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Agency and the telephone: Patient contributions to the clinical and interactional agendas in telehealth consultations

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ABSTRACT

Objective: Patient-centredness is central to providing safe care and is achieved, in part, through involving patients in developing the agenda of the consultation. Medical consultations have changed significantly over the last two years as a result of COVID-19 and thus understanding how patients contribute to the clinical and interactional agendas *within* a telehealth consultation is important to supporting quality care.
Methods: A collection (15) of consultations (in English) between specialists (3) and patients (14) were recorded in a metropolitan gastrointestinal clinic in Australia. These recordings were closely examined using conversation analysis, which focuses on the structural and sequential organisation of interaction.
Results: Patients used a variety of interactional approaches to contribute to the agenda throughout the consultations. This was achieved in collaboration with the doctors, whose responses generally allowed for these contributions. However, there were few doctor-driven, explicit opportunities provided to patients to contribute to the agenda.
Conclusion: Many patients and doctors are adept at managing the interactional challenges of telehealth consultations but there are clear opportunities to extend this advantage to those patients with less agency.
Practice implications: Providing an explicit space for patients to ask questions within the consultation would support those patients less inclined or able to assert themselves during a telehealth consultation.

1. Introduction

Over the past two years, telehealth has become, through necessity, a routine platform for medical consultations. While telehealth has been a reality for over 100 years [1] it has been uncommon. The COVID-19 pandemic has confronted many doctors and patients with the challenges of an unfamiliar format for doing medical work. To support this, governments and professional colleges and organisations have released advice for telehealth [e.g. 2], that, while timely, does not address important facets of telehealth consultations.

Existing advice such as 'ensuring privacy' and 'self and patient identification' is important, however reiterating well established guidelines for face-to-face consultations underspecifies the challenges of telehealth and leaves clinicians with little guidance regarding additional communication techniques they could employ to ensure more effective consultations over the phone. This is largely because research in this area is scarce, so evidence-based recommendations limited [3], as well as the underlying assumption that a telehealth consultation is basically the same as one held face-to-face.

Examining recorded telehealth interactions allows for comparison with existing knowledge regarding face-to-face consultations. In this article we explore agency, which is a key component of the patient-centred approach [4], and reappraise its role within the context of telehealth, specifically telephone-based, consultations. To do this, we examine ways in which additional concerns and questions were either elicited by doctors or initiated by patients in telehealth consultations in a gastrointestinal clinic. In particular we focus on the question: *is there space given to patients to raise questions and/or additional concerns in telehealth?*

'Patient agency' is an important component of patient-centred care [4] and refers to a patient's ability to participate in a consultation and associated decision-making about their care. In conversation analysis, 'agency' refers to the control and responsibility a person has over the design and direction of their communication [5]. Another way to view this is as 'proximal deontic authority', which Stevanovic argues relates to "people's rights to initiate, maintain, or close up local sequences of

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Table 1
Visit type and doctor- and patient-initiated contributions to the consultation agenda.

Video code	Visit type[a]	Opportunities explicitly provided by the doctor for the patient to raise another issue or concern	Consultations where patients raised concerns or questions without elicitation	Consultations where patients initiated transitions between consultation activities
MQ-TELE20-04	Post-procedure/investigation follow up	No	Yes	Yes
MQ-TELE20-05	Post-procedure/investigation follow up	No	Yes	Yes
MQ-TELE20-06	Post-procedure/investigation follow up	No	Yes	Yes
MQ-TELE20-12	Post-procedure/investigation follow up	No	No	No
MQ-TELE20-13	Post-procedure/investigation follow up	No	Yes	Yes
MQ-TELE20-16	Post-procedure/investigation follow up	No	No	Yes
MQ-TELE20-17	Check up	Yes	No	No
MQ-TELE20-18	Post-procedure/investigation follow up	No	Yes	No
MQ-TELE20-20	Check up	No	Yes	Yes
MQ-TELE20-21	Post-procedure/investigation follow up	No	Yes	Yes
MQ-TELE20-23	Post-procedure/investigation follow up	No	Yes	Yes
MQ-TELE20-24	Check up	No	Yes	Yes
MQ-TELE20-25	First visit	No	Yes	No
MQ-TELE20-26	Post-procedure/investigation follow up	Yes	No	Yes
MQ-TELE20-27	Post-procedure/investigation follow up	No	No	Yes

[a] Following visit type definitions by White et al. [9].

conversational action." [6 p86]. These two distinct, but overlapping concepts of *agency* are both explored here, with consideration of the opportunities for patients to contribute to the content of the consultation (the clinical agenda) and to the overall structural and sequential organisation (the interactional agenda) [7].

Medical consultations are constructed through a series on interrelated activities [8,9]. Transitions between these consultation activities are made possible through different interactional techniques which are dependent on the role of the participant and from and to which activities the transition is being made [10]. For the most part, patients have the most agency during the activity of problem presentation [11], while doctors maintain the role of determining the overall structure of the consultation [12]; that is, they have proximal deontic authority. This means that patient-led and patient-resisted transitions between consultation activities requires more "interactional work" by the patient, so that patients need to do more than a doctor would in order to lead or resist a transition between interactional activities within a consultation. This is not to say that patients cannot and will not have any agency, only that they are likely to need to do more interactional work to get the floor and be heard [cf. 13].

2. Methods

This is a qualitative, mixed methods study, with the broader project involving both recordings of actual telehealth consultations as well as interviews with doctors. Data was collected in a metropolitan gastrointestinal specialist clinic in Australia. Three doctors (one gastroenterologist and two colorectal surgeons) were recruited, including one of the authors (XX). Patients booked in for telehealth consultations were invited to participate by reception staff either on the day of booking, on an appointment reminder call, or on the day of the consultation if reception staff were making the initial call. Data was a convenience sample of patients self-selecting to participate and occurred across a period of several months.[1] The data is in English. The project was approved by the [NAME] ethics committee (no. ######).

During the data collection period, 27 consultations were recorded. Of those, seven were hampered by technical recording problems so that only the doctor was recorded. These were excluded, as were recordings that involved support people that had more than minimal involvement (five consultations). The remaining set of 15 consultations were essentially doctor-patient dyads across three doctors and 14 patients (average call length = 6 min and 31 s). All consultations were conducted over the telephone. The gastroenterologist generally conducted more telehealth consultations which resulted in a higher number of recordings, with 11 of the 15 in this data set. One of the colorectal surgeons, a co-author in this study, recorded three and the other recorded one.

All recorded consultations were transcribed strict verbatim. Using conversation analysis [15], we identified areas of interest through an inductive approach. Once these were identified, a collection of relevant excerpts was built and transcribed using the Jeffersonian system [16], with pseudonyms used to de-identify person and place names, and analysed at a more granular level. Conversation analytic research relies on very close analysis of data to identify how interaction actually works within consultations [17,18]. This analysis does not rely on numbers for validity [19], instead the focus is on data-internal validity – how did the participants understand what was going on as demonstrated in their responses. This approach is demonstrated in the analysis that follows.

3. Results

Across the 15 recordings, we identified any doctor-initiated or patient-initiated sequence that was possibly related to a new concern or question and included it in our collection. Through this we found that patient contributions to the agenda beyond the initial concern were rarely initiated by the doctor and that in most consultations patients initiated transitions between consultation activities (Table 1). Contributions to both the clinical and interactional agendas of the consultation are explored below, with comparison to existing research on face-to-face surgeon-patient consultations.

3.1. Explicit opportunities to contribute to the agenda

In two of the 15 consultations the doctor provided an explicit opportunity for the patient to contribute to the agenda beyond initial problem presentation. In these two consultations the opportunity did not occur until the end of the consultation where they were posed as questions to the patients regarding *other questions*.[2] Even with these

[1] While telehealth had been encouraged through reduced limitations on government rebates in response to COVID-19 during this time-period there were fewer restrictions on people leaving home and so there were not as many consultations conducted via telehealth as anticipated cf. [14].

[2] In another consultation the doctor asked the patient if they had questions specifically about the explanation that occurred just prior. In yet another consultation the doctor asked the patient how they had been in the previous four months. We have not included these as explicit opportunities to contribute to the agenda as the first is limited as an invited response to an explanation and the second is a general, non-clinical enquiry.

explicit opportunities provided to patients to contribute to the consultation, there were none specifically relating to upfront agenda setting [12] at the start of the consultation nor any about additional concerns.

In Excerpt 1, the doctor is re-confirming the next steps following a discussion about test results.

Excerpt 1: MQ-TELE20-26

```
1    DR:   tsk [um so i'll chase up your fibrosca:n¿ >like i said if it's
2          anything untoward i'll ring you:? .hh um otherwise i [think
3          ]we can touch base again early next year¿
4    PT:   [°uhkay°]
5          (0.8)
6    PT:   alright, excellent.=
7    DR:   =okay, >d'you have any other questions for me otherwise
8          stephen_
9          (0.8)
10   PT:   no no i think (0.2) you know it's just- (0.2) t- as you said
11         it's just ah [kind of  (0.3) keeping: keeping=
12   DR:                      [yeah
13   PT:   =maintaining the diet (.) an:d uh:m exer[cising,
14   DR:                                           [yeah:. (.)
15         definitely_ definitely. .hh well look after yourself, >during
16         this whole strange period¿ .hhhh and um hopefully next year
17         will be better.
18         (0.3)
19   DR:   nheh heh h[eh.
20   PT:              [excellent. (.) no[t a problem. thanks.
21   DR:                                [take care.
```

In lines 1–3, the doctor's summary helps progress toward closing the consultation [20]. The patient accepts this (line 6). Before moving to closing, the doctor explicitly provides a space for the patient to raise *any other questions* (lines 7–8). This is designed as a yes/no question, with the use of negative polarity item *any* more likely to elicit a no-response [21]. There is evidence of a dispreferred response (i.e. one that will not be a *no*), as the patient delays their response by 0.8 s (line 9) and then hedges and restarts following their initial *no* (lines 10, 11, 13).

Although the doctor's question design, along with positioning and the question following the main business of the consultation, might have encouraged the patient to respond minimally, the patient took the interactional space they were given and provided an extended response that demonstrated their understanding of the treatment plan. Note also that the doctor uses the word *otherwise* in their question (line 7), which may be why the patient links their response back to previous regarding treatment using *as you said* (lines 10–11) [22]. It is not a new activity, however this checking of the plan may not have occurred if that space had not been provided.

In Excerpt 2 the doctor and patient have been discussing the plan for a routine, follow-up colonoscopy.

Excerpt 2: MQ-TELE20-17

```
1    DR:   the hospital [will contact you a day before to confirm
2    PT:                [yep
3    DR:   =the time to come in.
4    PT:   terrific
5    DR:   tsk [-alright carol do you have any other [questions?
6    PT:       [(that's great.)                      [thanks doctor park_
7          no no no all good=
8    DR:   =alright well you take ca:re, all the be:st,
```

As with the previous extract, this is near the end of the consultation, w ith the doctor using re-confirmation of the plans to move to closing (lines 1 and 3). The patient accepts this with positive assessments (lines 4 and 6), which partly overlap with the doctor asking if they have *any other questions*. This again is a closed yes/no question with a negative polarity item and the patient responds to it as such, with additional confirmation that it is a *no* through repetition of *no* and assessment that it was *all good* (line 7).

These two excerpts show that when doctors explicitly provide space that it allows the patient to raise additional information either directly responding to the question (as in Excerpt 2) or extending beyond it (as in Excerpt 1).

3.2. Patient-initiated contributions to the agenda

Although there was a lack of doctor-led explicit opportunities provided to patients for contributions to the agenda, patients initiated contributions to the agenda both within consultation activities and between consultation activities. The former involved clarifications, questions, and sharing of additional information. The latter involved back tracking or moving forward between different activities of the consultation. These contributions to the agenda were generally implicit (i.e. not discussed as something the patient wanted to do or add) and were achieved through various interactional approaches available to participants in order to get and maintain the floor.

3.2.1. Patient-initiated contributions to the agenda within a consultation activity

In Excerpt 3 the doctor and patient have been discussing upcoming scan at a hospital and are reaching the end of the consultation.

Excerpt 3: MQ-TELE20-13

```
1   PT:  okay then. =thanks [a lot.
2   DR:                     [alright i'll s- i'll post you the: um script
3        for the antibiotics.
4   PT:  okay then. [thanks a lot.
5   DR:             [tsk okay, buh bye.
6   PT:  okay >uh [uh balmoral hospital .hhh balmoral hospital=
7   DR:           [oh yes yes.
8   PT:  =will ring me, [will they?
9   DR:                 [they- will yes,
10       (0.4)
11  PT:  okay [then.
```

In lines 2–3 doctor re-confirms the task of sending a prescription to the patient. This is known as a "pre-closing sequence" [20] and is done to indicate to the patient that the consultation is coming to an end. This means that there will be no other place to clarify or to raise additional concerns or questions. The patient responds to the first part of the closing sequence that occurs in line 5 (*okay, buh bye*) not with a reciprocal parting turn that might normatively be expected, but by opening-up the closing [23] with a request for clarification (line 6). As the turn is clarifying a point regarding the next steps rather than initiating a more robust action, such as introducing a new problem, this is achieved through a small amount of additional interactional work, with the patient not saying *bye,* but saying *okay uh* and also talking faster (line 6), which indicates to the doctor not to hang up. The doctor responds in overlap with the patient (line 7), indicating that they are still on the phone and listening to the patient. Although the doctor does not explicitly offer the patient a place in the interaction to raise questions, the patient is able to modify the activity of closing to do so, thus demonstrating agency in the final turns of the visit.

In Excerpt 4, the doctor calls a patient for a second follow-up after the first follow-up revealed a discrepancy between the doctor's recollection, the patient's recollection, and the doctor's report sent to the patient. This patient question occurs after the doctor has said that the patient's general practitioner will remind them of when to re-book a colonoscopy.

Excerpt 4: MQ-TELE20-05

```
1   DR:  so they um (0.4) they'll know,= (.) they will know as well_
2        (1.0)
3   PT:  yep. .hh (0.7) so: (0.7) you: wouldn't (.) send me another (.)
4        report with the correct=
5   DR:  =yes i will. (.) i'm goin' to send a letter¿
```

After a one second gap, the patient responds to the doctor's summary of what the next steps are in scheduling a repeat colonoscopy. This acceptance is followed with more pauses, which in an ordinary face-to-face consultation might signal resistance or foreshadow disagreement [5,24,25], but here is likely due to the multitasking that is mentioned earlier in the call as the patient is driving. These pauses and gaps occur throughout and are relatively unproblematic in this interaction. The patient starts their question with *so*, which in this placement works to connect what will be said with what has previously been said [26]. By doing this, the patient makes their question a relevant next turn in the context of the discussion.

These two extracts are similar to Sikveland et al.'s [13] work on the 'patient burden' pursuing confirmations after pre-closing. That is, what is an allowable contribution by a particular participant and what role they have within the interaction impacts how and when that contribution is made. In these examples we observe the patients are contributing to the interactional agenda of the consultation, for which, as noted above, the doctor usually has the role of managing the overall sequential organisation of the interaction (or proximal deontic authority).

3.2.2. Patient-initiated contributions to the agenda between consultation activities

In Excerpt 5, which is a first visit, the doctor and patient have been discussing investigative procedures.

Excerpt 5: MQ-TELE20-25

```
1    DR:  that one takes about half an hour or so¿ >i guess the main
2         (1.1) the main reason for the test is to see if you've got any
3         inflammation in the bowel to explain the pelvic pai:n (0.4)
4         .hh and the diarrhe:a¿
5         (0.6)
6    DR:  and [if I see: yeah.]
7    PT:       [d'you think it could be:]
8         (0.8)
9    PT:  sorry do you think it could be um: (0.4) i b s?
10   DR:  (0.2) .hh it probably is i b s (.) um [but i b s] is a=
11   PT:                                        [awh: okay]
12   DR:  =irritable i b s is irritable bow:el syndro:me¿
13   PT:  yeah yeah [yeah.]
```

In lines 1–4 the doctor is finishing their explanation of colonoscopy, one of the two investigative procedures they are recommending. This explanation is a "treatment plan" activity and, in order for the consultation to progress to closing, the patient needs to accept it, even in a minimally responsive way [27]. The patient does not respond (line 5) and the doctor pursues acceptance (line 6), which occurs in overlap with the patient raising a possible explanation for their symptoms (lines 7 and 9). This moves the consultation from discussing treatment back to a question about diagnosis, with the patient modifying the trajectory of the consultation to introduce their idea regarding the cause of their symptoms (line 9).

In Excerpt 6, the doctor is describing a potential scan result and subsequent procedures that might be required.

Excerpt 6: MQ-TELE20-13

```
1   DR:  and [if let's say the scan comes back saying it's=
2   PT:      [yep
3   DR:  =completely nor:mal? tsk unfor[tunately i think we may:=
4   PT:                                [yep
5   DR:  =need to look at surgery as the as the option.
6        (0.6)
7   PT:  *yeah [(i-)*
8   DR:        [tsk alri:ght¿
9   PT:  .h i'm also um
10  DR:  °ah [huh°.
11  PT:      [i (0.3) sa- i saw my g p the other day_ [i i've=
12  DR:                                              [yeah
13  PT:  =got to (.) ah go and see him tomorrow 'cause um
14  DR:  yes
15  PT:  on um like when i done that twenty four hour urine s- uh sample
16       for ya,
17  DR:  yeah_
```

Following the doctor's explanation that surgery may be a next step (line 5), there is a pause of 0.6 s before the patient responds. This may seem small, but is hearable as a gap between speakers and could indicate a lack of uptake of the treatment plan by the patient [28]. The doctor orients to this as a potential lack of uptake, by further pursuing a response in overlap with the patient in line 8. Instead of receiving a response that would allow for progression to the next activity in the consultation, which in this instance would be closing, the patient initiates a new activity, by raising a new, but related, concern (lines 11, 12, 15–16), thus moving the consultation to problem presentation. By leaving the treatment planning activity of the consultation effectively incomplete by not responding, the patient resists the transition to closing, thus actively gaining space to talk within the consultation at a point in the overall structure that does not explicitly or implicitly provide for it.

4. Discussion and conclusion

4.1. Discussion

Through a close analysis of recorded telehealth consultations, we found that while the doctors did not often provide opportunities for patients to contribute to the agenda of the consultation, that there was sufficient patient agency that allowed for patient-initiated contributions to both the clinical and interactional agendas. This is similar to face-to-face consultations, where patients are able to raise additional concerns and questions across the consultation and that "patients most frequently find and create opportunities to introduce new concerns by fitting them to the ongoing talk or activity." [29 p. 2219].

The structure of conversation more generally allows for people to change direction, make mistakes, and to revisit missed opportunities, in order to build mutual understanding. In our analysis we can see that the interactional system works as it is designed to – patients were able to bring up things not specifically asked for and able to contribute to the agenda of the consultation, with the doctors receptive to these patient-initiated concerns, questions and transitions.

In contrast to face-to-face consultations, telehealth does not include physical examination. In face-to-face surgeon-patient consultations, patients who specifically designed their concerns as inquiries, or raised them early and/or multiple times were more likely to have that concern addressed [30], with patients tending to initiate additional concerns prior to physical examination [29]. This is potentially problematic in telehealth as there is no examination, and here we observed patients initiate additional concerns and questions nearer the end of the consultation.

Specialist consultations in Australia tend to be single-concern visits, so it is not expected that doctors would initiate additional concerns. In face-to-face consultations (in the US), surgeons were more likely to initiate additional concerns, often incidental findings, during examination [31]. As telehealth precludes physical examination, the loss of examination also means the loss of doctor-initiated additional concerns based on what they notice during physical examination [31]. While uncommon in face-to-face consultations, these noticings can occur, thus use of telehealth may become problematic over time when considering the health implications of missed incidental findings.

The loss of the examination may have more consequences for these consultations than the physical examination alone as the routine spaces in the consultation for patients and doctors to raise additional concerns are lost in telehealth.

In another study that explored communication challenges experienced by specialists during telehealth, the authors noted that clinicians developed additional communication skills in response to being unable to receive visual cues, such as asking additional and open-ended questions [32]. This did not occur in this data set but was seemingly not a barrier for some of these patients in creating their own spaces. This study included one clinic with a small data set with heterogeneous visit types across doctors of different specialties, which limits the generalisability of findings. Future research in this space could homogenise some of the data and collect additional sources such as post-visit surveys to introduce patient and doctor perspectives on the consultation, both of which may allow for greater generalisation. Additional close analyses of a broader range

of telehealth consultations with consideration of visit types, reasons for the visit, and patient factors is required to provide more generalisable guidance to clinicians. Further interactional analysis could also be used to explore ideas of framing and how the telephone changes the roles and resources for participants, while interviews could be used to understand the clinician experience of telehealth.

The risk of (unintentionally) denying patients the opportunity to contribute may be greater for those within populations not specifically recruited or controlled for in this data set. Patients with lower general and health literacy or with less confidence in medical interactions due to language proficiency, culture, or age, may struggle to establish the level of agency they would wish to have in a consultation. This challenge appears to be amplified in telehealth where consultations appear to be shorter [33], where visual cues are not present [32] and with the loss of space to raise additional concerns that routinely occur around the physical examination [28].

4.2. Conclusion

There is a paucity of research on the moment to moment unfolding of telehealth consultations, although the field is growing [34–38]. Australian Health Practitioner Regulation Agency (AHPRA) guidelines state that telehealth should be used "as long as telehealth is safe and clinically appropriate for the health service being provided and suitable for the patient or client" and that "not all healthcare services are appropriate for telehealth" [2]. This means that clinicians need to factor in the visit type and clinical purpose of the consultation as well as patient factors in order to determine whether telehealth is an appropriate delivery mode. To support doctors to, as AHPRA puts it, "[u]se strategies and evidence-informed practices to reflect the standard of care expected in a face-to-face consultation, as far as possible" [2], continued research into telehealth is needed, particularly regarding how it works in practice. Fortunately, the telehealth consultation lends itself to recorded interactions and the opportunity to apply established communicative research techniques, in order to investigate improvements in telehealth delivery.

4.3. Practical implications

While it is comforting to find that patients were able to contribute to the agenda in the telehealth consultations we analysed, we argue that it costs little to ask a patient if they would like to contribute through phrases such as *do you have some other concerns today* near the start of a consultation or *what questions do you have* near the end.

CRediT authorship contribution statement

Sarah J. White: Conceptualization, Investigation, Writing – original draft, Revised draft, Project administration. **Amy Nguyen:** Conceptualization, Investigation, Writing – revised draft. **John A. Cartmill:** Conceptualization, Investigation, Writing – revised draft.

Declarations of interest

None.

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