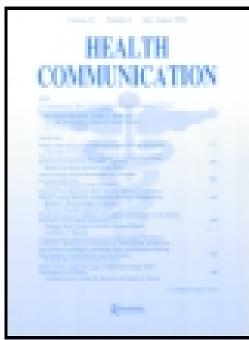

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Practitioners' Dilemmas and Strategies in Decision-making Conversations Where Patients and Companions Take Divergent Positions on a Healthcare Measure: An Observational Study Using Conversation Analysis

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ABSTRACT
The presence of companions adds complexity to healthcare interactions. Few studies have characterized challenges arising when interactions involve healthcare professionals (HCPs), patients, and companions, or how those challenges are managed. Using conversation analysis, we examined recorded episodes where patients and companions adopt divergent positions on healthcare measures (e.g., walking aids, homecare, medications). We found nine such episodes within a dataset of 37 palliative care consultations with 37 patients, their companions, and ten healthcare practitioners (HCPs) – doctors, physiotherapists and occupational therapists. Palliative care is one of several healthcare domains where companions substantially contribute to care, consultations, and decision making. We propose that, when patients and companions adopt divergent positions, HCPs face a 'dilemma of affiliation' wherein taking a position on the healthcare measure (e.g., recommending it) entails siding with one party, against the other. By examining what happens in the face of patient-companion divergence, we characterize HCPs' strategies and substantiate our proposal that these reflect an underlying dilemma. We show that: HCPs do not immediately take a position on the healthcare measure after patient-companion divergence emerges; and when HCPs take a position later in the consultation, they do so without ostensibly siding with the party who previously supported the healthcare measure. Further, once an HCP takes a position, the party who supports the measure can treat the HCP as an ally. We offer insights and propose implications for: palliative care; the interactional complexities of healthcare decision-making; and consultations in which companions participate.

Introduction

Healthcare encounters are places where multiple agendas converge; unsurprisingly, turbulence can result. For example, healthcare practitioners (HCPs) and patients tend to pursue different projects, which can align or disalign at different moments in an interaction. The presence of companions – people who know the patient and attend healthcare encounters with them – introduces yet another set of projects, alignments, and misalignments (Laidsaar-Powell et al., 2013; Troy et al., 2019). This paper furthers our understanding of some of these complexities by analyzing episodes in which patients and companions take divergent positions on a healthcare measure in hospice-based palliative care interactions. We examine the interactional dilemma that this generates for HCPs and the strategies that HCPs use to manage it. Whilst our study includes features that are specific to palliative care, we will argue that our findings have broader relevance for understanding the complexities of shared decision making in healthcare interactions.

Companion participation in healthcare interactions

Companions play several roles in healthcare interactions, including providing medical history and prompting patients to raise topics (Clayman et al., 2005). Prior research on companion participation has overwhelmingly used two approaches (Laidsaar-Powell et al., 2013; Troy et al., 2019). In one, retrospective accounts gathered via questionnaires, interviews, and focus groups (e.g., Griffin et al., 2019) are used to characterize companions' experiences of communication in healthcare interactions. These cannot reveal how that communication is organized. In the other approach, companions' communication within recorded interactions is quantified via pre-defined coding schemes. This provides broad characterizations of companions' communicative actions, such as asking questions (Eggly et al., 2011), facilitating patients' talk (Ishikawa et al., 2005), and expressing concerns (Street & Gordon, 2008). This approach enables correlational analyses, but it glosses over the nuances of asking questions, expressing concerns and so on – nuances that fundamentally determine their meaning and functioning. It also glosses over the fact that companions' actions respond to and impact upon other participants' actions. We use the approach of conversation analysis (CA; Sidnell & Stivers, 2013), which enables fuller characterization of the structure and functioning of all the participants' communicative actions in context. This level of detail is necessary for adequately understanding the complex activities that comprise healthcare interactions.

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Discussion of healthcare measures

Many healthcare interactions entail discussing patients' health problems with the expectation, shared by participants, that this will culminate in recommendations for measures to resolve, manage, or further investigate those problems (Robinson, 2003). We will refer to these as *healthcare measures*: preventative or ameliorating actions including healthcare interventions (such as walking aids and medications), social care provision, tests, and medical referrals. Prior CA research has documented how discussions of healthcare measures can become sites for tensions and negotiations. For example, patients can respond to HCPs' treatment recommendations with tacit or explicit resistance (for a systematic review, see Land et al., 2017). In the face of patient resistance, HCPs typically pursue acceptance, sometimes by modifying their recommendations (Stivers & Timmermans, 2020). Doctors sometimes design recommendations in cautious ways, which appear sensitive to the possibility of resistance (Land et al., 2017). In this paper, we examine how the presence of companions adds complexity to discussions of healthcare measures. We focus on cases where one party (patient or companion) adopts a favorable position on a healthcare measure whilst the other opposes it. We propose that, in such polarized interactional environments, HCPs face a *dilemma of affiliation* wherein taking a position on the healthcare measure entails being heard as siding with one party and against the other. The term 'affiliation' refers to actions supporting someone else's position, whereas 'disaffiliation' refers to opposing or challenging someone else's position (Lindström & Sorjonen, 2013). Our aims are (a) to examine the interactional dilemma that HCPs face when a patient and a companion take divergent positions[1] on a healthcare measure; and (b) to document strategies that HCPs use to manage that dilemma. Before describing our methods, data and findings, we further situate our work in relation to shared decision making (SDM) and palliative care.

Shared decision making

There are numerous definitions of SDM (Makoul & Clayman, 2006). For our study we conceive SDM as "a process by which health-related decisions are made jointly by the client and his/her health professional and in which both the available evidence and what matters most to the client are used to inform an agreed-upon decision" (Legare et al., 2014, p. 2). CA contributes to understanding decision making by characterizing the interactional problems and practices involved, and it does so through rigorous analysis of actual, recorded interactions (for a systematic review, see Land et al., 2017). Our own study contributes to research on decision making in two ways.

First, to our knowledge, no empirical studies or guidance have looked in detail at how patient-companion divergence impacts SDM in healthcare interactions. In this particular scenario, participants' agendas diverge, making SDM potentially difficult. Makoul and Clayman (2006) acknowledge that SDM does not always result in full agreement. Guidance suggests that, in such cases, HCPs should at least make a clear recommendation provided there is evidence that a healthcare measure would likely benefit the patient (Blair & Legare, 2015). This nevertheless does not clarify how HCPs can navigate difficult interactional environments where making a recommendation has the potential to fuel relational tensions. Our study addresses this gap by documenting the dilemma HCPs face in these circumstances and strategies they can use.

Our second contribution to SDM concerns companions' involvement in decision making – a hitherto underexamined issue (Blair & Legare, 2015; for an exception see Ekberg et al., 2015). In interviews, some companions of cancer patients say that they prefer to be involved in decision making; however, some report deliberately avoiding influencing the patient's decision (Laidsaar-Powell et al., 2013). Another interview study documented that companions of older and frailer patients can experience conflicts between their own needs (as carers) and patients' needs (Legare et al., 2014). We can anticipate these complexities and tensions will be evident in decision-making interactions involving patients and companions and will place significant demands upon HCPs. In this paper, we examine actual interactional episodes in which tensions emerge and the strategies that HCPs employ in the face of these. We thereby contribute both intellectual understandings of how companion participation impacts SDM, and evidence-based insights for clinical practice.

Palliative care

This study is part of a larger project whose foci include communication practices HCPs use to put the palliative care approach into practice in healthcare interactions. Hospice-based palliative care aims to improve the quality of life of patients whose disease is not responsive to curative treatment (Faull, 2015). As palliative care attends to patients' physical, social, and spiritual needs, it follows that it emphasizes supporting patients and their significant family and carers alike (Faull, 2015).

Guidance on communication in palliative care highlights the importance of reaching mutual understanding between all participants involved (Albrecht et al., 2010). This guidance also describes some challenges associated with the presence of companions in consultations, such as some companions' tendency to dominate the discussion (Albrecht et al., 2010). In contrast to this individualistic perspective, we consider communication challenges as being interactionally generated and dealt with by all participants involved, each introducing projects that can align or disalign at different points in the interaction. Communication guidance also considers circumstances of disagreement between patients and companions within a consultation. One recommended strategy is "avoiding the tendency to 'take sides' with a patient or family member/companion that may polarize parties or create defensiveness" (Albrecht et al., 2010, p. 161). Relatedly, this guidance recommends a mediation-like approach wherein doctors should "acknowledge that the difference in perspectives exists, and whether there might be room to explore ways that the differences might be bridged" (Albrecht et al., 2010, p. 161). Our study investigates, in a palliative care context, whether and to what extent HCPs use these or other strategies. Our findings characterize how strategies (such as avoiding taking sides) are implemented and the dilemma that underlies their use.

Methods

We used a dataset collected in a large English hospice in two phases, with ethical approval to collect the data from UK NRES Committees: Coventry & Warwickshire (Ref: 14/WM/0128) in 2014, and Nottingham 2 (Ref: 17/EM/0037) in 2017. Recordings were made of patients having an outpatient or inpatient consultation with a doctor (in 2014), or an occupational therapist or physiotherapist (in 2017). Patients who spoke conversational English were invited to participate if care staff assessed that they had capacity to consent and were not in acute distress. All participants gave consent for inclusion of pseudonymised transcripts in publications. All patients had been diagnosed with life-limiting (sometimes called 'terminal') conditions and were attending the hospice for review or management of difficult symptoms (physical or emotional) and/or help with planning future care. The hospice is an independent charitable organization providing services to the UK National Health Service, meaning that patients and their companions are not charged for the care and support they receive. The entire dataset comprises 85 consultations (72 audio-visually recorded, 13 audio-recorded) involving 85 patients, six palliative medicine doctors, three physiotherapists, and five occupational therapists. For the present study, we identified the 37 consultations that involved companions. These involved 37 patients and 10 HCPs (three doctors, three physiotherapists, and four occupational therapists); 36 patients attended with one companion, one attended with two. These companions were relatives, partners, friends and one paid carer.

Our methodological approach, CA (Sidnell & Stivers, 2013), involves examining naturally-occurring, recorded interpersonal interactions, and analyzing how participants accomplish social activities – or more simply do things – through interactional practices both verbal and visible (e.g., gaze and gesture). We used transcription methods that capture temporal and prosodic aspects of participants' speech (Jefferson, 2004) and visible actions (Mondada, 2018). Nods and changes in gaze direction are important for our analysis, but for readability, transcripts here only include these features when important for following who is being addressed within the interaction. Following central CA tenets, we base our claims about participants' actions upon how their co-participants observably treat them (Schegloff & Sacks, 1973).

In preliminary analyses, we identified episodes where patients and companions diverged about: (1) a state of affair, such as the presence or degree of a particular problem or symptom, and/or (2) a healthcare measure (i.e., supporting or opposing it). Our preliminary analyses clarified that these entail very distinct dilemmas for HCPs, patients, and companions. Therefore, we confine our analysis in this paper to divergence on healthcare measures. A thorough search of the 37 consultations involving companions located nine such episodes within eight consultations (that is, in one consultation the patient and companion diverged about two different healthcare measures at two different time points). None of the episodes concerned multiple possible measures; all were about whether or not to pursue one possible healthcare measure. These measures were: pain medication (1/9), home care (3/9), walking aids (1/9), a wheelchair (1/9), energy conservation strategies (1/9), referral to hospital for diagnostic X-Ray and other tests (1/9), and preferred place of death (1/9).

We analyzed all nine episodes in detail. First, we identified the ways in which participants introduced the healthcare measure that later became contested. Second, we examined what HCPs did immediately after a patient and companion had taken divergent positions on the measure. We found that HCPs did not immediately take a position on the healthcare measure but rather took other actions; we analyzed these. Third, we examined how discussion of the healthcare measure subsequently developed. We found that the HCPs opted to take a position on the healthcare measure later in the same consultation but that usually they did so without ostensibly taking sides; we analyzed how they did so and the consequences. Fourth, we examined two episodes where the HCPs used somewhat different strategies. We developed an analysis in order to explain those differences.

Selection of extracts for this paper followed a specific rationale, consistent with our research aims. First, we selected episodes that represent wider patterns found in all nine episodes of divergence. Second, in each episode we identified the parts where the patients and companions take a divergent position, and where the HCPs take a position on the healthcare measure for the first time. We present these in the next section.

Findings

In outline, we propose that, when the patients and companions take divergent positions on a healthcare measure, the HCPs face a dilemma of affiliation wherein taking a position on the healthcare measure entails being seen as siding with one party and against the other. We provide three sources of support for this argument. First, when a patient and companion take divergent positions on a healthcare measure, the HCPs do not immediately take a position (such as recommending the measure). Second, when the HCPs take a position on the healthcare measure later in the consultation, they do so in ways that avoid ostensibly siding with the party (patient or companion) who has supported the healthcare measure. Third, despite the HCPs' observable efforts to avoid being heard as taking sides, the party supporting the measure can then treat the HCP as effectively backing their position.

HCPs do not take a position immediately after a patient and companion have taken divergent positions on a healthcare measure

When a patient and companion take divergent positions on a healthcare measure, the HCPs do not immediately take a position themselves; they take other actions. This constitutes the first source of support for our proposal that HCPs are dealing with a dilemma of affiliation.

Before examining precisely what the HCPs do, we first use Extract 1 to show what divergence between patient and companion can look like. The extract also exemplifies one of three ways in which a healthcare measure that later becomes contested is introduced: it is introduced by the patient's companion (the other two ways, shown later in this paper, are: the HPC introduces the measure without recommending it, and the HCP introduces the measure whilst recommending it).

Extract 1 occurs toward the beginning of a consultation involving Jason, a patient with chronic obstructive pulmonary disease (COPD, a lung condition causing breathing difficulties), his wife Julie, and a physiotherapist. The physiotherapist explains that she can talk through exercises to help manage Jason's breathlessness (lines 1–3). Jason mentions his previous experiences with breathing exercises (lines 4, 6–8, and 11). Julie introduces a different healthcare measure by somewhat jokingly instructing the physiotherapist to get Jason to "use his walking stick" (line 12). We know from talk within the consultation that using walking aids could help Jason conserve his breathing better. Therefore, Julie's reference to the walking stick is fitted to the topic of alleviating Jason's breathing difficulties.

Extract 1. "Walking stick" – first segment

VERDISAHP12 07,55 VT236 COM12.1 AD MP
PT = physiotherapist (Sharon). P-Jas = Jason (patient). C-Jul = Julie (companion). Another physiotherapist is present. They sit around a round table.

```
01    PT:  +So u::m mtch +so: from a physiotherapy point of vie:w
           +lks papers-->+looks at Jason-->
   c-jul:  >>looking down, drinking from a mug-->
02         we might be able to talk through some breathing
03         exe[rci:ses  to    h]elp with clearing your=
04 P-Jas:     [Yeah. Certainly.]
05    PT:  =che[:s:t,      ]
06 P-Jas:      [I keep %try]ing to: do the ones that I
   c-jul:            -->%looks at Jason-->
07         got sh::own me in the hospital.=But- .hhh u::hhh
08         it helps sometimes, someti:mes it don't
09         (0.3)
10    PT:  tk [  <  O k a ]%y_>
   c-jul:               -->%looks at PT-->
11 P-Jas:     [do anything].
12 C-Jul:  °°Get him +to [u:]se his walking s[tick.°°]
      pt:          -->+looks at Julie-->
13    PT:               [So-]                [  £O:h ]+ri(h)g(h)ht,£=
                                                   -->+looks Jason-->
14    PT:  =£So [>we [c-<£ [.hhh   ]
15 P-Jas:       [What.
16 C-Jul:             [Huh  [huh huh] +(.) Hah% .h hh
      pt:                          -->+looks at Julie-->
   c-jul:                                  -->%looks at PT-->
17 P-Jas:  .hhh hh[%hhh
18 C-Jul:         [%Get you to +use your walking stick.=The doctor
                -->%looks at Jason-->
      pt:                      +looks at Jason-->
19         +to:ld you:: [that it would he:lp you.]
    pt: -->+looks at Julie-->
20 P-Jas:               [Nah I can't use  +them.]
      pt:                              -->+looks at Jason-->>
21         (0.8)%(0.3)
   c-jul:    -->%looks at PT-->
22 C-Jas:  .hh
23 C-Jul:  HHHh ((=sigh))
24         (0.4)
25 C-Jas:  mk .HHH
26    PT:  °Okay.°% We'll have a think about that.
   c-jul:      -->%looks at Jason-->>
```

With her semi-serious demand (line 12), Julie implies that Jason is not using a walking stick and that he should do; she exhorts the physiotherapist to "get him" to do so. The physiotherapist's response ("Oh right", line 13) acknowledges but does not support Julie's position. It is interspersed with laughter, which is aligned to the semi-serious quality of Julie's demand, and also enables the physiotherapist to adopt an equivocal stance, neither affiliating nor disaffiliating with Julie (Ekberg et al., 2015; Holt, 2012). Jason initiates repair with "what" (line 15), which signals a problem with hearing or understanding Julie's turn (which she stage-whispered toward the physiotherapist) but also possibly forecasts disaffiliation (Drew, 1997; Schegloff, 2007). Julie repeats the healthcare measure and adds a reason for supporting it (lines 18–19). Jason then *takes a divergent position* by reporting that he "can't" use walking sticks (line 20). At this point, Julie and Jason have taken divergent positions on the healthcare measure. Our next step is to examine how the HCPs conduct themselves in these circumstances.

Postponing discussion of the healthcare measure

In Extract 1, after Julie and Jason take divergent positions on the use of walking sticks, the physiotherapist proposes to *postpone discussion* of that healthcare measure until later in the consultation (line 26). This is possible in the particular context in which Jason and Julie voice divergent positions: an initial, agenda-setting part of the consultation. Here, the physiotherapist can treat the matter of walking sticks as something that can be added to a list of topics to discuss later.

The physiotherapist could relevantly take a position, both because Julie's semi-serious demand invites her to do so, and because advice on use of walking aids falls squarely within her expertise. However, taking a position in a polarized environment of patient-companion divergence could be seen as siding with one of them and against the other.[2] This is what we refer to as a dilemma of affiliation. The physiotherapist's response and laughter at line 13 is a first way in which she observably avoids either affiliating or disaffiliating with Julie's position. Postponing discussion of the healthcare measure arguably is another way in which she does so. This strategy enables her to avoid taking a position now whilst still leaving open the possibility of taking one later.

Leaving space for further talk by the patient and the companion

A second alternative to taking a position on a contested healthcare measure is for the HCPs to leave space for further talk by the patient and the companion. The "Walking stick" episode again illustrates this. After Extract 1, Jason further objects to using walking sticks, and the physiotherapist again proposes that they go back to that matter later. All three go on to discuss aids that Jason is using at home and others that he might consider using. Just before Extract 2, Jason reports having breathing difficulties, especially when walking. This extract also exemplifies the second of three ways in which a healthcare measure is introduced: the HCP introduces it, but without recommending it. Specifically here, the physiotherapist asks Jason a pre-recommendation question (Barnes, 2018) about whether he uses a stick (line 1). This is a question that stops short of recommending using a stick but

can be heard as being preliminary to a recommendation to follow.

Extract 2. “Walking stick” – second segment (2min16sec after Extract 1)

```
01     PT:  And y[ou don’t u:]se a s::- you don’t use a [stick  o::r_ ]
02 C-Jul:        [(          )]
03 P-Jas:                                                [No it’s- I c-]
04          I don’t know, I j(h)ust c(h)an’t get o:n [with them.
05 C-Jul:                                             [He’s
06          [ got them,] she brou:ght them specially for him=
07     PT:  [You can’t.]
08 C-Jul:   =two sticks.
09          (0.3)
10 P-Jas:   °°(Eh)°°
11 C-Jul:   “I ain’t using those.”=
12     PT:  =O:[ k[ay.
13 P-Jas:      [(I[ain’t gonna)]
14 C-Jul:         [ And  like- ] and I says we::ll ffhh (.) you know=
15 C-Jul:   =°°what men are. [(Hm?)°°
16 P-Jas:                    [I used one?
17          (0.2)
18 C-Jul:   (U-) (.) (m-) No: you don’t. You fib?=
19 P-Jas:   =Once_
20 C-Jul:   °Oh on(ce) hhn hhn hhn hhh°
```

The physiotherapist’s question (line 1) introduces the walking stick as if for the first time, without reference to the earlier talk about it, although the negative polarity of her question (“you don’t use a stick”) implies acknowledgement of that earlier talk. With this, the physiotherapist initiates discussion of the walking stick as a new topic, effectively separating it from its earlier mention in Extract 1, where it became a contested matter. Despite this, the physiotherapist’s question provides an opportunity for Jason and Julie to adopt divergent positions again. Jason articulates his position against walking sticks (lines 3–4). Julie complains that a community HCP brought sticks “specially” for him, thus implying that he should use them (lines 5–6, 8, 11, and 14–15). Subsequently, Jason’s and Julie’s divergent positions evolve into disagreement, although in a somewhat lighthearted way (lines 16–20).

There are points where the physiotherapist could intervene but does not do so, such as after Julie’s complaint at lines 5–6 and 8 (see the emerging silence at line 9). Also, the physiotherapist merely acknowledges Julie’s position at line 12 and does not take a position herself (see Ekberg et al., 2015). After Jason counters Julie’s complaint (line 16), the physiotherapist could intervene but does not do so (see the emerging silence at line 17). The physiotherapist could relevantly take a position at any of these points because the matter of the walking stick falls within her expertise. By not doing so, the physiotherapist *leaves space for further talk* on the healthcare measure by Jason and Julie. This makes sense as a way of navigating the dilemma of affiliation: it avoids entering into and fueling the polarization, it leaves open the possibility of taking a position later, and it can provide the HCP with information on the participants’ positions that can be used later to tailor a recommendation (we will see an example of this in Extract 5). However, in Extract 2, leaving space for further talk by Julie and Jason also leads to an exacerbation of the polarization between their positions (although with a somewhat lighthearted tone; lines 16–20).

Inviting the perspective of the party who has rejected the healthcare measure

Another alternative to taking a position is for the HCPs to invite the party opposing the healthcare measure to elaborate on their perspective. To examine this, we turn to a different consultation. This is one of the episodes where a healthcare measure is introduced by the HCP, but without recommending it. The consultation involves Alex, a patient who has motor neurone disease (a degenerative neurological condition also known as amyotrophic lateral sclerosis), Trish, who is his wife and also his main carer, an occupational therapist (OT), and a doctor. The OT and the doctor have been asking questions about their living situation and current needs. Alex and Trish have reported that they have been struggling with Alex’s condition. In the extract, the OT introduces a healthcare measure by asking Trish whether Alex is receiving professional homecare (line 1). This is a pre-recommendation question (Barnes, 2018): it can be heard as preliminary to a recommendation to use homecare (should this not already be in place). Importantly, though, with this question the OT does not take an on-record position in favor of homecare. To understand what happens here, we need to know that Alex received full time paid-for homecare some months earlier, when Trish had a hospital admission. Trish and Alex’s financial circumstances mean that further homecare at this stage would also have to be paid for.

Extract 3. “Homecare” – first segment

VERDISAHP31 41.01 VT455 COM31.1 AD MP
OT = occupational therapist (Michelle). P-Ale = Alex (patient). C-Tri = Trish (companion). A doctor (Hannah) is present. Alex is in an electric partially reclined wheelchair, and the other participants sit on chairs, all roughly arranged in a circle with no table or desk in between.

```
01     OT:  %And have you got any help coming in? Or no[:t.
            %looks at Trish-->
02 C-Tri:                                              [No.
03     OT:  So [you-
04 C-Tri:      [I’m not payi:ng.
05          (0.4)
06 C-Tri:   +.hh ↑↑Do ↑↑you ↑↑know +↑↑how ↑↑much they want
       ot:  +palm up gesture-------+
07          of- of Alex’s pension.
            (0.2)
08     OT:  #Mm$::.$#=
               $nod$
09 C-Tri:   =And I can think of a lot more (.) things that I want
10          $to do with it. Like holi$da:ys and stuff_
       ot:  $multiple nods-----------$
11          (0.2)
12 P-Ale:   But you %could have ‘em in no:w and the[n].
       ot:       -->%looks at Alex-->>
13 C-Tri:                                          [N]o_
14          (0.4)
15     OT:  .hhhh
16 C-Tri:   %They want one thousand three hundred.
     ot: -->%looks at Trish-->
17          (0.2)
18 P-Ale:   Yea:h, but [  t  h  a  t  s :  ]
19     OT:             [And what would that] be for.
20          (0.4)
21 P-Ale:   That’s [%for  full  time.]
       ot:          %looks at Alex-->
22 C-Tri:          [(For) three three] three times
23          %a da[:y:. (      )]
     ot: -->%looks at Trish-->>
24 P-Ale:        [We don’t need] that.
```

Trish answers the OT’s question negatively (line 2) and then conveys her aversion to homecare (lines 4, 6–7, and 9–10; see Barnes, 2018). With this, Trish both treats the OT’s question as projecting a recommendation and pre-empts it. Alex *takes a divergent position*, proposing a lower level of homecare (line 12). Trish firmly rejects

this (line 13) and complains about the high cost of homecare (1300 pounds sterling, line 16). Arguably, Alex starts at line 18 the objection that he fully articulates later (line 21). He abandons this when the OT asks a question in overlap (line 19). The OT starts her question after Alex has articulated “Yeah, but” (line 18), which projects disagreement with Trish’s position. Introducing a question there (line 19) could be designed to preempt that projectable disagreement. Gazing toward Trish as she asks her question, the OT *invites her to elaborate on her perspective*, pointing to the level of homecare that would cost 1300 pounds sterling. Doing so arguably enables the OT to avoid taking an on-record position that could easily be seen as taking sides, either with Alex or with Trish.

At the same time, the OT’s question (line 19) is not neutral and can be heard as implicitly supporting homecare: it exposes a possible weakness in Trish’s argument, specifically, exaggeration (Drew, 2003). That is, the cost stated by Trish (1300 pounds sterling) is for extensive homecare, which Alex characterizes as “full-time” (line 21), and Trish as “three times a day” (lines 22–23). Trish’s objection can be seen as mis-fitted to Alex’s proposal (homecare “now and then”, line 12) and defused on that basis. Thus, the OT’s question indirectly lends support to Alex’s position. We see evidence for this when, following a silence in which Trish does not respond (line 20), Alex answers the question (line 21) and then highlights the incongruence between his proposal and Trish’s objection (line 24). Alex thus treats the OT’s question as an opportunity to undermine Trish’s argument.

Inviting the perspective of the party opposing the healthcare measure makes sense as a way of navigating the dilemma of affiliation: it keeps the healthcare measure on the table for further consideration whilst avoiding positioning the HCP on either side of the divide (at least explicitly). Additionally, by inviting elaboration, the HCP can gather information on a party’s grounds for rejecting the healthcare measure. The HCP can address those grounds subsequently, when recommending the healthcare measure (Extract 5 provides an example). However, by keeping the topic open, polarization is also kept open and can be exacerbated; as in Extract 3, where the OT’s invitation to Trish to elaborate provides an opportunity for Alex to land a blow against her argument.

Extract 4 is another episode where an HCP invites the perspective of the party who has rejected the healthcare measure to share their perspective, and it illustrates a different way of doing so. This episode also exemplifies the third of three ways in which a healthcare measure is introduced: the HCP introduces it whilst recommending it. John, who has advanced throat cancer, and his wife Jean are meeting a doctor at an urgently organized appointment. John has recently been experiencing more breathing difficulties. The doctor has taken a history and has physically examined John. Before the extract, the doctor has recommended that John goes to a nearby hospital for additional tests. John has rejected this. The doctor has pursued John’s acceptance, partly by sharing a concern that John might have a pulmonary embolism, a potentially fatal condition which the hospice cannot diagnose or treat. As the extract begins, the doctor reiterates his recommendation (lines 1–3, and 5–7). Faced with John’s silence, the doctor pursues a response (line 10; Pomerantz, 1984). In an attempt to encourage John’s participation, the doctor voices John’s position on his behalf (lines 12–13, and 16 – a so-called ‘my-side telling’; Pomerantz, 1980). John confirms (line 17). The doctor invites John to elaborate (line 19).

Extract 4. “X-rays” – first segment

VERDISDOC10 35,45 VT994 DM10.1 MP

Doc = doctor (Mick). P-John = John (patient). C-Jean = Jean (companion). A healthcare assistant is present. John and Jean sit side by side, and the doctor sits on a chair facing them with no desk or table in between.

```
01     Doc:  .hhh So my su↑ggestio:n, (.) and it may +just be that
             >>looks at John-------------------------+looks Jean-->
   c-jean:   >>looks at Doc-->l.14
02           you go in=they do some ecs rays +and things
                                          -->+looks at Jonn-->
03           and they send you out again,
04 C-Jean:   Y+eah.
     doc:-->+looks at Jean-->
05     Doc:  +is tha’ we get you to hospital and they have
         -->+looks at John-->
06           a quick look at ↓you .hhh from the breathing
07           point of view, +(0.4)
                         -->+looks at Jean-->
08 C-Jean:   Right,
09           (0.2)
10     Doc:  That’s my sugges+tion.
                          -->+looks at John-->>
11 C-Jean:   Right.
12     Doc:  U:m (1.1) clearly_ (0.2) that’s not top of your
13           list=of [u:h (.)
14 C-Jean:           [%HH
                  -->%looks at John-->
15 C-Jean:   .HH hh
16     Doc:  of %what you’re a:fter,%
   c-jean:   -->%looks at Doc-------%looks at John-->>
17 P-John:   tk N[o.
18 C-Jean:       [(      )
19     Doc:  What are [ you   what ] are you thinking about with that?
20 C-Jean:            [(Yes please)]
21     Doc:  (   [      ?)]
22 C-Jean:      [I think] he shou:ld_
23     Doc:  Tell me a bit more.
24           (2.6)
25 P-John:   No.
26           (1.1)
27    Doc:   #What wuh- what’s# what’s it making you say no_
28           (0.6)
```

The doctor’s question, asked whilst gazing at John (line 19), is clearly directed to John. Jean is looking at John, not the doctor, and she responds to the doctor’s question by voicing the *divergent position* that John “should” accept the recommendation (line 22). Before this, she has already addressed John, urging him to reconsider (line 20).

The doctor dis-attends Jean’s answer and instead *invites John to elaborate on his position* against going to hospital, maintaining his gaze on him (line 23). In fact, the doctor does not look at Jean during or following her answer at line 22. Line 23 is hearable as the doctor tacitly repairing his own question at line 19, clarifying that the question was addressed to John, not Jean. In this way, the doctor does not take a position himself but keeps discussion of the healthcare measure open. It is clear in this case that the doctor has already taken a position on the healthcare measure (by recommending it), but what we highlight is that he avoids pursuing that position immediately after Jean has adopted a divergent position to John’s.

There are two important differences between Extracts 3 and 4 in how the HCPs invite a perspective. First, in

Extract 3 ("Homecare"), the OT's question lends support to the party who has endorsed the healthcare measure (Alex); in Extract 4 ("X-rays"), the doctor's question does not do this. Although the doctor's question makes John accountable for his position, it does not target a weakness in that position.[3] The second difference is that the doctor's question in Extract 4 temporarily excludes Jean from the discussion of the healthcare measure. The doctor is able to do this because of features of the sequence in progress: he dis-attends Jean's answer at line 22 on the basis that his question at line 19 was directed to John, not Jean. Temporary exclusion of Jean from the discussion arguably reduces the possibility that disagreement between her and John develops, at least provisionally. The doctor's question promotes a participation framework in which the healthcare measure is discussed between the patient and the doctor. This means that John only has to deal with one person whose position diverges from his, not two.

Summary

When the patients and companions take divergent positions on a healthcare measure, the HCPs do not immediately take an on-record position on that measure, even though they could relevantly do so. We have proposed that, in this way, the HCPs manage the dilemma wherein taking a position entails supporting one party's position against the other. The HCPs' actions that we have examined allow them to keep the healthcare measure on the table and keep open the possibility of taking a position on it later. Importantly, the HCPs avoid siding with one of the parties, which could exacerbate the divide between them – risking conflict escalation, definitive rejection of the healthcare measure, and frustrating shared decision-making endeavours. At the same time, though, the HCPs' work to avoid taking an immediate position does not halt or reverse the divergence. The actions we identified keep discussion of the healthcare option open, and this in turn provides opportunities for divergence between patients and companions to be reaffirmed and potentially escalated.

We have contended that the HCPs' actions examined so far provide evidence for our proposal of a dilemma of affiliation. Admittedly, this evidence is indirect: the HCPs *do not* take a position when they could relevantly do so. This suggests but does not yet demonstrate that they are orientated to and managing the risk of being heard as taking sides if they take a position. We now turn to more direct evidence derived from examining what the HCPs do when they subsequently take a position on the healthcare measure, and how the patients and companions respond.

HCPs take a position in ways that avoid ostensibly taking sides

In all cases in our collection, the HCPs take a position by recommending the healthcare measure later within the same consultation. In all but two cases (which we will discuss later), they do so in ways that avoid ostensibly siding with the party (patient or companion) who has previously supported the healthcare measure. The HCPs support the recommendation through independent arguments, rooted in their professional expertise, rather than trading on arguments already put forward by the supporting party. This provides evidence that the HCPs are attuned to the dilemma of affiliation: in ways that are observable, they display a sensitivity to the risk of being seen as taking sides by working to minimize it. Further evidence for the dilemma of affiliation is that, when an HCP takes a position, the party who has previously supported the healthcare measure can treat the HCP as effectively backing their position (despite the HCP's observable attempts to ward off the risk of being so heard). To illustrate these points, we turn to the point where the OT takes an on-record position in the "Homecare" episode.

After Extract 3, Trish proposes that she is coping in her role as Alex's carer and, therefore, that homecare is not needed. Alex contradicts this, stating that Trish is not coping. Following the OT's invitation to elaborate, Trish concedes that sometimes she cannot find the time to have a shower or wash her hair. The OT also invites Alex to elaborate on his position. Just before Extract 5, he reiterates that he and Trish could benefit from some homecare, for example, to shower him. In Extract 5, Trish further objects, invoking prior experience that carers did not wash Alex properly (line 1). Alex rebuts (lines 3, 5, and 7). The OT appears to be starting to take an explicit position for the first time at line 6, but she cedes the floor, allowing Alex to complete his turn (pro-homecare, line 7). The OT then takes a position, supporting the healthcare measure, from line 9.

Extract 5. "Homecare" – second segment (1min26sec after Extract 3)

```
01 C-Tri:  They don't wash you properly (             )
02         (0.9)
03 P-Ale:  Well you could come i:n.
04         (1.9)
05 P-Ale:  You [could
06     OT:     [.hhh (.) S[o all I'm]
07 P-Ale:                 [they   wo]uld help you:.
08         (1.7)
09     OT: So some (0.2) so I know you- I- I hear what you're
10         saying about even if you were having three visits
11         [a day, it'd cost this [much.=
12 C-Tri:  [Mm_                   [°Mm_°
13     OT: =.hhh Sometimes people have a sort of a personal payment
14         type a♦rrange[ment,♦ (0.3) whe:re they then find (0.2)
   c-tri:        ♦nods--[-----♦
15 C-Tri:               [Mm:,
16     OT: ±some[body,±
17 P-Ale:       [(   )
   p-ale:  ±nods------±
18         (0.4)
19 C-Tri:  ♦Mm[:
           ♦nods-->
20 P-Ale:     [Yeah_♦
   c-tri:        -->♦
21         (0.3)
22     OT: So you [ge:t (1.1) you get thats- (0.4) continuity, (.)
23 P-Ale:         [(  )-
24     OT: you get somebody you are happy wi:th, (0.5) in your house.
25         (1.9)
26 P-Ale:  You've al- she's already got (0.3) a phone number (0.5) of
27         one of our carers,
28 C-Tri:  The carer who said they'd come and do it.
29         (1.2)
30 C-Tri:  She was a nice girl.
31         (0.6)
```

The OT acknowledges Trish's reasons for rejecting homecare (lines 9–11). She also promotes the healthcare measure in a way that addresses some of Trish's stated concerns (lines 13–14, 16, 22, and 24). Importantly, she *does not invoke Alex's arguments* (for example, the proposal that Trish is not coping) to support her position. Rather, she refers to what other "people" do (line 13), thereby hearably *drawing on independent arguments* in support of the healthcare measure, based on her professional experience of supporting other patients and carers. The OT *thereby detaches her position from Alex's*, arguably working against being heard to be siding with him. This supports our proposal of a dilemma of affiliation: the OT's own actions embody an orientation to the risk of being seen as taking sides, which she works to minimize. One additional piece of evidence is the fact that, despite the OT's attempts at framing her recommendation as independent, Alex treats her as effectively backing his own position. This is possible because, although the OT uses independent arguments, her actual position is *de facto* in line with Alex's position (i.e., in favor of some homecare). This provides Alex with an opportunity to come in and reinforce the OT's position (lines 26–27); in so doing, he concurrently treats the OT as backing his position.[4] Subsequently, Trish conveys something rather more positive relating to homecare (line 30); nevertheless, she later goes on to further oppose it. In what follows we show the same patterns occur in the "Walking stick" and "X-rays" episodes.

Extract 6 is a direct continuation of Extract 2 ("Walking stick"). In it, the physiotherapist takes a position, supporting the healthcare measure, from line 21.

Extract 6. "Walking stick" – third segment (continuation of Extract 2)

```
21     PT:  So the reason be%hi:nd using a walking aid, (0.2)
            >>looks at Jason-->
   c-jul:   >>looking down->%looks at PT-->
22           %it's not because we think you need a walking aid to help
   c-jul:-->%looks away-->
23          w[ith your bala:nce, o:r because you're as- of a certain=
24 P-Jas:    [No.
25     PT:  =age, or anything like tha:t,
26 P-Jas:   I'm [getting %old.
   c-jul:             -->%looks at Jason-->
27     PT:      [.hhhh
28 C-Jul:   That's what the doctor %told you +yeah?
                                -->%looks at PT-->
      pt:                                 -->+looks Julie-->
29          $(0.4)$
      pt:   $nods-$
30     PT:  What +it- (.) what it's abou::t is actually suppo:r↓ting(.)
              -->+looks at Jason-->
31          your shoulders, (.) be[cause a lot of people u:se=
32 P-Jas:                         [#Mm#
33     PT:  =their shoul+ders to +help with their breathing=
                     -->+lks Jul-+looks at Jason-->
34 P-Jas:   =(Yeah).=
35     PT:  =and that's [not a very [%e f fe[c t i[ve way,]
36 C-Jul:               [Yeah,      [%which [I've [not-   ] you do:.=
                                 -->%looks at Jason-->
37 P-Jas:                                     [(     )
38 C-Jul:   And it- uh +d- d-don't you.=And 'course when he's
      pt:           -->+looks at Julie-->
39          cou%ghing as we:ll (.) he is: .hh $sort of
            -->%looks at PT-->>
      pt:                                     $multiple nods-->
40          try[ing to (.)  pu]sh it up (0.5) man-=
41 P-Jas:      [No:t alwa↑↑ys.]
42 C-Jul:   =uh bodily, instead of (0.2) relaxing a little$ bit,=
      pt:                                             -->$
43     PT:  =Y+e:ah.
         -->+looks at Jason-->>
```

Unlike the "Homecare" episode (Extract 3) and the "X-rays" episode (Extract 4), in Extract 6, the physiotherapist does not invite Jason to further articulate his position; nor does she acknowledge his reasons for opposing the walking stick measure (cf. Extract 5). Rather, she articulates, via generalization, reasons for using a walking stick; an action that implies recommending its use (Toerien, 2018). She does so by addressing two possible misconceptions about the recommendation to use a walking aid (lines 22–23 and 25). Similar to Extract 5 ("Homecare"), the physiotherapist *does not build upon Julie's arguments* in favor of the healthcare measure. When Julie reinforces the physiotherapist's position (line 28, at the end of which Julie looks at the physiotherapist), the physiotherapist only acknowledges this with a nod (line 29). She goes on *supporting the recommendation as independent* from Julie's arguments, drawing on her professional expertise: she explains that using a walking aid could help improve Jason's breathing (lines 30–31, 33, and 35). She thus *detaches her position* from that of Julie (the "we" at line 22 is not inclusive of Julie; on uses of "we", see Sacks, 1992, Spring 1966, lecture 8). Despite this, the position the physiotherapist takes is *de facto* in line with Julie's; it supports the healthcare measure. This gives Julie the opportunity to again step in and reinforce that position (lines 36, 38–40, and 42), thereby treating the physiotherapist's position as being in line with her own. Additionally, Julie constructs the physiotherapist's arguments as redundant; that is, she conveys that the problem is not that Jason does not know what walking aids are for, it is his reluctance to use them. Julie treats Jason as a recalcitrant party who needs persuading.

Next, we return to the "X-rays" episode. After Extract 4, John voices reasons for not going to hospital. Then, in Extract 7, the doctor pursues acceptance of the healthcare measure.

Extract 7. "X-rays" – second segment (3min47sec after Extract 4)

```
01     Doc:  U:m (0.4) I mean if you wanted +to: (.) we could >try
             >>looks at John----------------+look at Jean-->
02           some antibiotics< and send you home, .hhh my
03           con+cern would +be: >if it's not< an infection if it's a
             -->+lks John---+looks at Jean-->
04           blood cl↓ot I'm +giving you the wrong treatment,
                          -->+looks at John-->
05 C-Jean:   Ye[s.
06 P-John:     [Mh hm?
07           (0.2)
08     Doc:  And it +might get wo:rse, in fact (0.2) +an:-
                 -->+looks at Jean-------------------+looks John-->
09           you know potentially it could be very serious.
10           (0.6)
11     Doc:  That's +my c- (.)Th[at's where] I'm coming from I suppose?
                 -->+looks at Jean-->
12 C-Jean:                      [ And  I'm ]
13 C-Jean:   [Yeah. And then and therefo:re (.)
14 P-John:   [M:h.
15 C-Jean:   then it would be left to me: .h to phone for
16           an ambula[nce you see? .hh[h
17     Doc:           [↑Yeah.          [Yes.
18 C-Jean:   (So [it's- )          [it's  as sim]ple as th- Yeah?=
19     Doc:      [That's the +back-[up  plan  is]
                          -->+looks at John-->
20     Doc:  =we- we wait until you get worse, and then Jean calls an
21           am+bulance,
               +towards Jean-->>
```

Earlier, we observed how the doctor's actions temporarily excluded Jean from the discussion of the healthcare measure

(Extract 4). In Extract 7, the doctor supports the measure by articulating the risks entailed in rejecting it (lines 2–4 and 8–9). This is *de facto* the same position that Jean has previously endorsed, which gives her a basis for intervening (furthermore, the matter being discussed has implications for Jean, as John's wife and primary carer). She reinforces the doctor's position (lines 13, 15–16, and 18), articulating what the consequences could be for her (having to call an ambulance), should John not agree to go to hospital for tests. In context, this can be heard as an attempt to persuade John. Noticeably, the doctor reframes Jean's complaint in more neutral terms (as a "backup plan", lines 19–21), stripping it of some of its affective and moral overtones, and thus defusing its challenging (and possibly, conflict-inducing) character. In this, the doctor observably *detaches* the recommendation from the particulars of Jean's position and designs it in independent terms, rooted in his medical expertise.

Summary

When the HCPs take a position on a healthcare measure, they avoid ostensibly siding with the party who has previously supported that measure. They foreground considerations rooted in their professional expertise, rather than drawing on arguments that the supporting party has put forward. Therefore, if the opposing party opts to accept the measure at this point, they can ostensibly do so based on what the HCP has argued, rather than as a capitulation to the supporting party's arguments. At the same time, the HCPs' strategies can only go so far toward defusing patient-companion opposition. We have seen that, despite supporting the healthcare measure via different considerations, the HCPs *de facto* take a position consistent with that of the party who has supported the measure. As a result, that party is provided with grounds for interjecting and reinforcing the HCP's position, hence treating them as an ally. All these findings support our proposal that the HCPs face a dilemma of affiliation. This is evident in how they work to minimize the risk of being heard as taking sides when they take a position. The fact that despite this, the HCPs cannot avoid being treated as taking sides, demonstrates that taking a position in the context of patient-companion divergence indeed entails being seen as affiliating with a party's position, against the other – what we term a dilemma of affiliation.

Apparently anomalous cases

We have so far described two patterns: first, that the HCPs do not immediately take a position after a patient and companion have taken divergent positions on a healthcare measure; second, that when the HCPs take a position later on, they design it as independent, without trading on arguments put forward by the party who has supported the measure. However, two of our cases do not fit with the second pattern. Specifically, in these cases, when the HCPs recommend the healthcare measure, they use arguments previously articulated by the supporting party. Upon close analysis, we can see that this only happens after the opposing party has made some concession toward the supporting party's arguments. This feature explains why the HCPs invoke the supporting party's arguments at this point. Indeed, this reinforces rather than disproves our argument. We show one of the two cases here.

Extract 8 comes from a consultation involving Joanne, a patient who has cancer and COPD and is currently a hospice inpatient, her daughter Nicky, and an occupational therapist (OT). They have been discussing the types of support that Joanne will need when she is discharged home. They have agreed that Joanne will need professional carers to visit twice a day (morning and evening). In Extract 8, divergence emerges with regards a third 'lunchtime' visit. The OT offers the lunchtime visit at line 1 (on offers, see Stivers et al., 2017).

Extract 8. "Lunchtime visit"

VERDISAHP06 41,50 VT1021 COM06.2 AD MP

OT = occupational therapist (Melanie). P-Joa = Joanne (patient). C-Nic = Nicky (companion; not visible on camera in this part). Joanne sits on a chair facing Nicky and Melanie, who sit side by side.

```
01    OT:  Do you want somebody at lunch+ti:me.
   p-joa:  >>looks at OT--------------->+looks away-->
02         (1.2)
03 P-Joa:  U:h, .hh (0.4) not parti+cularly.
                                -->+looks at Nicky-->
04         (0.4)
05 C-Nic:  Well. It might be helpfu:l, .hh for li:ke uh to
06         bring you something to eat %or drink,
      ot:                             %multiple head nods-->
07         (1.0)+(1.2)%(0.6)
   p-joa:    -->+looks away-->
      ot:          -->%
08 P-Joa:  I think you see=
09 C-Nic:  =You know +becau::se (0.4) you [CAn't +rely on=
   p-joa:         -->+looks at Nicky-->--------->+lks away-->
10    OT:                                 [It’s-
11 C-Nic:  dad any+mo:re can we.
   p-joa:      -->+looks at Nicky-->
12         (.)
13 P-Joa:  No. We can’t rea[lly.
14 C-Nic:                  [No:.
15    OT:  .h[h I’m just thinking .hhh sometimes it’s: (0.4)
16 P-Joa:    [(   )
17    OT:   u::m (0.3) if we set a full care package up
18          for when you lea:ve +here, you can then see
   p-joa:                    -->+--> looks at OT-->
19          how it goes, $(0.7) and you can reduce$ i:t.
   p-joa:             -->$one big nod---small nods$
20          (0.2)
21    OT:   $.hh +Whereas sometimes when you’re at$ home
   p-joa:   $nods+--------------------------------$
                 +looks away-->
22          if you’ve got to wait for it to be started, (0.5)
23          it’s someti::mes (0.6)+ u::m (0.4) takes a while.
   p-joa:                      -->+looks at OT-->
24          (.)
25          It could $take a +few da:ys, .hhh  and if your
   p-joa:            $nods
                          -->+looks away-->
26          husband’s not as well or you- +you’re not able to [rely
27 P-Joa:                                                     [No.
28    OT:    on him,
```

Joanne rejects the lunchtime visit (line 3), but Nicky supports it, thus taking a *divergent position* (lines 5–6). As Joanne starts to elaborate (line 8), Nicky interjects with an additional argument in support of the lunchtime visit: that Joanne's husband can no longer be relied upon to support her (lines 9 and 11). In line with our other cases, the OT does not intervene immediately (e.g. line 7) and rather leaves space for additional talk between Joanne and Nicky. When the OT proceeds to intervene in support of the lunchtime visit, she does not draw on Nicky's arguments but, rather, invokes practical reasons (lines 15–25), which fall squarely within her expertise. She thus designs her recommendation as independent. However, as she continues, she *invokes the same argument* that Nicky has raised: that Joanne can no longer rely on her husband to support her (lines 25–26 and 28). This apparently anomalous pattern can be explained by the fact that Joanne has agreed with

that argument at line 13. Although this does not equate to Joanne accepting the lunchtime visit, it is *a concession* to Nicky's argument, which creates a more favorable (less polarized) environment for the OT to intervene.

The difference between Extract 8 and our other cases reinforces our proposal of a dilemma of affiliation. It suggests that the HCPs monitor the relational environment for signs of affiliation and disaffiliation and act accordingly. They avoid drawing on supporting parties' arguments when the patient and the companion's positions diverge. By contrast, when the divergence is less pronounced, they can and do draw on supporting parties' arguments to shore up their recommendations (Extract 8). The HCPs' *selective* use of strategies, such as designing their position as independent, shows that they are attuned to and manage the dilemma that results from the risk of taking a position within polarized environments.

Discussion

We have examined cases in palliative care consultations where patients and companions take divergent positions on a healthcare measure. We have identified a dilemma HCPs face in those circumstances, and strategies they deploy in managing it. Here, we discuss our findings in relation to research and guidance on SDM, palliative care, and companion participation; consider some limitations; and draw conclusions.

Central to SDM is the balancing of medical evidence with patient preferences and values (Legare et al., 2014). This has clear applications to situations where HCPs and patients are not aligned. However, such balancing can be more complex when there are three parties (patient, companion, and HCP) and when a patient and companion take divergent positions on a healthcare measure. The SDM literature suggests that, when it is difficult to reach agreement, HCPs should make clear recommendations, provided there is evidence that a healthcare measure would likely benefit the patient (Blair & Legare, 2015). Our observational analysis indicates that, at least where decision making involves an HCP, a patient, and a companion, it might not be advisable for HCPs to do so immediately because of the risk of being heard as siding with one party and against the other (we term this a dilemma of affiliation), with damaging relational consequences. The HCPs in our data are clearly attuned to this risk. Most current SDM thinking focuses on balancing medical evidence with the preferences and values of individual patients. Our findings point to the importance of bringing relational considerations into focus too.

Our findings have implications for healthcare practice with regards how HCPs can sensitively promote decision making when patients and companions diverge about healthcare measures. Firstly, HCPs can avoid making a recommendation immediately. Secondly, when they come to recommend, they can use independent arguments rather than those put forward by the party who has supported the measure. In proposing these as valuable strategies, we do not rely on our findings alone because what we found is consistent with findings from other CA studies. These show that people recurrently delay actions that would indicate they are taking a different position to the parties they are interacting with. In CA terms, they delay disaffiliative actions (Clayman, 2002). Previous studies have also shown that in most social contexts people implement disaffiliative actions in ways that tone down the distance between their position and the position of those with whom they are interacting (Clayman, 2002). This is consistent with a broader interactional regularity: in both everyday and healthcare interactions, people act in ways that promote rather than hinder social solidarity. The strategies we have documented embody a concern with solidarity, collaboration, and deciding things together (rather than with imposing decisions).

Our study contributes to understanding how the palliative care approach can be accomplished through specific interactional practices. Within its holistic framework (Faull, 2015), a central concern is to promote and maintain positive relationships between all parties involved. This includes avoiding exacerbating tensions and conflicts that patients and companions may be experiencing. The interactional strategies we have identified are ways in which these principles are put into practice through the ways in which practitioners communicate within consultations.

We have provided new knowledge about companions' participation in consultations. The interactional dilemma and strategies we documented are inaccessible to studies that use retrospective accounts (e.g., interviews) or coding schemes that only characterize communicative actions in broad terms. Some existing guidance considers scenarios where a patient and companion express disagreement within consultations (Albrecht et al., 2010), advising HCPs not to take sides and instead to adopt a mediation-like model, giving both patients and companions opportunities to voice their perspective. However, that guidance glosses over the complexities entailed when patients and companions take divergent positions on a healthcare measure. Our findings show that it is possible for HCPs to postpone taking a position (resonating with Ekberg et al.'s, [2015] CA findings about companion participation in healthcare consultations) and to design their recommendations as independent. However, our findings also show that being heard as 'taking sides' is inescapable, at least to some extent, when HCPs eventually make a recommendation. Why is this so? First, in all the episodes of divergence in our data, just one healthcare measure is on the table. This means that only two positions are possible: either in favor or against. Second, when the three active parties are the HCP, the patient, and their companion, and if patient and companion diverge, then whenever the HCP opts to take a position, this will *de facto* support one or the other. These two factors (that a single measure is on the table, and this specific triadic configuration) means that HCPs are inevitably vulnerable to being heard as taking sides. We have shown that once an HCP supports the healthcare measure, the party who has already expressed their support for it can step in, effectively treating the HCP as taking their side. So, HCPs can actively work to build a sense that they are not taking sides, but like any interactional participant they are not in sole charge of determining the sense of what is going on in that interaction. HCPs can deal with the dilemma of affiliation by avoiding ostensibly siding with patient or companion. Nevertheless, this may clash with patients' or companions' agendas and projects (such as getting explicit professional support for something they have strong views on).

Caution is needed when considering the transferability of our findings. First, our collection comprised the nine episodes we

could find in a dataset of 37 recordings, and data came from one UK hospice. However, as noted, our findings are consistent with other findings about how people in healthcare settings and beyond manage situations where divergent views emerge. Second, our findings are specific to circumstances in which there is one healthcare measure (rather than several measures) on the table. At the same time, this is also a strength because this specific form of decision making is an understudied one (Entwistle et al., 2012; Land et al., 2017). Importantly, whilst we have focused on the interactional dilemma that emerges when patients' and companions' positions diverge, in analyses not reported here, we identified companion interventions that positively contribute to reaching agreements about important healthcare measures. We aim to focus on this in future research.

Despite limitations, our findings address parts of a large gap in the literature about the interactional dilemmas and strategies entailed in consultations involving patients and their companions. Guidance on communication (particularly in palliative care) has considered challenges from an individualistic perspective, for example, by suggesting that some companions seek to 'dominate' conversations (Albrecht et al., 2010). This suggests that one party is causing problems and others have to deal with them. By contrast, our perspective highlights that dilemmas are interactionally generated by all participants, as their actions embody priorities and agendas that converge and diverge at different points in a consultation. In turn, this perspective yields more ecologically valid understandings of interactional dilemmas and strategies for managing them.

Notes

1. We refer to patients' and companions' *divergent positions* as a broader phenomenon than disagreements (the latter being the preferred term in the SDM literature). We take it that a disagreement happens when a participant explicitly and directly opposes or disconfirms another's position on a state of affairs. In the cases we examine, patients and companions can take divergent positions on a healthcare measure without explicitly disagreeing with one another. For example, they can voice their divergent views whilst addressing the HCP (as opposed to addressing one another; see Extract 4). We use *divergent positions* to capture the range of ways in which patients and companions can voice competing perspectives (beyond explicit and direct disagreement).
2. An anonymous reviewer proposed that, when a party (patient or companion) supports a healthcare measure, this can be a benefit for the HCP (e.g., in Extract 2, the HCP could join with Julie in trying to persuade Jason to use a walking aid). Our argument is that the HCPs in our data treat this as a problematic scenario, which they seek to prevent.
3. It is important to note that John's "no" (line 25) is not a refusal to say more but, rather, a re-stating of his rejection of the healthcare measure. This is the understanding that the doctor displays in his follow-up question at line 27.
4. Alex's self-repair from "*you*'ve al-" (addressing Trish) to "*she*'s already got a phone number of one of our carers" (addressing the OT) further embodies Alex's treatment of the OT as being 'on his side'.

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Appendix

Transcriptions conventions adapted from Jefferson (2004):

,	Slightly upward intonation
?	Upward intonation
.	Falling intonation
_	Level intonation
[	Overlapping talk begins
]	Overlapping talk ends
(0.8)	Silences in tenths of a second
(.)	Silence less than two-tenths of a second
wo:::rd	Lengthening of the sound just preceding
wo-	Abrupt cut-off or self-interruption of the sound in progress
word	Stress or emphasis (usually conveyed through slightly rising intonation)
↑ ↓	Marked pitch rise or fall
=	Latching
()	Talk too obscure to transcribe
(word)	Best estimate of what is being said
hhh	Hearable out-breath
.hhh	Hearable in-breath
w(h)ord	Aspiration internal to a word
((words))	Transcriber comments
°word°	Quieter or softer talk
WORD	Louder talk
°°word°°	Particularly quiet voice or whispering
>word<	Faster or rushed talk
<word>	Slower talk
£word£	Talk delivered with a smiley voice quality
#word#	Talk with a creaky voice quality

Conventions for the transcription of visible actions adapted from Mondada (2018):

% % + +	Descriptions of visible action are delimited between two identical symbols (one symbol per participant's line of action) and are synchronized with corresponding stretches of talk/lapses of time
—> —>	The action described continues across subsequent lines until the same symbol is reached
>>	The action described begins before the extract's beginning
–>>	The action described continues after the extract's end
————	Full extension of the action is reached and maintained
p-john	Participant doing the embodied action is identified when they are not the speaker