broadly, their desire to engage in sexual activities, leading to unavoidable implications for couples (Boehmer and Clark, 2001; Galbraith *et al.*, 2005; Sanders *et al.*, 2006; Bullen and Tod, 2013). Accordingly, the sexual impact of prostate cancer was considered as a topic with a high degree of relevance, with substantial consequences for the co-present couples in these consultations.

This chapter offers a summary of the findings from each of the analytical chapters, while considering how these findings relate to previous studies within similar settings. Following this, some of the implications of these findings will be outlined along with some prospective explanatory accounts for the observed findings. The limitations of the research in this thesis, and directions for further research are then outlined and considered. Finally, the chapter conclusion provides a succinct summary of the entire thesis.

7.2 Summary of analytical findings

7.2.1 Partner contributions during localised prostate consultations

This chapter offered an examination into the conversational practices relating to how partners came to contribute across all phases of the consultation. The analysis centred upon the conversation analytic concepts of turn-allocation and next speaker selection to initially offer a general participatory framework of the consultation. This framework related to the sequential locations in the consultation where partners came to contribute, and how they came to obtain their turn-at-talk (Lerner, 2003; Clayman, 2013). The initial analysis demonstrated that, instead of being invited to speak, the overwhelming majority of partner turns-at-talk came about as a result of the partner having selected themselves as the next speaker, with this method of obtaining a turn-at-talk accounting for 97% of all partner contributions in the corpus of twenty-eight consultations. This meant that partners went unaddressed for the vast majority of these consultations. Specifically, the entire corpus featured just three instances of a healthcare professional selecting the partner as the next speaker, and four instances of a patient selecting the partner as the next speaker. Notably, while none of the healthcare professionals' three invitations were of sequential import for the consultation business at hand, the four invitations from the patient all related to the partner being invited to provide either practical or decisional support. However, the paucity of instances where a partner was selected as next speaker meant that a systematic analysis of this conversational practice was not possible. Nevertheless, these examples were subjected to detailed, line-by-line analyses as an important step in addressing the overarching research aims and objectives.

Turning to the process of self-selection, where a speaker obtains a turn-at-talk by selecting themselves as the next speaker, this chapter outlined the ways that partners could initiate repair, make information requests, and offer information while supporting, representing, and protecting the patient's position in the consultation. The chapter then offered an analysis of a practice that has been considered as problematic in everyday and clinical settings (Stivers and Robinson, 2006; Mazer *et al.*, 2014). In this, the process of the partner selecting themselves as next speaker after the patient was selected was subjected to a detailed analysis to examine the sequential organisation of these interactional moments. The analysis demonstrated a consistently prosocial configuration in these exchanges. Instead of the intuitive understanding of the partner speaking for the patient as if they were not able to speak for themselves, the analysis showed that partners consistently displayed due orientation to the patient's primary rights and obligations as the selected next speaker, initiating only after a substantial delay from the end of the healthcare professional's turn. Moreover, the partner's initiations consistently opened an opportunity space for the patient to initiate to elaborate upon, or collaborate with the partner, with patients regularly taking the opportunity to present a unified stance with the partner, often in direct resistance to the healthcare professional's individualised turns-at-talk. These findings offered an indication as to the social and clinical utility of partner contributions during these consultations.

The finding that partners are almost entirely unaddressed throughout these consultations stands in sharp contrast with similar research in the context of the seizure clinic. This setting is noteworthy as it is a condition in which patients regularly attend with a companion, and moreover, the companion is formally sanctioned participant as they are considered to be a reliable witness to the patient's seizure experiences (Doehring, 2019). In this research, just under half of companion turns were the result of the healthcare professional inviting the companion to speak (Doehring, 2019). Even when considering only explicit, verbal forms of next speaker selection, the difference between the two findings is substantial. Doehring reported that 20.2% of companion turns-at-talk were the result of explicit invitation from the healthcare professional. These findings are of particular significance as the majority of the companions in this study were romantic partners. The findings in this research differ greatly where a mere 1.6% of partner turns-at-talk were the result of explicit invitation from the healthcare professional. This disparity in the quantity of partner invitations is only highlighted further with the understanding that the only three instances of a healthcare professional inviting a partner to speak took place outside of the primary 'business' of the consultation, with one invitation asking the partner to confirm their presence at a previous consultation, one asking a partner to confirm that they are "a partner" and one asking the partner what another consultant "had to say". The difference in the clinical setting might go some way to explain these differences, as patients attending seizure clinics are typically advised to bring a companion to the consultation, with the companion officially sanctioned as a participant during the consultation (Robson *et al.*, 2012; Robson, Drew and Reuber, 2016; Doehring, 2019).

Within the context of prostate cancer, despite research that indicates both the desire and expectation of partners to be involved, and the understandings of the ways that prostate cancer can affect couples, partners of people with prostate cancer are, at this time, not formally ratified participants within the conversation (Galbraith *et al.*, 2008; Bullen and Tod, 2013; Stewart, Roberts and Brindle, 2021). Moreover, the conversational actions observed in this research indicate that partners are not socially sanctioned participants as the social practices enacted in these consultations consistently exclude the partner with the processes of turn allocation and recipient design consistently serving to construct a near exclusive focus on healthcare professional-patient dyad with no interactional work attempted to bring the partner into the consultation

(Sacks, 1992). Indeed, the conversational practices observed in these consultations are reflective of a system that favours a dyadic configuration (Stivers, 2021). Absent of interactional work and an institutional sanction, partners can be seen as doubly inhibited by the structure of these consultations.

The findings relating to the ways that partners self-select after the patient was selected as next speaker compare well to findings across multiple settings. Like the findings in this research, previous studies have demonstrated that when companions initiate to speak after the patient has been selected, they do so while in orientation to the patient's primary rights to take their turn as selected next speaker (Stivers, 2001; Doehring, 2019). Likewise, these findings compare well to research into everyday social interaction that has proposed a set of interrelated social preferences, one of which is a preference for the selected next speaker to take their turn, and a second order preference for the receipt of a response versus no response at all, should the selected next speaker 'pass' on their turn (Stivers and Robinson, 2006). The findings in this study however present a challenge to the consideration from previous research that this form of participation might represent a threat to patient autonomy (Mazer *et al.*, 2014). Indeed, far from posing a threat, the sequential analysis in this study demonstrated that this form of partner contribution was consistently prosocial, while demonstrating that such turns created contributory spaces for the patient who in turn, consistently took up this opportunity to elaborate upon, or collaborate with the partner, while regularly constructing a unified stance of "we" or "us".

7.2.2 Expressing preferences in a preference sensitive consultation

Chapter 5 examined interactional moments where couples expressed preferences relating to the available treatment choices, with an analytical focus upon the sequential organisation of these expressions. The chapter examined moments when couples expressed preferences for or against particular treatment choices as well as expressing a preference for an expert recommendation. The analysis showed that when healthcare professionals disaligned with these expressions of preference, it led to a sequential misalignment that shifted the activity toward an adversarial configuration. Moreover, this misalignment was shown to result in couples silencing themselves in the subsequent moments, even when healthcare professionals initiated in pursuit of a response from them. This silencing was considered as an interactive move, indicative of conflict management and mitigation (e.g. Toerien and Jackson, 2019). This pattern was evident in all but two of the collected cases in this chapter, with the two exceptional instances offered as an alternative approach to the prevailing pattern observed in these moments. In highlighting these sequential misalignments, this chapter underlines the immediate consequences of the healthcare professional's approach to these expressions of preference as the interaction shift posed a threat to the maintenance of social solidarity in a setting where cooperation and social solidarity is desirable. These findings are of particular importance when considering that prostate cancer and its treatments have direct implications for couples, and the understanding that this is a setting in which the healthcare professional is expected to be sensitive to expressed preferences relating to treatment choices (Giarelli, McCorkle and Monturo, 2003; Bullen and Tod, 2013; NICE, 2014).

These findings compare well to studies across several clinical settings. The sequential misalignment observed in this research compares well with the concept of discordance and activity contamination from earlier research into clinical and institutionalised interactions (Whalen, Zimmerman and Whalen, 1988; Heritage, 2011). Heritage highlighted the presence of dysfunctional communication practices in American primary care visits, while Whalen and colleagues' seminal single case analysis highlights the fatal consequences of discordance and activity contamination during a call to an emergency service.

The ways that the couple expressed their preferences as a form of resistance to particular courses of action as framed by the healthcare professional also compared well with research in settings of paediatrics and primary care that has indicated that such resistance should be acknowledged and accepted as a resource for agency and negotiation relating to treatment decisions (Stivers, 2005; Koenig, 2011). The finding that couples were observed to silence themselves as a consequence of these sequential misalignments also compares well to research into multi-party interactions in the seizure clinic where such self-silencing was considered as an act of conflict management (Toerien and Jackson, 2019). What this research adds is the observation of an inverted configuration when compared to the study by Toerien and Jackson. In their study, they outlined the interactional delicacy of attempting to differentiate between a diagnosis of epilepsy and a diagnosis of psychogenic non-epileptic seizures. In their detailed, single case analysis, the patient and their companion expressed discordance with the proposals of the healthcare professional, with the healthcare professional observed to silence themselves in a manner indicative of keeping explicit disagreement below the surface in service of maintaining social solidarity. While the same sequence is observed in this study, the configuration is inverted. In this, it is the healthcare professional that acts to disalign with expressed preferences of the couple, with a direct sequential outcome of the couple silencing themselves during a time where their expressions are of demonstrable importance to the treatment decision-making process (Elwyn *et al.*, 2012; Elwyn, 2020).

7.2.3 **Communicating the sexual impact of localised prostate cancer**

Chapter 6 examined the ways that the healthcare professional communicated the sexual impact of prostate cancer and its treatments to couples during the consultation. These sequences typically took place during the presentation of treatment choices, where the healthcare professional could outline the sexual impact with or without the production of the polar question “are you sexually active?”. In examining sequences that included the polar question, a form of preference organisation was noted as healthcare professionals performed the question with hitches, lowered volume, hesitations, re-initiations, and tags onto the core question, all of which projected the action of asking this question as ‘doing taboo’. This was further demonstrated in the ways that couples responded to the question as affirmative responses were performed in a manner indicative of a dispreferred response, with the only negative response performed in a manner indicative of a preferred response (Pomerantz and Heritage, 2013; Enfield *et al.*, 2019). This preference organisation was demonstrated further in the ways that healthcare professionals followed on from couples’ responses to this question, offering vague, exclusively biomedical descriptions of the sexual impact, with the entire concept regularly reduced to “that” or “that side of things” before they transitioned to the next phase of the consultation at the first opportunity. Moreover, in the only example with a negative response, the healthcare professional is hearable as ‘relieved’ of the burden of having to outline the sexual impact, as they instead offer an account of why they had to ask the question, appealing to the demands of the form they ‘have to’ complete. Overall, these sequences provided no genuine opportunity for couples to engage with discussions relating to the sexual impact of prostate cancer and its treatment.

Discussion and Conclusion

The sequences that proceeded without the polar question “are you sexually active” served to elucidate further the configuration of these exchanges as proceeding in orientation to stereotypes of sex and ageing, and absent of orientation towards any form of relational aspects of sex and sexuality. In not leading with the polar question “are you sexually active?” healthcare professionals still introduced the topic with hitches, hesitation markers, re-initiations, and reduced volume. The transitions to the topic were regularly hearable as awkward, and consistently performed in a manner that projected a degree of reluctance to introduce the topic into the consultation. The delivery design of the healthcare professionals across all of these sequences projected the ‘taboo’ of the incoming topic, as they delivered this sequence exclusively as a series of unilateral informing turns that described the impact exclusively in terms of erectile and male reproductive function. The sexual impact of prostate cancer was never introduced or discussed in relational terms, and the sequences proceeded absent of orientation to the inevitable impact that this would have on the couple’s sexual relationship and the associated impact upon the couple’s psychological and emotional wellbeing.

As evident as it was that healthcare professionals were drawing upon outmoded concepts of sex and ageing in the framing of this topic in the consultation (Ussher *et al.*, 2013), it was made abundantly clear in the example where the healthcare professional addressed a patient that they considered to be “younger”, as the healthcare professional remarked that the situation is ‘different for a younger patient’. In this particular instance, the healthcare professional persisted with the topic of fertility in the face of repeated resistance from the couple who made it explicitly clear that this is something that did not concern them.

Overall, the exclusive focus on the biomedical and physiological impact upon the patient’s erectile and reproductive function, including talk relating to reproduction that proceeded absent of any orientation to the partner can be seen to not only minimise opportunities for the couple to engage in discussions relating to the sexual impact of prostate cancer, but can be seen to erase the partner from the experience.

The findings from this research compare well to studies carried out across multiple oncology settings. Despite previous studies indicating that the sexual impact of cancer is a topic that couples wish to discuss, issues relating to sex and sexuality continue to be identified as a prominent unmet need within oncology settings (Forbat *et al.*, 2012; Ussher *et al.*, 2013; Stewart, Roberts and Brindle, 2021). However, research examining the ways that sex and sexuality are discussed in clinical settings have, in the main, relied upon methods that collect retrospective accounts of the experience, rather than a systematic examination into the site of the interaction itself (O'Brien *et al.*, 2011; Forbat *et al.*, 2012; Ussher *et al.*, 2013; Traa *et al.*, 2015). Nevertheless, the findings from this study indicates that discussions relating to the sexual impact of prostate cancer, as enacted in the consultation persistently marginalised the topic, and provided limited to no opportunities for couples to discuss the ways that prostate cancer would impact upon their sexual relationship.

What this research adds is a detailed examination into the conversational practices of the healthcare professional, demonstrating that their approach to the topic can reproduce social structures relating to sex as a 'taboo' topic, while also reproducing outmoded understandings and attitudes relating to sex and ageing. Additionally, this research shows that the persistent biomedical focus upon the patient's sexual and reproductive function effectively erased the co-present partner for whom, these concerns are of substantial importance.

7.3 **Implications of analytical findings**

Combined, the findings from the analytical chapters demonstrate that, despite the consultation being structured in a manner that inhibits partner contribution, partners can serve as a valuable interactional and informational resource for the patient and the healthcare professional. The overall paucity of partner contributions that came about as the result of an explicit invitation, and the lack of healthcare professional orientation toward issues with clear repercussions for patients and partners as a couple, raises questions about the interactional, structural, and societal influences involved during these consultations. To that end, consideration is given here to the membership categories enacted in these consultations, how these might relate to outmoded, unhelpful attitudes towards sex, ageing, older couples, and constructions of masculinity. Additionally, consideration is given to the enactment of patient autonomy within the context of a clinical condition that has inevitable impact upon both a patient and their partner as a couple.

7.3.1 Membership categories and the consultation

The consultations in this research all take place within the clinical context of localised prostate cancer. These consultations comprise what is, to all intents and purposes, the same configuration of participants; that of a healthcare professional, a patient with localised prostate cancer, and their partner. Without offering any further information about these participants, the labels used to describe them makes salient a wealth of possible inferences that can be made about these participants, and moreover, how these participants might typically interact. It is the ease in which such inferences become salient that underpins the concept of Membership Categorisation Devices (MCD).

Membership categorisation devices are said to comprise two parts. The first part relates to collections of categories, and the second part is a set of rules for application (Schegloff, 2007). In these terms, a category collection relates to a set of categories that are understood to be typically grouped together, such as a collection of nationalities, genders, professions. Although membership categories can be formulated and made salient depending on a particular situation, they can also be considered to be socially organised methods for understanding self and others. Sociology has drawn upon social categories as a key step in doing sociological research. Categories such as age, race, and gender are regularly used as presumptively adequate means of organising and categorising people in a consistent way, with the expectation being that members of particular categories tend to behave in consistent ways in relation to the topic being researched.

Sacks considered that certain category memberships can be related, with the relationship between these categories understood by members of each category as well as members who observe these categories without necessarily being members of either. In this respect, categories and their relevant relationships can be considered as socially organised, and understood by members and non-members accordingly (Sacks, 1992). Sacks described this concept as a standardised relational pair, where members of a pair can know and orient toward their own, and the other’s pair position in this relationship, while an external observer can also understand the socially organised relational dynamics of this pair. Sacks went on to propose two types of relational pair: Collection R (Relational/Obligatory) and collection K (Knowledge/Epistemics). Examples of collection R include parent/child, a married couple, two friends, or even two strangers. Examples of collection K include teacher/student, doctor/patient, and solicitor/client. Unlike collection R, which emphasises the socially organised norms of a relationship, collection K relates to the organisation of these pairs relative to a difference or gradient within a specific type of knowledge of which one member is considered to hold to a substantially greater degree than the other, producing an epistemic gradient between the two members of this relational pair. In the context of this thesis, there are two distinct relational pairs of category memberships: The patient and partner as a spousal relational pair (category R), and the patient and doctor as a doctor-patient relational pair (category K).

With relational pairs of categories, there are socially organised expectations in the ways that members of these pairs interact. Despite these not being fixed entities, these expectations can be considered to be at least normative, if not prescriptive. For example, the heteronormative assumption of a couple within a romantic relationship comprising a man and a woman can be empirically incorrect, yet the monogamous, heteronormative concept of romantic relationships can still be argued to persist due to its continued intuitive appeal. It is such organisation that is typically resistant to induction insofar as situations that run contrary to normative expectations, as these situations that appear to run contrary to the ‘norm’ are considered as exceptions to it, or even problematic in some way (Schegloff, 2007).

The category collection of a doctor and a patient within a clinical setting is one such highly organised relational pair. Likewise, the category collection of a spousal couple is highly organised. With these category relationships comes the intuitive knowledge about the kinds of activities and forms of conduct that can be expected from members of these categories (Ruane and Ramcharan, 2006). For example, the doctor-patient relationship has a highly normative set of category-bound activities relative to the clinical consultation. For example, the doctor is typically understood to have both the epistemic rights, and moral obligations to diagnose, and subsequently treat the patient who, as a patient, has the obligation to seek help, and have a desire to ‘get better’. Likewise, the spousal relationship is strongly bound to normative activities relative to most aspects of their everyday lives, such as mutual support, intimacy of relations, and to a certain extent, sexual activity.

In this respect, the categories used to describe the participants within these consultations serve as more than neutral descriptive labels. In categorising each individual, or collection of individuals, it serves to imbue them with a set of normative expectations toward which, all participants can mutually monitor for orientation to norms and where relevant, breaches thereof, with considerable ease. However, the application of these categories is not something that is necessarily set within a particular context. As Sacks described it, people can be categorised at least two ways within a given situation (Sacks, 1992; Schegloff, 2007). Within the context of this research, the patient in the consultation is also a spouse, with each category having a degree of relevance for the doctor and the partner, respectively. However, it can be argued that, within the context of this clinical encounter, the category-bound activities of the doctor-patient relational pair are being prioritised over the category-bound activities of the spousal couple. In accordance with Sacks' rules of application, the doctor-patient relationship is more accessible, and fitted to the context of the encounter, making it the more adequate category distinction. This could go some way to explain the dearth of partner invitations during these consultations. However, given the fact that partners have been shown to be explicitly addressed by healthcare professionals over 20% of the time in other clinical settings (e.g. Robson, Drew and Reuber, 2013; Doehring, 2019), the category memberships and category-bound activities by themselves cannot be considered as a sufficient explanatory account. However, the consultations within the settings studied by Doehring, and Robson and colleagues, bear the distinction of being institutionally configured in a manner that sanctions the companion as an active participant in the consultation. Based on the findings in this thesis, it is evident that, should the consultation be configured in relation to the dyad-focused category collection of a doctor and a patient, the consistent application of this rule can be arguably involved in the exclusion of the partner from the interaction as this category collection makes no provision for the sanctioned inclusion of a partner during the consultation. In effect, the setting, and a lack of institutionalised sanction for the partner can be argued as at least partly responsible in the production of an interactional membrane around the patient-doctor dyad into which the partner has to consistently work to enter (Goffman, 1983; Sacks, 1992).

The lack of invitations made to partners across the entire collection of consultations used for this thesis provides some evidence as to the extent to which partners are institutionally excluded from the normative organisation of the consultation. However, there are also moments within the data that are indicative of all participants orienting to institutionally bound prioritisation of the doctor-patient category relationship. An illustrative example comes in the form of one of the few sequences where a healthcare professional selects a partner as next speaker:

From excerpt 2

```
1 HCP:   An:d uhm (.) so yo:h (0.3) mister ((Name)), an:d=
2 PAT:   =((Na[me]))
3 HCP:        [you] a::re >#a# [partneh< (0.4) yeah ].
4 PAR:                         [((Name)) (.)    Yes:s] I- yeah.=
5 HCP:   =S:o- a:nd- (.) u:hm (0.8) thee:e uh:h (2.0) ((5 taps
6        of computer keyboard)) plan tda:y is to throu:gh (.)
7        you:r results,
```

In a rare example of the healthcare professional addressing, and therefore selecting the partner as the next speaker, the healthcare professional's turn on line three projects a clear trouble source and searching repair as they elongate the word "are" (Kitzinger, 2013). The two consequences of this self-repair initiation are of sequential import. The first is that the partner displays orientation to the word-search repair as a trouble source, and initiates with a repair solution in the form of their name. However, the healthcare professional initiates in direct overlap with a repair solution of their own. Of all the possible solutions upon which to land, the healthcare professional uses "a partner". The compressed nature of the turn followed by the swift acknowledgement of the partner's name projects the formulation as sub-optimal. To say "a partner" instead of a relational person reference to describe the partner as the patient's partner, or alternatively, by their surname, demonstrates a specific lack of situated interactional resources available to the healthcare professional for addressing the partner.

Likewise, the sequences in which the couple express a preference for an expert recommendation can be seen to draw upon the categories of the doctor and the patient in the normative expectations relating to the doctor both diagnosing and recommending a treatment for the patient who has presented with a problem. In this, the expectation of the recommendation orients to the expected epistemic gradient between a patient and their doctor. The examples below illustrate how these categories were employed in the consultations:

From excerpt 31

17 PAR: [>b'd obviously< y:ou] must h:ave (0.3) an opinion,

From excerpt 32

5 PAR: W:we will be goveren- (0.4) ~£bec'z yo(h)u're
6 exp(h)e:rience£~
7 HCP: ↑#Buddi#↑ [I thin-]
8 PAR: [By::y] (.) You'r=
9 =o[pinion (.) is >to wha-< (.) ↑you kn↓ow?]
10 PAT: [Yeah but wh't you're sayin' is we have] a choice.
11 HCP: Yes >↑you do have a↑< choice >an I thin'< (.)
12 PAR: >Bu[t there must be a fa:v'rit-<]

Likewise, healthcare professionals were seen to draw upon the category collection of a doctor and patient when making treatment recommendations as they were seen to lean heavily into the normative expectation of the epistemic gradient inherent to the doctor-patient relationship. The example below elucidates this with the healthcare professional constructing the two distinct categories in a single turn; the doctor category is constructed as a group of “we” relative to the patient category of “you”, as in “the best option for you”.

From excerpt 29

1 **HCP: So we've discussed it >in one of our< meetings,** and
2 **everyones** agreed re:ally that the **bes:t (.) option >for**
3 **you<** would be something we ca:ll active surveillance,=

Accordingly, the absence of orientation toward the partner by way of invitations to contribute to the consultation appears to be, at least in part, a product of the institutionalised configuration of the consultation, and its consistent application of the category-bound activities relating to a doctor and a patient. However, there was a particular part of the consultation that made this institutionalised configuration particularly clear, as discussions relating to the sexual impact of prostate cancer and its treatment proceeded absent of any orientation toward the partner, despite this topic having undeniable relevance for them as part of the co-present couple who could be seen as positioned within the distinct category of the ‘older couple’.

7.3.2 **Sex, sexuality, and ageing**

While describing the available treatment options and their related side-effects, healthcare professionals regularly introduced into the consultation, the ways that prostate cancer and its treatment can substantially affect the patient's sexual function, and as such, their sexual wellbeing. Prostate cancer and its curative treatments are known to impact upon a patients sexual and reproductive functions, primarily related to the patient's ability to obtain and maintain an erection (Gacci *et al.*, 2003; Dubbelman, Dohle and Schröder, 2006). The sexual impact however is not limited to physical function as treatments can also lead to the loss of desire to engage in sexual activity (e.g. loss of libido), which can in turn have profound psychological and social impact for the patient (O'Brien *et al.*, 2011; Ussher *et al.*, 2013; Iavazzo *et al.*, 2015). Such marked impact upon the patient's ability to enact and interact as a sexual entity is of clear, inescapable concern for patients who are in any kind of romantic relationship where there is a sexual component to the relationship. Accordingly, the sexual impact of prostate cancer is of equally inescapable importance for couples as the impact affects them in multiple, complex ways from unavoidable changes to their sexual activity, to finding ways to cope with the psychosocial impact relating to how the patient responds to what can represent a threat to their sexual and gendered identity, how their partner responds to this threat, and how they work together to adjust to these changes (Wootten *et al.*, 2014).

Research to date, along with the research in this thesis indicates that the sexual impact of prostate cancer, along with several other genitourinary cancers continues to be communicated only in biomedical terms, such as erectile and male reproductive dysfunction (Forbat *et al.*, 2012; Ussher *et al.*, 2013). Moreover, the ways that the sexual impact was communicated during the consultations in this thesis shows that the topic was discussed in particular ways that not only erased the partner from the topic, but in ways that also served to construct the topic as somehow inapposite for the co-present 'older couple'. This finding might be explained by examining the prevailing attitudes towards sexuality and the category of the 'older couple', and with it, a set of category-bound activities that evidently do not include sexual intimacy.

Prevailing attitudes towards sex and ageing are so deeply entrenched within most societies, that they can often be drawn upon as natural 'facts of life' by healthcare professionals and couples alike with clear social, clinical, and methodological implications. Specifically, there remains a socially organised understanding that, when people reach what might be described as ‘older adulthood’, that they suddenly become ‘too old’ for concerns relating to sex and sexuality.

Research has shown how patients, their partners, and healthcare professionals mutually orient to this prevailing attitude towards sex and ageing. However, this mutual orientation should not be mistaken for consensus. Healthcare professionals in oncology have been shown to draw upon cultural discourses relating to older adults, positioning them as effectively asexual entities and using this discourse as justification for positioning the topic of sex as irrelevant for older adults (Ussher *et al.*, 2013). This finding was also reported in the context of lung cancer, where healthcare professionals were reported to assume that older couples would not be interested in sex (Lindau *et al.*, 2011). Likewise, the same findings have been reported in the context of general practice as GPs noted that sexual health is a concern for ‘younger people’ and therefore not a ‘legitimate’ topic for older adults (Gott, Hinchliff and Galena, 2004).

This discourse can be seen to construct a particular relational category of the ‘older couple’ standing distinct from the category of the ‘younger couple’. In this, the ‘older couple’ relational category can be seen as embedded with a particular set of category-bound activities that evidently exclude sexual intimacy. Such is the appeal of the discourse of sex and ageing, that patients and their partners will adhere to its embedded expectations in their self-presentation within clinical settings. Men with prostate cancer reported being too embarrassed to raise psychosexual concerns during the consultation as they feared that the healthcare professionals would consider them as too old for such concerns to be considered as valid (O’Brien *et al.*, 2011). However, the same study noted that these same patients came to realise that this was a mistake, as they later came to genuinely realise the sexual impact of their treatment.

The intuitive appeal of sex and older couples can also be seen as reflected in research practice. In their qualitative study into the unmet psychosexual needs of prostate cancer patients, O’Brien and colleagues had to establish a means to facilitate patients exploring their experiences of psychosexual problems as they were initially reluctant to discuss these matters (O'Brien *et al.*, 2011). In this study, the researchers oriented toward the discourse of sex and ageing while working to mitigate the impact of it. By contrast, research into sexual, marital, and life functioning of couples coping with colorectal cancer actively excluded participants that were older than 75, offering no explanatory account for this exclusion, with the study limiting the concept of 'older couples' to those who were younger than 75 (Traa *et al.*, 2015).

These prevailing assumptions relating to sex and older couples can be seen to construct a dual silencing effect that leads to a self-fulfilling prophecy. As healthcare professionals raise the topic, providing little by way of real information relating to the sexual impact of prostate cancer, they do so in ways that are structurally informative for the patient and their partner. In turn, patients and partners orient to the normative assumption that this is something that should not concern them, despite research evidence that emphasises the importance of adopting a biopsychosocial approach that emphasises the active participation of the patient and their partner (Matthew, 2016).

Likewise, as couples remain silent in these matters, both inside and outside of the clinical context (Lindau *et al.*, 2011; Ussher *et al.*, 2013), it can close a feedback loop in which healthcare professionals can have their assumptions 'confirmed', as the silence of the couple is taken as an indication that sex is not important to them, which in turn serves to justify their approach to the topic in the first instance. This behaviour was observed in the ways that healthcare professionals outlined the sexual impact of prostate cancer to couples in this research, particularly in the organisation of the polar question "are you sexually active", which was consistently asked with orientation to the category of the 'older couple', with both healthcare professionals and couples alike, designing their talk around the prevailing assumptions about sex and ageing.

Moreover, in the only consultation in which the couple are openly described as 'younger than normal', the healthcare professional makes their exceptional status clear, noting that it is 'different for them' because they are 'young'. In this particular consultation, the discussion relating to the sexual impact not only proceeds absent of the polar question "are you sexually active", but it is the only consultation in the collection where the healthcare professional repeatedly pursues the matter of fertility, despite facing repeated resistance from the couple relating to the matter. In this, the ‘young couple’ can be seen to have been categorised differently to the ‘typical’ older couple, in both the way that they were described, and the ways that the sexual impact was communicated to them.

7.3.3 **Sex, men, and masculinity**

While the sexual impact of prostate cancer has inescapable implications for couples (Forbat *et al.*, 2012; Wootten *et al.*, 2014), the findings from this thesis, together with several related studies have shown that the sexual impact of prostate cancer is exclusively communicated in terms of its direct physiological impact for the patient, namely the ability to obtain and maintain an erection, the ability to ejaculate at climax, and the ability to conceive a child through sexual intercourse (Forbat *et al.*, 2012; Huber *et al.*, 2016). This can be seen to be related to concepts of hegemonic masculinity, and the heteronormative primacy of the penis in the act of sexual intercourse.

With masculine identity so tightly intertwined with both the size and potency of the penis, the sexual impact of prostate cancer and its treatment can represent a substantial threat to this identity (Bullen and Tod, 2013). This relationship between the sexual impact of prostate cancer and constructions of masculine identity is further exacerbated by unrealistic masculine ideals in which men are expected to be able to ‘soldier on’, or ‘take it on the chin’ and critically, avoid seeking help (Addis and Mahalik, 2003). It is with this understanding that the ways that the sexual impact of prostate cancer might be better understood. In describing the impact exclusively in terms of the patient’s erectile and reproductive function, healthcare professionals can be seen to construct the impact in exclusively individualised terms, which by extension, exclude discussing the impact in any relational terms. Furthermore, in doing this, the proposed solutions were designed to exclusively focus on restoring the patient’s erectile function, with consistent talk about ‘maximising’ the patient’s ability to obtain and maintain an erection.

Moreover, these solutions themselves were delivered in ways that aligned with constructions of hegemonic masculinity, with patients informed about ways that they could help themselves, rather than proffering solutions relating to how the couple could work through this experience together. This exclusive emphasis on patient erectile and reproductive function was observed throughout all collected cases in this study. The emphasis upon the patient helping themselves in accordance with hegemonic masculinity was so appealing, that it became evident in one particular example where the healthcare professional was observed to offer a 'humorous' solution to ameliorate some of a patient's symptoms relating to their biopsy. In offering this solution, the healthcare professional twice gave the patient 'permission' to 'fire off some blanks' as a euphemism for masturbation. It is in these interactions that the constructions of masculinity, sex, ageing, and the category of 'older couple' can be seen to intersect, producing a structure that serves to inhibit the relevance of the partner.

Combined, the emphasis upon the configuration of the healthcare professional and the patient as the doctor-patient standardised relational pair, the category-based assumptions of the 'older' couple' and concepts of hegemonic masculinity can be argued as strong contributing factors to the ways that these consultations are structured, as these concerns work to position the patient as a self-sufficient individual, isolated from their surroundings, despite attending the consultation with their partner. It is in this, that concepts of patient autonomy might offer a further explanatory account for the observed findings in this study.

7.3.4 **Patient autonomy: The island, or the relational patient?**

In considering autonomy, it is of importance to first note that the concept of autonomy stands distinct from three separate, yet interrelated principles of capacity, agency, and consent. The principle of capacity is considered as the ability to use and understand information for the purposes of decision-making. The principle of agency relates to the capacity for initiating intentional actions, which is an important element of decision-making. Finally, the principle of consent relates to the capacity to making voluntary, informed decisions. For the purposes of this research, the principles of capacity, agency, and consent fell outside of the feasible scope of this research as the data together with the chosen method, offered no genuine way to examine these concepts. Accordingly, based upon the available data, assumptions had to be made in relation to the capacity, agency, and provision of consent in relation to treatment choices for all participants.

In describing and interpreting autonomy, the principle is regularly related to the etymology of the word, as it's Greek roots translate to self-governance

(Beauchamp and Childress, 2019, p. 120). In taking the etymology of the term as the starting point, the concept of self-governance can be easily seen to be transformed into the somewhat tautological concept of ‘personal autonomy’, and the right to self-determination. Indeed, as described by Beauchamp and Childress, they consider any ‘weakening’ of autonomy as diminished autonomy, noting that “A person of diminished autonomy, by contrast, is in at least some respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans” (2019, p. 121). Staring from the definition of self-governance, the principle of autonomy can be seen to be transformed into a continuum of individual control, with ‘strong personal autonomy’ conceptualised as full individual-determination, independent of controlling influences, and ‘diminished personal autonomy’, controlled by others. This conceptualisation compares well to Kant’s concept of liberal autonomy in which individual decisions are considered to be the result of solo-cognitions that should take place in isolation from external influences (Kant, 1996). Indeed, despite offering a criticism of Kant’s liberal autonomy, noting that it underemphasises relationships (2019, p. 61), Beauchamp and Childress go on to propose that respect for autonomy requires independence from ‘controlling influences (2019, p. 121). In this respect, it is this form of autonomy that was seen to be enacted during the twenty-eight consultations used in this study. It was evident through the examination of turn-taking practices, the ways that healthcare professionals oriented to expressions of preference relating to treatment choices, and the ways that healthcare professionals communicated the sexual impact of prostate cancer. Across all areas of enquiry, healthcare professionals were seen to enact the Kantian conceptualisation of liberal autonomy. This included designing turns that all but exclusively addressed the patient, re-orienting the conversation back to the patient when partners expressed preferences relating to treatment choices, and describing the sexual impact of prostate cancer and its treatment in exclusively individualised, biomedical terms. This persisted, despite patients and partners regularly taking up a unified stance during the consultations, presenting themselves as a couple of “we” and “us”, including times where the patient explicitly endorsed this status. It is in this, that the limitations of individual autonomy might be considered, along with consideration to alternative conceptualisations of the patient, and by extension, the partner.

Autonomy is one of the guiding ethical principles in clinical practice and is considered as a desirable goal in accomplishing the principles of shared decision making (SDM). Research into the ways that SDM is accomplished in routine clinical practice has shown that there remains a lack of clear guidance about how it can be accomplished, while illustrating how autonomy is consistently framed as an individualist concept, despite the availability of alternative interpretations (Elwyn *et al.*, 2012). Indeed, research into decision-making has shown that decision-making is never an individualist pursuit, arising from solo cognitions, but instead, it is an iterative process that takes places across time, and is shared with a range of others (Rapley, 2008; Elwyn, 2020). This aligns well with Keller's model of relational autonomy in which social relations are not conceptualised as 'diminishers' of autonomy, but instead, Keller notes that the expression of individual agency need not be accomplished through the denial of relations with others (Keller, 1997). This interpretation of autonomy as inherently relational can be seen as reflected in research into triadic medical encounters where companions have been shown to be instrumental in bringing vital information to the clinical encounter (Cordella, 2011). Likewise, research into the involvement of others such as family members and caregivers in treatment decision-making have underlined that patient's treatment decision-making processes are not constrained to those who attend the consultation. In this, it has been reported that treatment decision making is a concern for a wide social network that extends beyond the clinical encounter, with everyday social relations inextricably related to decision-making (Laidsaar-Powell, Butow, Bu, Charles, *et al.*, 2016; Laidsaar-Powell *et al.*, 2017, 2018). In this framework, it is more than reasonable to argue that a romantic partner or spouse, followed by family would typically be close to the centre of such a network of social relations. This was evident in some of the consultations as patients and partners referred to others with whom they would discuss their situation and decisions to treat, for example:

From excerpt 16

1 PAR: Our daughters a ((HCP)) (.) she's >coming over frum<

2 ↑((place)) tonight so=

3 =[shell sit do:wn an £talk toim, ((cough))]

4 PAT: [And ↑and I↑ wont↑ make any decisions >] 'til I've<

5 spoken to ↓he:r↓ so:o,=

6 (0.4)

7 HCP: ↑Okay↓ so in ↑terms↑ of (0.3) gle:ason scores and

8 [things,]

9 PAT: [Yeah?]

10 PAR: °mhm°

11 HCP: Uh:m (.) [its- it's a]three plus four?

12 PAT: that [I undehstand yeah?]

In this sequence, the partner self-selected, offering important information in the form of a news update, which also served as a prompt for the patient who in turn endorses the news delivery, picks up from the initial informing, and goes on to note that they will not make any decisions until this conversation with their daughter has taken place. Notably, the healthcare professional fails to orient to this news, and instead, after a noticeable gap, initiates a topic transition on lines 7, moving onto talk about the diagnosis. Such failure to orient to the process of decision-making as interconnected throughout social networks has been demonstrated in previous research where healthcare professionals have acted to isolate patients from 'outside influence', including co-present family members (Rapley, 2008). However, the need to isolate patients from this so-called "controlling" influence overlooks the importance of everyday social relations in making decisions. This has become increasingly apparent as patients make use of the internet to better understand their conditions as well as to inform their decision-making processes (Stevenson *et al.*, 2021).

In the context of localised prostate cancer, the internet was reported as the most commonly used source of information, followed by family and friends, underlining the decision-making as tightly interconnected with social relations and external networks (Steginga *et al.*, 2002). Moreover, research has shown how patients with localised prostate cancer can connect in online support groups to communicate their experiences to support shared decision-making across a wide, internet-mediated discussion forum (Huber *et al.*, 2011). In this respect, the adherence to the concept of individualised autonomy in these consultations is being accomplished in a manner that is effectively denying the patient their relations with others, including their co-present partner (Keller, 1997). However, it has been argued that relationships, and interdependence on others should not be considered as factors that limit or diminish autonomy, but that they should instead be considered as the resources that patients utilise in their accomplishment of their autonomy (Struhkamp, 2005).

The evidence from this thesis, combined research across several medical settings, and research into concepts of autonomy offers a good argument for reconsideration of what it means to enact patient-centred care, what it means to accomplish patient autonomy, and in particular, a reconsideration of the patient as an entity. It has been demonstrated by research that the pursuit of patient-centred care can be accomplished by incorporating the voices of related others in the consultation (e.g. Doehring, 2019), and it has also been demonstrated that autonomy as a concept can be inherently relational with individuals inextricably interconnected with their social relations and culture (e.g. Keller, 1997). As an extension of these findings, this thesis argues for a reconsideration as to what it means to be a patient, particularly for conditions like prostate cancer, where the impact of the condition has inescapable impact for the patient and those who care for them. This should be especially important for situations when the patient has chosen to attend the consultation with their romantic partner or spouse. Accordingly, with conditions that are relational, the patients who experience these conditions should be considered as relational. From the starting point of a relational patient, their interdependence upon others such as their partners can be institutionally recognised and incorporated into the structure of the consultation. For those patients who attend with their partner, this conceptualisation of the patient would enable, with consent, the conceptualisation of the couple as the patient, endorsing the stance that couples were shown to regularly take during the consultations in this thesis.

In this, instead of a strict, unwavering focus upon individual autonomy, while working to protect the patient from ‘controlling influences’, the concept of a relational patient might serve to promote the understanding that no man – no *one* is an island, entire to themselves.

7.4 Implications of findings for clinical practice

The findings from this study constitute an original contribution to knowledge that serves to elucidate some of the conversational practices and unfolding social actions among a patient, their partner, and a healthcare professional within the context of clinical consultations for localised prostate cancer. In order to translate this original knowledge contribution into implications for clinical practice, they must first be incorporated into the broader body of findings produced by the wider study, TrueNTH Decision Support: Understanding Consequences.

The overall aims of the wider project are to help people with prostate cancer, and their families to better understand impact that low and intermediate risk prostate cancer, and its related treatment has on both patients and those who care for them. One of the key objectives of this project was to develop evidence-based clinical training packages, including communication skills training designed to improve communication practices within these consultations. Communication training packages relating to dyadic HCP-patient encounters have been developed and evaluated. However, packages that address triadic consultations comprising an HCP, a patient and their partner have yet to be developed. The findings from this thesis have clear implications for the development of such communication skills training packages. The findings from chapter 4 can be implemented to make salient the lack of explicit selection of the partner as the next speaker within these consultations, while offering alternative social practices that might serve to ratify the partner's participation. The findings from chapter 5 can be implemented to elucidate the impact of the observed sequential misalignments, while making salient the alternatives that demonstrate how these misalignments can be avoided. Finally, the initial findings in chapter 6 can offer an indication as to the limitations of the ways that the sexual impact of prostate cancer is being communicated to couples, while giving pause for consideration as to the genuine utility of asking the question “are you sexually active?”.

7.5 Limitations and directions for further research

7.5.1 Limitations

The main limitations of this research largely relate to the ways that the data were collected, and the constraints this placed upon the research process. As data that were collected for a wider study, this study was limited to the availability of consultations that met the criteria of consultations comprising patient, their partner, and a healthcare professional. As the analysis of multi-party interactions with a focus on partner contributions was not the primary aim of the wider study, this thesis was limited to the twenty-eight consultations that were included in the final corpus. Due to difficulties in gaining ethical approval to record cancer consultations, the data collected from these consultations were audio only, placing unavoidable constraints in both building the corpus of consultations for this study, and the process of analysis. These constraints related to the inability to attend to non-verbal and embodied actions that could have offered greater analytical insight into the situated practices in the unfolding interactions (Mondada, 2019). While selecting the consultations for this corpus, it was apparent that there were consultations in which a partner was present, but due to the fact that they were not audibly present either by making contributions, or by another party making reference to them, the consultations could not be included in the corpus. The lack of video data precluded the possibility of an analysis involving gestures, nodding, gaze, and embodied configuration of participants. As a result, the analyses in Chapter 4 were only able to attend to explicit forms of next speaker selection as it was not possible to discern forms of implicit selection. However, while these elements may have served to enhance this study, they would not be considered as fundamental to the research carried out here as the audio provided a sufficient record of the interactions to address the questions asked by this research.

The constraints related to the wider project also meant that the data were constrained to four particular locations across England only. While the locations were across various regions of England, it does raise the possibility that the findings from this study may only be applicable to these settings in England, and furthermore, limited to the context of low or intermediate risk localised prostate cancer.

A further constraint relating to the way that the data were initially collected relates to the ethics agreement entered into for the wider study. One of the constraints placed upon the data was that it could not be played back in any format during presentations. This meant that the audio data could not be brought to, or used in group analytical sessions otherwise known as ‘data sessions’ (Stevanovic and Weiste, 2017). The constraints meant that even anonymised audio data could not be used during these data sessions. Conversation analysis is fundamentally a collaborative activity, and the act of presenting and analysing data in these sessions is a fundamental part of doing CA. This is regular practice among analysts at all levels of development, from novices to fully qualified experts. These sessions enable researchers to engage with the CA community, presenting fragments of their data in what has been described as a “mutually inspiring playground” in order to test analytical ideas, and moreover, have analytic findings strengthened and subjected to the rigours of peer-led scrutiny. To mitigate for this, supervisory meetings were structured to serve as data sessions. These meetings were structured in the format of a data session and involved the researcher and their two supervisors. This allowed for the requisite collaborative activity of the data session, and also enhanced the validity of the findings.

While the inability to bring the data from this research to data sessions has not lessened the analytic findings, it has lessened the analytic experience. Future studies seeking to apply conversation analysis or related methods to clinical encounters should proceed with the understanding that these data sessions are a core provision for the experience of doing conversation analysis, and that the analytical experience will only be improved by the analyst’s ability to play back at least some of their data during presentations and data sessions.

7.5.2 **Directions for future research**

There were several areas of research that were identified but were beyond the scope of this research and its corpus of data. Future studies could immediately enhance and extend the findings of this thesis by using video-recorded data, to enable the incorporation of embodied actions to the analysis, as well as including consultations where the partner is present, but verbally silent. Additionally, future studies might consider how these unfolding consultations related to both treatment outcomes, and the participants reflections upon the consultation by combining an analysis of the consultation itself with an analysis of follow-up interviews (Stevenson *et al.*, 2021). Finally, a number of consultations in this study were identified as candidates for single case analyses in order to offer a fine-grained understanding of these consultations from start to finish. Single-case analyses have proven to be highly informative in understanding accomplished social actions in healthcare and institutionalised settings (Tannen and Wallat, 1986; Whalen, Zimmerman and Whalen, 1988; Toerien and Jackson, 2019).

In addition to these overarching research directions, several topic specific research ideas were identified that might warrant further investigation. In Chapter 4, the analysis focused exclusively upon the turn-taking processes that led to partners obtaining a turn-at-talk, while reporting that partners were almost exclusively unaddressed during these consultations. The lack of video data meant it was not possible to provide an analysis that included implicit invitations such as gaze direction from either the patient or the healthcare professional. Additionally, the configuration of the participants in the room could not be considered as an influencing factor. A future study, ideally using multiple video sources could offer a more meaningful and complete analysis of the ways that partners come to contribute to these consultations that might serve to offer a more nuanced participatory framework, particularly in the work done during partner's self-selected turns where they were heard to initiate a new action to the consultation.

In Chapter 5, the ways that healthcare professionals responded to the couple's expressions of preference relating to treatment choices were examined. In doing so, the analysis considered expressions for or against treatment, along with expressions of preference for a recommendation as equivalent. A more nuanced analysis was not possible due to the limited number of consultations and expressions of preference. However, these findings could be extended by future research that considers expressions of preference for a treatment, expressions of preference against a treatment, and expressions of preference for an expert recommendation as distinct social actions worthy of individual analyses. Moreover, future studies would find value in examining healthcare professional's orientations to these expressions as related to their particular specialty (surgeon, radiotherapist, or cancer nurse specialist). While there were hints of specific differences, this study was unable to offer a systematic exploration into these possible connections.

As an exploratory analysis, chapter 6 offered insight into the ways that the sexual impact of prostate cancer was communicated, showing how the social organisation of the topic and the ways that the sexual impact was outlined, served to erase all relational aspects to an area of life that is inherently relational. However, the study was limited by the dearth of analytical examples found in the study. A future study that systematically examines the ways that the sexual impact of prostate cancer is communicated would do well to consider the differences in communication of impact depending on whether the patient is present with their partner, or if they attend the consultation alone.

One final, overarching consideration to this study that should be addressed in future research, is that the patient-partner participants were, in all but one consultation, man-woman dyads that were, as far as is known, cis-gendered insofar as their gendered identity was the same as what as assigned to them at birth. Future studies must engage with the fact that prostate cancer impacts anyone who has a prostate, and this will include transgender women, and non-binary individuals. In addition to ensuring that future studies incorporate and include these populations, they should also be sure to include relationships that do not conform to the heteronormative configuration of a man and a woman, as the experience of prostate cancer will affect couples regardless of their gendered configuration.

7.6 Conclusion

This research examined how partners are involved during clinical consultations for people with low to intermediate risk localised prostate cancer. The analyses across chapters 4 – 6 indicated that, despite being almost entirely unaddressed during the consultations, partners act as valuable clinical and interactional resources for both the patient and the healthcare professional. As patient advocate, they attend closely to what the healthcare professional outlines and describes in the consultation, they identify elements of information delivery that can be considered as insufficient or inadequate within their sequential location, they request information that is of clinical and practical importance for the couple, and the take the initiative in providing vital information for the progressivity of the consultation. They support the patient during times when the patient was hearable as hesitant or otherwise unable to offer an initial response to a question, regularly giving the patient the required conversational momentum to initiate in collaboration with the partner. Moreover, they contributed to the consultation while consistently displaying due orientation to the patient's primary rights and obligations as the primary respondent in the consultation. In this, despite healthcare professionals consistently individualised turn-design, and persistent orientation to addressing the patient as isolated from their social relations, partners worked to insert themselves into the consultation in a manner that was facilitative for both the patient and healthcare professional, while supporting and protecting the patient's position throughout. In considering the implications of these analytical findings, this thesis argues for a reconsideration of what it means to enact patient autonomy in these consultations, suggesting a shift away from the concept of individual autonomy to that of relational autonomy. Additionally, this thesis argues for a reconsideration of what it means to be a patient, with the suggestion that patients should be themselves considered as inherently relational, with the structure of the consultation adjusted accordingly.

Appendix A **Participant tables**

A.1 Participant table for Chapter 4

Chapter 4			
PAT + PAR	**NO. OF EXCERPTS**	**HCP**	**NO. OF EXCERPTS**
1	3	1	1
5	1	2	2
6	1	3	7
7	1	5	4
8	2	6	3
9	1	7	2
10	2	8	3
11	1	11	2
12	1	12	2
14	1	15	1
15	4		
17	1		
21	3		
22	4		
27	1		

A.2 Participant table for Chapter 5

Chapter 5			
PAT + PAR	NO. OF EXCERPTS	HCP	NO. OF EXCERPTS
1	1	3	3
2	1	7	2
8	1	8	1
9	2	9	2
15	1		
16	1		
21	1		

A.3 Participant table for Chapter 6

Chapter 6			
PAT + PAR	NO. OF EXCERPTS	HCP	NO. OF EXCERPTS
5	1	3	1
8	1	5	1
9	1	6	1
10	1	7	2
16	1	11	1
18	1	12	1
22	1		

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