

# **‘WHEN DO WE WANT THE FINAL DISCHARGE?’ HOW THE POTENTIAL TENSIONS BETWEEN MEDICAL EXPERTISE AND INSTITUTIONAL REQUIREMENTS ARE DEALT WITH IN DISCHARGE PLANNING**

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## **Abstract**

To increase patients' compliance, clinical guidelines insist on their participation in the entire rehabilitation process, including discharge planning (DP). However, very little is known about how this institutional requirement is implemented in the everyday business of a clinic. Adopting a conversation analytic approach, our paper tackles the question of how patients are involved in DP in one particular rehabilitation clinic in French-speaking Switzerland.

*Keywords: discharge planning; patient participation; interdisciplinary meeting; medical visits; conversation analysis; video analysis.*

## **1. Introduction<sup>1</sup>**

Discharge Planning (DP) refers to a large process that involves the development of an individualized plan aimed at facilitating the transition from hospital to home and preventing problems following discharge (Mistiaen, Francke & Poot 2007). Over the last few decades, patients' participation in healthcare interactions in general and discharge planning in particular has been recommended and promoted in both policy papers and professional guidelines: patients are expected to voice their expectations and to be involved in decisions

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regarding their care (DoH 2010; SIGN 2002; WHO 1978, 1984, 2008). In these guidelines, the notion of patient participation has been broadly related to the patients' right to informed consent, i.e. to receive sufficient information on treatment options, potential risks, etc. and to participate in the negotiation of the treatment objectives in an environment that respects the patient's personality, autonomy and dignity (FMH 2008; Physioswiss 2009; ASE 2005).

Although studies on discharge planning have found that most patients wanted to participate in the planning (Anthony & Hudson-Barr 2004), and that participation has delivered positive outcomes (Popejoy, Moylan & Galambos 2009), very little is known about how this institutional requirement is concretely dealt with in rehabilitation settings that usually involve a whole interdisciplinary team (Barnard, Cruice & Playford 2010; Nielsen Beck 2009; Schoeb et al. submitted).

Adopting a conversation analytic approach (CA), our paper tackles the question of how patient participation is dealt with in a rehabilitation clinic in French-speaking Switzerland. For the official organization of discharge planning, the rehabilitation clinic schedules two separate meetings: the interdisciplinary meeting (IM) and the medical visit (MV). Both meetings take place on Mondays. During the IM, patients' discharge planning is discussed by the professionals involved in the patient's care at the clinic, and the patient in question is absent. For the subsequent MV, however, the patient must attend, along with two (or more) physicians and one or two nurses. Our analysis focuses on the medical visits. It examines the way the physician initiates talk regarding a possible discharge date and/or the duration of the stay at the clinic, and how he or she manages to meet the institutional patient-participation requirement. Our paper takes into account the professionals' use of gaze, gesture, body posture, etc., thus offering a multimodal analysis of several initiation practices and showing how each professional handles the institutional patient-participation requirement differently.

Moreover, we explain the way in which the physician initiates the discharge-date talk and involves the patient to achieve a shared agreement regarding a specific discharge date and/or the planned duration of the continued stay with the discussion of these same points by the professionals in the preceding IM, and argue that the former is strongly influenced and/or constrained by the latter. Our analysis suggests that if a *high congruence* between the professionals'

position and the patient's reported expectations is manifested in the IM, the physician's initiation of discharge-date talk in the MV allows for direct and straightforward patient participation (extract 2). After IMs in which there is a *low congruence* between the professionals' and the patient's point of view, the physician's way of initiating discharge-date talk in the MV strongly constrains the patient's participation (extract 3). After IMs in which the *patient's point of view has not been clearly discussed*, the physician's initiation in the MV might be prefaced by the elicitation of this point of view (extract 4) and engender some confusion.

## 2. Method and Data

Our study adopts a conversation analytic (CA) approach. In the last few decades, CA has been widely applied in examinations of naturally occurring medical (see Heritage and Maynard 2006) and healthcare interactions such as nursing (Jones 2009), pharmacy (Pilnick 1998), physiotherapy (Parry 2004, 2009; Schoeb 2014) and interdisciplinary geriatric case conferences (Beck Nielsen 2009). In CA, a commonly used analytical procedure is *analysis of a collection* (Schegloff 1987: 101). In this approach, a researcher looks at a set of different fragments in which a particular phenomenon, such as discharge-date talk, has occurred. In describing and analyzing the phenomenon's detailed interactive organization across various occurrences, the researcher aims to discover participants' communication patterns, which may involve embodied features (Drew, Chatwin & Collins 2001; Mondada 2010), and to explain the interactive implications of the systematic organizational features he or she has revealed.

In our clinic of focus, 47 interdisciplinary meetings (IM) and 46 medical visits (MV) were video-recorded. In this large corpus, we identified 27 situations in which a discharge date and/or the length of the patient's stay were discussed in the IM and 25 situations in which these topics were discussed with the patient during the subsequent MV. To constitute a mini-collection of the phenomenon examined here, we selected the 13 occurrences of discharge-date talk that occurred in the IM and were initiated by the physician in the subsequent MV. We transcribed these 26 sequences using the conventions developed by Gail Jefferson (2004: 24-31). For the initiation sequences

occurring in the MV, participants' use of other multimodal resources, such as gaze, gesture, posture, etc., were transcribed according to the conventions developed by Mondada (2007). In the original data, participants speak in French. The spoken words were therefore translated according to ten Have's (2007) suggestion: original transcript and a line-by-line translation in English. Ethical approval was granted by the local Ethics Committee and informed consent was obtained from all participants.

### **3. Organization of discharge-date talk in the interdisciplinary meeting and the medical visit**

The IM involves the participation of an interdisciplinary team of medical, healthcare and socio-psychological professionals, but is held without the patient being present. The MV follows the IM, and involves the participation of the patient, two (or more) physicians and one or two nurses. Before looking at physicians' initiation of discharge-date talk in the MV, we will briefly outline the activity structure and the aims of these two different clinical events.

The IM usually requires the participation of two medical doctors, a nurse, an occupational therapist, a physiotherapist, a social worker, a psychologist and, if needed, a vocational trainer, but it is held without the patient being present. The main purpose of the interdisciplinary meeting is to clarify the state of recovery the patient has reached in the clinic thus far, and to discuss questions regarding discharge planning (DP). The IM also serves as an opportunity to achieve shared (interdisciplinary) decisions regarding the adjustment of therapeutic interventions, further medical examinations and/or different discharge planning issues. The head medical doctor acts as the chair of the meeting, whereas the other health-care professionals might be requested to report on the patient's progress so far (in general the physiotherapist and the occupational therapist are asked to do this). They might be asked to evaluate the various issues being discussed *or* they might self-select to do so (for a more thorough discussion of the IM's activity structure and organization, see Schoeb et al. submitted). Indeed, the chair might for example suggest a possible discharge date for the patient, providing a medical line of argumentation. Following this, the chair might ask the other professionals to give their assessment, the professionals

might self-select to do so, or the chair might treat the absence of overt objection to his/her line of argumentation as a tacit agreement with the suggestion.

Before the following extract begins, medical doctor I (MDI) reports on PA10's current health status and recovery so far.

**Extract 1:** (10\_2c EXDPT)

*Participants' acronyms:* MDS: medical doctor S; MDI: medical doctor I; PSYF: psychologist F; PTC: physiotherapist C; NUR: nurse R; NUW: nurse W.

- 1 MDI Donc on va essayer de commencer à gagner. .h si ça s'passe  
**PART we are going to begin to win. .h if that goes**  
 2 bien (1.0) elle peut même sortir e:h la s'maine prochaine.  
**well (1.0) she can PART leave eh next week.**  
 3 (1.2)  
 4 MDI J'entends médicalement.  
**I mean medically speaking.**  
 5 (0.4)  
 6 PTC Ouais.  
**Yeah.**  
 7 (0.7)  
 8 MDI De (te/ton) point de vue.  
**From your point of view.**  
 9 (1.5)  
 10 MDI Mh:m on lui propose déjà un weekend (0.2) thérapeutique  
**Mh:m we suggest PART a therapeutic (0.2) weekend to her**  
 11 pis c'est une femme au foyer alors on n'a pas d'enjeux  
**PART she's a housewife so we do not have**  
 12 professionnels. .hh et si ça ça se passe bien  
**a job to take into consideration .hh and if that that goes well**  
 13 après on décide eh ((phone ringing)) ensemble.  
**afterward we decide eh ((phone ringing)) together.**  
 14 (0.9/((phone ringing)))  
 15 MDS Ouais.  
**Yeah.**  
 16 (0.4/((phone ringing)))  
 17 MDI Selon comment elle se sent (etc.)  
**Depending on how she feels (etc.)**  
 18 (1.9/((phone ringing)))  
 19 PSYF Juste une chose ( ) (0.2) (mh) par rapport au week-end  
**PART one thing ( ) (0.2) (mh) with respect to the therapeutic**  
 20 thérapeutique il faut vraiment voir parc'que (0.4) eh::  
**weekend we really need to look at that since (0.4) eh::**  
 21 j'sais qu'elle disait enfin (0.5) si elle so:rt elle aurait  
**I know that she said PART (0.5) if she le:aves she would have**  
 22 beaucoup, beaucoup de difficultés à rentr[er.]  
**lots and lots of trouble coming ba[ck.]**  
 23 MDI [C'est ce] que je dis=  
 [That's ] what I say=  
 24 PSYF=[(Hein)] [Do]nc eh:: (0.3) à voir si elle préfère eh une  
 =[ (Huh)] [PA]RT eh:: (0.3) we have to see if she prefers eh one  
 25 NUR =[°A:h] oua[is.° ]  
 =[°O:h] yea[h.° ]  
 26 PSYF semai[ne en plus ici (et pis] s'en) sortir [(tout à fait)]  
**more wee[k here (and PART] to come to terms with it [(indeed)]**  
 27 MDS [Sortir directement mh:m.]  
**[Leave right away mh:m.]**  
 28 MDI [Ce- c'est ce qu']  
**[That- that's what]**

29           [on dit.]  
               [we say.]  
 30 MDS     [Ouais.]  
               [Yeah.]

Looking at the physiotherapist (PTC), MDI concludes her medical report regarding PA10 by suggesting a possible window of time for the discharge: “next week” (lines 1-2). Her suggestion is first followed by a silence (line 3) that is not treated as agreement-implicative: instead of moving on to another topic, MDI produces an increment (line 4) that retrospectively casts her suggestion as being limited to “her side,” the “medical” point of view, thus potentially inviting/fishing for another point of view on the issue (cf. Pomerantz 1980). However, her increment merely engenders PTC’s agreement (line 6), which MDI does not treat as sufficient grounds for moving ahead in the agenda. Instead, she invokes a supplementary step—“a therapeutic weekend” (line 10)—to assess the patient’s readiness for discharge (line 12) before reaching a joint decision (line 13) regarding a final discharge date. This modified line of action is supported by MDI’s colleague MDS (line 15), whose simple agreement induces MDI to formulate another increment indicating the need to elicit and take into account the patient’s point of view for the final decision (line 17).

Despite MDI’s repeated orientation toward shared decision-making and patient participation in the final decision, the psychologist (PSYF) self-selects in line 19 to invoke first-hand knowledge—“I know...” (line 21)—of PA10’s point of view regarding the discharge planning (lines 21-26). By initiating her turn with “Just one thing” (line 19), PSYF casts what follows as something that has not been considered yet. Furthermore, she formulates the patient’s preference—to stay another week without going home for a therapeutic weekend—as potentially constituting a challenge to MDI’s proposed line of action (lines 24 and 26). However, in overlap with PSYF’s turn, MDI dismisses PSYF’s comment, insisting that her point has already been considered (lines 23, 28-29). Throughout the further interaction (omitted for reasons of space), PSYF’s and MDI’s potential disagreement on the issue is neither clarified nor induces MDI to further specify/clarify the weight given to the patient’s point of view/preference with respect to her initial plan of action. In this extract, the *congruence* between MDI’s final plan of action and PA10’s expectations/preferences as reported by PSYF is potentially *low*, or at least *arguable*.

The analysis of extract 1 shows moreover that in IMs, discharge-date talk involves:

1. medical, healthcare and socio-psychological indications, or contraindications regarding a possible discharge date, a physician's suggestion of a specific discharge date/duration of stay at the clinic and the other professionals' agreement (overt or tacit) with the proposed line of action;
2. a professional's report of the patient's expectations/point of view regarding a possible discharge date/duration of stay at the clinic.

The first dimension is treated as belonging to the medical domain of expertise: the medical doctor suggests a possible discharge date/duration of stay and has the last word on the line of action that is to be taken (see discussion of extract 1). However, in certain cases the medical doctor might request an external doctor or an on-staff professional to give his/her assessment of the matter and/or actively pursue another person's professional agreement (see lines 1-18 of extract 1 above).

The second dimension is oriented to as belonging to the patient's personal realm. Since the patient is not present at the IM, any participating professional might act as a facilitator to bring in his or her point of view (see lines 19-26 of extract 1). However, in certain cases the patient's point of view might merely be touched on, or not mentioned at all during the IM. Furthermore, professionals' understanding of the weight the patient's point of view should have in the IM can differ: As we have seen in extract 1 above, MDI's responses (lines 23, 28-29) to PSYF's report of the patient's preference indicate that the former treats the patient's point of view as being sufficiently oriented to in the suggested plan of action, whereas PSYF treats it as needing more consideration (lines 21-26).

With respect to these two dimensions, the professionals' discussions regarding a possible discharge date/length of stay at the clinic may thus manifest a high congruence (4/13) or a low congruence (2/13) between the professionals' and the patient's respective points of view. With regard to the remaining instances of our mini-collection (7/13), neither the medical professionals' (1/13) nor the patient's point of view (6/13) is overtly stated/discussed. In the analytical section below (4), we will seek to show how these different

configurations affect the way physicians initiate their talk of discharge date/duration of stay in the subsequent MV.

The medical visit (MV) follows the IM and takes place in the patient's room. The aim is to examine the patient's current state of health, discuss therapeutic measures and discharge issues with the patient and eventually reach a joint decision regarding these matters. The MV is composed of six activity phases: 1) the opening, 2) information about IM and test results, 3) history-taking: inquiry/description of symptoms, etc., 4) physical examination, 5) treatment proposal/advice-giving 6) closing. In general, it is the head medical doctor who chairs the visit throughout these six activity phases and thus initiates the talk about the discharge date, for example. The nurses in attendance contribute only peripherally: they take notes and/or lend a hand if the patient's medical examination involves giving him or her some care (for a more thorough discussion of the MV's activity structure and its organization, see Schoeb et al. submitted). It is therefore not surprising that we did not identify an initiation of discharge-date talk by a nurse in an MV. However, in our mini-collection we identified one instance (1/13: PA8\_3v) in which the patient initiates the discharge-date talk: the patient asks if he can stay at the clinic some more time. In this case, the patient's question stands in alignment with the agreement reached by the professionals in the preceding IM, and immediately engenders the head medical doctor's agreeing response.

#### **4. Physicians' embodied initiations of discharge-date talk**

In the analytical section that follows, we focus on the physicians' embodied initiation of discharge-date talk in the MV (extracts 2-4). The aim is to describe different practices for accomplishing initiations, paying special attention to the way patient participation is dealt with. We argue that depending on the level of congruence—high versus low—between the patient's expectations and the professionals' position as manifested during the IM, the physician's initiation in the MV is organized either in a straightforward, unmarked manner, implying the patient's participation in a direct way (extract 2), or in a mitigated, marked way that makes it (more) difficult for the patient to manifest his or her point of view (extract 3). Moreover, our analysis shows that if the patient's point of view/preference is merely touched on during the IM or not talked about at all,



the initiation of discharge-date talk might not be intelligible as such for the patient and can engender misunderstanding (extract 4).

To make it easier to understand the main argument of the paper—the organization of discharge-date talk during the IM has an impact on physicians' initiations in the MV and on patient participation—we will briefly summarize the discharge-date talk of the IM, referring to the two above-mentioned aspects, before looking at the physician's embodied initiation of discharge-date talk in the subsequent MV in more detail.

#### **4.1. High congruence between medical point of view and patient expectations during the IM**

In IM 1, (10\_3c), the medical point of view is clear: there are no medical contraindications regarding PA10's discharge on the day of the IM or later. Moreover, for insurance reasons, discharge has to occur at *latest* on the Monday the week after the IM. The patient's point of view regarding a possible discharge date in the near future is invoked by the physiotherapist and the psychologist: using reported speech, they both mention the patient's preference to leave the clinic permanently at the end of the week. Taking PSYF's and PTC's invocation of the patient's point of view into account, medical doctors MDI and MDL agree on "next Friday" as the appropriate discharge date for PA10. In IM 1, *high congruence* between the patient's reported point of view and the doctors' final decision regarding the final discharge date is achieved.

#### **4.2. Physician's initiation of discharge-date talk in the MV: Straightforward question addressed to the patient**

After completing her examination of PA10 and assessing her medical status positively, MDI walks away from the patient, then turns around to look at the patient and crosses her arms behind her back. MDI's movement engenders PA10's adjustment of her sitting position on the bed (see multimodal description below) so that she is clearly oriented toward MDI (see image 1) when the latter begins talking:

**Extract 2: CRR10\_3v\_EXDPT**

Participants' acronyms and symbols for multimodal transcription: MDI: medical doctor I (f); MDS: medical doctor S (not visible); MDL: medical doctor L (not visible); PA10: patient 10 (\*); NU: nurse (not visible).

1 (1.£6\*)  
 pa10 <<adjusting her sitting position on bed\*  
 mdi flks at PA10, head slightly inclined to the left->>  
 pa10 \*lks at MDP->>  
 2 MDI \*Quand est-c'qu'on veu:t\* le départ définitif alors?  
 When do we want the final discharge PART?  
 pa10 \*retracts lh into her lap\*  
 3 (2.0)  
 4 MDI (.H)=  
 5 PA10 =Moi j'aurais en tout cas pas voulu: (0.6) dépasser le  
 =Me I would've in any case not wante:d (0.6) to go past the  
 6 week-end, j'aurais pas voulu: (0.4) sortir l'week-end et  
 weekend, I wouldn't have wante:d (0.4) to leave for the weekend and  
 7 revenir lundi [prochain.]  
 come back next [Monday.]  
 8 MDI [Nous non] plus.  
 [Us neith]er.



9 (#1.0)  
 im. #image 1  
 10 PA10 (A) partir de là e[:h ( )]  
 (From) that point onward e[:h ( )]  
 11 MDI [Alors on vous laisse par]tir vendredi?  
 [PART shall we let you g]o Friday?  
 12 (0.4)  
 13 PA10 Alo[rs (ouais.)]  
 PAR[T (yeah.)]  
 14 MDI [Fin de] journée?  
 [End of the] day?  
 15 (0.3)  
 16 PA10 (Ouais.)  
 (Yeah.)

With her embodied orientation, MDI addresses her straightforward question: “When do we want the final discharge?” (line 2), clearly to the patient. At the same time, MDI’s use of the pronoun “we” projects a collective answer, which includes the medical point of view that MDI represents (for a more thorough discussion of participants’ use of personal pronouns, see Bovet 2014: 170-172). As such, it contrasts with MDI’s contained posture: with her arms folded behind her back, looking at the patient, she is displaying *waiting for the patient’s*

*answer*. Following MDI's question, PA10 does not immediately answer (line 3), thus displaying some reluctance/hesitation to do so. However, latching with MDI's audible inhalation in line 4, which might indicate her readiness to resume talking, PA10 eventually begins her turn, highlighting that what follows constitutes her *personal preference*: "Me, I..." (line 5). As such, the beginning of her answer achieves a distancing move with respect to MDI's "we"-formulated question. Moreover, instead of being formatted positively—as projected by MDI's question—PA10's answer states what she does not want (lines 5-6). Despite these two non-aligning features of PA10's answer, MDI agrees with it even before PA10 completes it (line 8). After a silence (line 9) and PA10's attempt to elaborate on her answer (line 10), MDI resumes talking in overlap with PA10's turn (line 11), regaining control of the conversation and thus of the modalities of the final decision: In line 11, MDI asks PA10 to confirm the previously-agreed-upon discharge day (see discussion of IM): "Friday" (line 11). In overlap with PA10's immediate confirmation (line 13), MDI then asks PA10 to confirm the discharge time of day too (line 14), immediately engendering PA10's confirmation (line 16).

Our analysis shows that after an IM in which a *high congruence* between medical and patient point of view becomes apparent (see section A)), physicians tend to initiate talk about discharge date/duration of stay (in the subsequent MV) in a way that enhances direct patient participation. Patients thus get the opportunity to manifest their point of view/preference directly and to contribute to the final decision. In contrast to this extract (2), the analysis of the next extract (3) will reveal that after IMs in which a *low congruence* between medical and patient point of view becomes apparent, the physician's initiation in the subsequent MV tends to be more complex and thus constrain patients' participation.

### **4.3. Low congruence between the medical point of view and the patient's expectations during the IM**

In IM 2 (4\_3c), all the professionals in attendance agree with the head medical doctor's (MDL) suggestion to extend PA4's stay at the clinic for two more weeks. In contrast to this professional agreement, MDL himself reports PA4's expectation of leaving the clinic as soon as possible. The patient's point of view thus stands in conflict with the agreed-upon extension. In IM 2, a *low*

*congruence* between the professionals’ position and the patient’s expectations becomes apparent.

#### 4.4. Physician’s initiation of discharge-date talk in MV: Prefaced by an account of patient’s progress

After examining and discussing PA4’s medical problems at length, the medical ward physician (MDP) achieves the initiation of discharge-date talk in two steps: she first accomplishes a rather long preface and then invokes the medical requirement to prolong the patient’s stay (see discussion of IM 2 above):

##### Extract 3a: CRR4\_3v\_EXDPT

*Participants’ acronyms and symbols for multimodal transcription:* MDL: medical doctor L (É); MDP: medical doctor P (\$); PA4: patient 4 (\*)

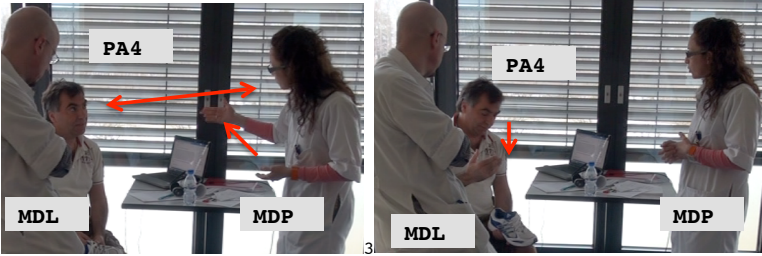


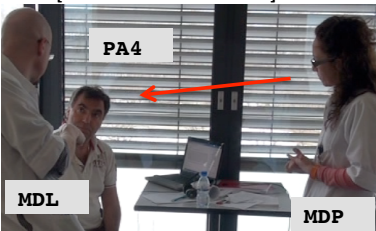
- 1 MDP #Bo:n en tout cas pour nou::s c'qui:: est important\$ à (p)  
(PART) in any case for u::s what is important to (t)  
im. #image 1  
pa4 << lks at MDP->  
mdp << lks at PA4->  
mdp \$ra/la forward, up->
- 2 (0.2) parler \$et re#tenir au\$jourd'hui:: (0.3) c'est  
(0.2) talk about and remember today:† (0.3) it is  
im. #image 2  
mdp \$ra/la downward stroke\$ra/la twd left/up\$ra/la twd  
right->
- 3 qu'on voit que (0.2) y a un processus\$ dé(.) améliora\$tion  
that we see that (0.2) there is a process of (.) improvement  
mdp \$ra twd right---\$la twd left->
- 4 qui est progress\$[(i:f)]  
that is† progress[(i:ve)]  
pa4 [\*>Beaucoup, beaucoup] beaucoup\*<  
[>Lots and lots] and lots<  
mdp \$ brings rh/lh together in front->  
pa4 \*rh up: circular movement->  
pa4 \*lks down at shoe in his lap--\*lks twd MDP->
- 6 MDP \$Voilà.\$  
There you go.  
mdp \$nodding - head slightly inclined to the right\$  
(0.2)
- 7

At the beginning of extract 2, MDP stands in front of PA4, who is sitting on a chair (image 1). MDP has her arms behind her back. The head medical doctor, MDL, is standing to PA4's right and leaning against the patient's bed. MDP and MDL are both looking toward the patient. However, given the angle of the camera, it is difficult to identify the precise focus of their gaze. The patient in turn is clearly looking at MDP. In line 1, MDP starts her turn with the particle "Bo:n", which might best be translated as "Oka:y" in this conversational context. It achieves the completion of the previous examination/discussion of the patient's medical problems, and at the same time initiates a new action: the medical doctors' assessment of the patient's progress at the clinic so far (lines 1-4). In contrast to the previous extract (2), in which the medical doctor kept her arms behind her back during the whole extract, thus giving the patient maximum space, here MDP brings both of her hands forward at the end of line 1 to add emphasis to her talk and continue her speakership with stroking gestures (see image 2 and multimodal transcription; for a thorough discussion of participants' use of gestures/pointing to indicate speakership, see Mondada 2007b). MDP's positive assessment is immediately agreed with by the patient, who uses an intensifier (line 5), at the same time accompanying it with circular hand movements that work to further upgrade the assessment's valence. While PA4 agrees (line 5), MDP brings her hands together into "home position" (Sacks & Schegloff 2002), closing the positive assessment with her hand movements and the use of a terminal marker (line 6). Following it, there is a short silence, after which MDP resumes talking (line 8):

**Extract 3b: CRR4\_3v\_EXDPT**

Participants' acronyms and symbols for multimodal transcription: MDL: medical doctor L (F); MDP: medical doctor P (\$); PA4: patient 4 (\*)

- 8 MDP [Et \$que:::] pour nous c'est imp\$ortant de continuer dans  
[And tha::t] for us it's important to continue in
- 9 PA4 [Beaucoup]  
[Very much]
- mdp \$rh/lh palm open up-----\$ra twd right->
- 
- 10 MDP cette même# voie.  
this same direction.  
im. #image 3  
(\$0.\*4\$)  
mdp \$rh back to middle\$  
pa4 \*gaze shifts downward; head inclines downward->
- 12 MDP Donc \*[eh] (0.3#) \* nous on pen\$s\*[e qu']i faudra juste  
PART [eh] (0.3) we we thin[k tha]t it is necessary to PART  
im. #image 4  
pa4 \*lifts rh; drops rh\*  
mdl \$rh/lh open ->
- 13 MDL [((clears his throat))]  
14 PA4 [((click with the tongue))]  
15 MDP eh\* après\$ (0.4) >parler de\$ cette histoire d'ablation du  
eh afterward (0.4) >talk about this topic of ablation of the  
pa4 \*gaze shifts to MDP->  
mdp \$rh/lh come together->
- 16 MDP matériel<\$ .h et pour l'instant n(ous) parlons pas  
material< .h and for the moment w(e) won't discuss  
17 d'une date de sortie:: on pourrait discuter d'ici deux  
a discha::rge date we might discuss it in two  
18 semaines (0.3) mais j'pense il faut qu'on on profite (.)  
weeks (0.3) but I think it's necessary that we we take advantage  
(.)
- 19 de cette bonne évolution\* pour encore continuer dans  
of this positive development to PART continue in  
pa4 \*gaze shifts downward->
- 20 ce::tte .h >dans cette idée dans cette\* façon de< (0.4)  
thi::s .h >in this idea in this way of< (0.4)  
pa4 \*gaze shifts to MDP->
- 21 dé travailler en (0.3) dans les thérapies les prochaines  
of working in (0.3) in the therapies these next  
22 deux semaines.  
two weeks.  
(\*1.5)  
pa4 \*gaze shifts downward->
- 24 MDP ((click with the tongue)) >\*j'sais pas c'que vous\*  
>I don't know what you  
pa4 \*very subtle head-shake\*

- 25 [en pensez↑<]  
[think about this↑<]
- 
- 26 MDL EST-C'QUE LES] é biennois ont- ceux qui vous ont opéré#  
[DO THE ] people in Bienne have- the ones that operated on you  
pa4 é gaze shifts to MDL->  
im. #image 5
- 27 c'est à Bienne heint vous\$ [( )] éBienne ouais#.
- 28 PA4 [Bienne ouais.]  
It was in Bienne huh you [Bienne yeah.]  
mdp \$ gaze shifts to MDL->>  
mdl fgaze shifts downward->>

Beginning her turn with an “And” (line 8), MDP links what follows directly to her preceding talk and thus implies that it may be in line with the preceding positive assessment. PA4’s agreement in overlap with the beginning of MDP’s utterance (line 9) indicates that he understands it in this way. However, in what follows MDP makes it clear that she was using the preceding positive assessment as a preface or a justification to provide a conclusion that “foreshadows” what she knows to be “bad news” for the patient (Maynard & Frankel 2006): “it’s important to continue in this same direction.” (lines 8 and 10), again using her hands to add emphasis to her talk (image 3). After MDP brings her hands together to accentuate the completion (line 10), PA4 immediately displays his disappointment by inclining his head downward and lifting and dropping his right hand in a resigned way (image 4). By doing so, he manifests his understanding of MDP’s turn as projecting a line of action that is not in alignment with his own expectations, eventually glancing back at MDP just in time to receive the “bad news”: “for the moment we won’t discuss a discharge date, we might discuss it in two weeks” (lines 16-18). As is common with dispreferred actions (Heritage 2008; Pomerantz 1984) such as the delivery of “bad news,” this announcement is accompanied by a lengthy account from MDP (lines 18-22), which is followed by a silence (line 23). After this silence, during which PA4 lowers his gaze, MDP, still looking at PA4, eventually tries to elicit the patient’s point of view.

In contrast to extract 2, in which MDI deploys a straightforward question format, here MDP rather “fishes” (Pomerantz 1980) for the patient’s position by stating her own lack of knowledge regarding the issue (line 24). Moreover, MDL comes in in overlap (line 26) with a request for clarification, thus occupying the slot designated for PA4 who, instead of providing his point of view regarding the proposed extension of his stay at the clinic, merely grants MDL’s request in line 28, at the same time shifting his gaze to him. For reasons of space, we are omitting the further interaction. However, it becomes clear at this point that after an IM in which a *low congruence* between medical and patient point of view becomes apparent (see section C)), physicians “forecast” the delivery of what they already know to be “bad news” (Maynard & Frankel 2006) before initiating discharge-date talk in the MV. Moreover, this extract shows how patient participation regarding the discharge date/duration of stay might be strongly constrained by the two physicians’ ways of organizing their talk.

#### **4.5. The medical point of view is clearly set, but no mention of the patient’s expectations regarding the discharge date is made during the IM**

In IM 3 (5\_2c), the medical doctor (MDI) states her point of view clearly. According to her, there is no reason to keep the patient until the eleventh of March, i.e., the date until which the patient’s stay at the clinic is covered by the insurance. This implies that from her point of view, discharge has to occur sometime before this date. Her colleague MDS agrees with her. No mention, either by the doctors or another professional in attendance, is made of the patient’s expectations, point of view and/or preference regarding the discharge date or duration of stay. However, before moving on to the next topic, the medical doctor mentions that the *patient’s point of view will have to be elicited* in the subsequent MV: “We will see how he sees things.”

#### **4.6. Physician’s initiation of discharge-date talk in the MV: Open questions are addressed to the patient**

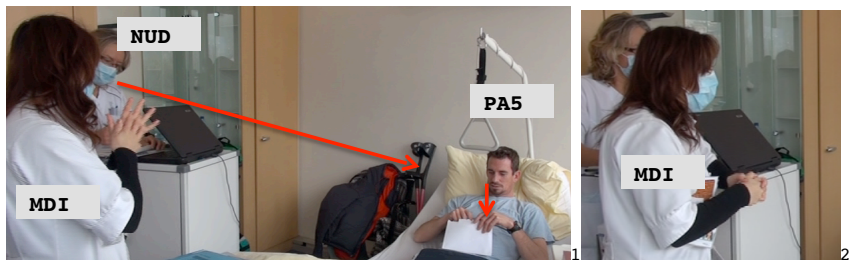
After examining PA5’s injured leg and assessing it positively, MDI asks him where he spent the previous weekend. While PA5 answers the question (he spent it in France with a friend), MDI walks away from the bed and toward her



colleague, who is standing at the end of the bed, and invokes the “future development” using a rising intonation which leads MDS to provide her with the date of PA5’s next medical exam: “the eleventh of March.” While acknowledging this information, MDI shifts her gaze toward PA5 in order to look at him:

**Extract 4a:** CRR5\_2v\_EXDPT

*Participants’ acronyms and symbols for multimodal transcription:* MDI: medical doctor I (£); MDS: medical doctor S (not visible); NUD: nurse D; PA5: patient 5 (\*)



- 1 (1.9)  
 pa5 << lks down at documents->  
 mdi << rubbing lh/rh together->  
 2 MDI Comment vous fvu::s sente:z†# et quelle suite?f  
**How do you:: fee:l† and what future developments?**  
 mdi forients upper body twd PA5£  
 im. #image 1  
 3 (0.3)  
 4 MDI Parc'quef là:† vous ave:z bienf récupéré jusqu'au  
**Because here:† you've recuperated well until the**  
 mdi fleans twd her left, placing her elbow on some furniture->  
 mdi £-holding lh/rh crossed->  
 5 o:nze# \*ma:rs†\*  
**e:leventh of Ma:rch†**  
 pa5 \*nods\*  
 pa5 \*rh: removes a post-it from a document\*  
 im. #image 2  
 6 (1.3)

While rubbing her hands together and orienting her upper body toward PA5, MDI addresses two distinct open questions to him: “How do you:: fee:l†”—“what future developments?” (line 2). By connecting them with an “and,” MDI indicates that the projected answer to the latter question is logically linked to the former one. The answers thus need to be in accordance with each other. After a short silence (line 3), MDI resumes talking in order to give her own, positive, appreciation of PA5’s progress so far, and to invoke the above-mentioned date, “the eleventh of Ma:rch†,” as the relevant time period. By deploying rising intonation, she signals to PA5 that a response from him might be expected.

However, he is still looking at his documents, removing a post-it from one of them and nodding very subtly while MDI completes her second turn; he is not displaying any other embodied signs of possible imminent speakership. After another (longer) silence (line 6), it is thus MDI who resumes talking:

**Extract 4b:** CRR5\_2v\_EXDPT

*Participants' acronyms and symbols for multimodal transcription:* MDI: medical doctor I (f); MDS: medical doctor S (not visible); NUD: nurse D; PA5: patient 5 (\*)

7 MDI O::n va \*continuer le même programme de toute façon.  
**We:: will continue the same program in any case.**  
*pa5 \*lks at MDP->*  
 8 (0.2)  
 9 PA5 \*Ouai:s†\*  
**Yea:h†**  
*pa5 \*nods\**  
 10 (1.2)  
 11 MDI E:t puis on va adapter se\*lon \*le fcontrôle.f  
**A:nd PART we will adapt it depending on the exam.**  
*pa5 \*lh moves post-it to the left side->*  
*pa5 \*lks at document->*  
*mdi frubs hands togetherf*  
 12 (1\*\*6)  
*pa5 \*lh puts post-it down on table->*  
*pa5 \*lks at MDP->*  
 13 MDI Et co\*mmment voyez-vous les choses?  
**And how do you see things?**  
*pa5 \*brings lh behind head->*  
 14 (0.9)



3

15 MDI \*Est-ce qu'o:n peut gentiment vou:s (1.5) vous lâcher?#  
**Can we gently let you:: (1.5) you go?**  
*pa5 \*brings rh behind head->*  
*im.* #image 3  
 17 (1.5)  
 18 PA5 >\*Je sais pas< c'est vou:s qui:: >voilà<=  
**>I don't know< it's you: tha::t >PART<=**  
*pa5 \*lks in front of him-----\* lks twd MDI->*  
 19 MDI =Vous all[ez ren\*trer] en Fran\*ce?  
**=You ar[e going back] to France?**  
*pa5 \*lks away\*lks twd MDI->>*  
 20 PA5 [(°Qui dites°)]  
 [(°That says°)]

As in extract 3 above, MDI says that they will “continue the same program” (line 7). While she is talking, PA5 shifts his gaze in order to look at her and responds to this prospect with a simple acknowledgment token (line 9). In contrast to extract 3, PA5 receives the physician’s information with a kind of indifference instead of manifesting disappointment. After another silence (line 10), and while PA5 moves his post-it to the left, MDI produces an increment referring to the forthcoming medical exam, thus further specifying PA5’s future program (line 11). Following a longer silence (line 12) during which PA5 puts his post-it aside he looks toward MDI again, inducing her to formulate another open question: “And how do you see things?” (line 13). Although MDI deploys a classic question format, and leaves PA5 enough time to respond (line 14), he does not respond. This noticeable absence of an answer induces MDI to produce a request for confirmation, making it clear not only that it is PA5’s discharge date/duration of stay which is at stake, but also that she is expecting PA5 to express his point of view regarding the matter (line 15). While MDI is talking, PA5 brings his left hand behind his neck, thus taking a rather casual posture (image 3). After the completion of MDI’s utterance, another long silence emerges (line 17). Following it, PA5 responds (line 18), invoking a lack of knowledge regarding the matter and delegating his right (and/or obligation) to manifest his point of view to MDI (lines 18 and 20). This delegation induces MDI to move ahead in the discharge planning by producing a series of requests for information regarding the patient’s discharge context without further eliciting PA5’s position on the matter (see for example line 19).

For reasons of space we have opted not to consider the further interaction. However, our analysis indicates that after an IM in which the second dimension—patient point of view—is not elicited (see section E)), physicians might first seek to determine it before they bring forward their “own” plans and ask the patient to state his or her own position. At the same time, our analysis of extract 4 suggests that MDI’s deployment of a series of open questions is not very successful in actually getting PA5’s point of view. In fact, such open and/or vague questions may even engender misunderstanding/confusion on the part of the patient. Indeed, as becomes apparent in the further interaction (omitted for reasons of space), PA5 seems not to understand MDI’s questions as an initiation of discharge date/duration of stay talk, and thus as a moment at which his participation is required: only much later—after MDI has gone through a whole series of questions regarding his discharge context—does PA5 manifest some

resistance, and state his personal preference for staying longer at the clinic instead of going home before the eleventh as suggested by MDI.

## 5. Conclusion

At rehabilitation clinics, discharge planning requires medical expertise and patient participation. As a result, discharge planning is expected to take into account two factors: 1) medical and healthcare expertise and 2) patients' preference/point of view, and these two perspectives may be either congruent or in conflict with each other. In this paper, our analysis shows that the level of congruence reached between these two factors in the IM strongly influences the way physicians initiate discharge-date talk during the subsequent MV and thus how they involve patients in decisions regarding the planning of their discharge. When congruency between the medical point of view and the patient's point of view becomes apparent in the IM, the physician's initiation in the MV seems to be formatted as a straightforward question that is directly addressed to the patient. This question in turn gives the patient the opportunity (or even obliges him or her) to clearly state his or her point of view (extract 2). When the level of congruency between the medical and patient points of view is low in the IM, or when the patient's point of view is not invoked at all (extract 4), the physician's initiation in the MV tends to be organized in a way that delays and/or otherwise hinders direct patient participation (extract 3) or in a way that engenders misunderstandings regarding the issue (extract 4). More generally, a close examination of how discharge date/duration of stay is discussed in the patient's absence and how discharge date talk is then initiated by the physician during the subsequent MV thus strongly suggests that the former has a direct impact on the level of patient involvement. As such, our analysis shows how potential tensions between medical expertise and the institutional patient-participation requirement might arise in seemingly "banal" actions, such as initiating discharge date/duration of stay talk in the presence of patients, and how they thus might have an impact on how patients are eventually involved in decisions related to discharge.

As mentioned in the section on our data (2), the scope of our study is limited. Moreover, the selected data involves a significant bias: in certain IMs in our collection (N=13), the discharge date/duration of stay issue is discussed for

the first time (5/13), while in others (8/13) the matter has been discussed before. In this second sub-collection (8/13), the patients' expectations may have been reported/invoked previously and the professionals may be aware of them without necessarily restating them in each IM (5/8). However, regardless of these shortcomings, we argue that by rendering explicit practices whose interactive order is tacitly achieved in the daily clinical routine and by revealing the interplay that may exist between them, our study can stimulate professionals' reflection on their own practices, and thus initiate a reflective process for enhancing these practices (Schoeb, Hartmaier & Keel 2015).

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