Qualitative Health Research

Strategies Used in the Pursuit of Achievability During Goal Setting in Rehabilitation

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Abstract

We used conversation analysis of six audio- and video-recorded goal setting meetings that were attended by patients and their respective treating team to explore and describe the interaction of participants during interdisciplinary goal setting, and to identify the strategies used to agree goals. The health care professionals involved in the six sessions included four physiotherapists, four occupational therapists, four nurses, one speech and language therapist, and one neuropsychologist. The participants included 3 patients with multiple sclerosis, 2 patients with spinal cord lesions, and 1 patient with stroke from an inpatient neurological rehabilitation unit. Detailed analysis revealed how the treating team shaped the meetings. The most notable finding was that there was rarely a straightforward translation of patient wishes into agreed-on written goals, with the treating team leading goal modification so that goals were achievable. Despite professional dominance, patients also influenced the course of the interaction, particularly when offering resistance to goals proposed by the treating team.

Keywords

conversation analysis; health care; health care, interprofessional perspective; health care, teamwork; rehabilitation

Goal setting is crucially important within rehabilitation, yet there is very little empirical evidence underlying its practice (Wade, 1999). The existing evidence base originates primarily from investigations into enhancing performance on tasks in the workplace, and the finding that specific, challenging goals can improve immediate performance (Locke & Latham, 2002). A recent systematic review of the evidence for the effectiveness of goal planning in rehabilitation lent some support to this finding (Levack et al., 2006). Within the rehabilitation context, goal planning is about much more than performance on a task. The process of goal setting within the overall rehabilitation plan is thought to enhance patient autonomy (Holliday, Cano, Freeman, & Playford, 2007) and interdisciplinary team work (Schut & Stam, 1994). Within the United Kingdom, patient involvement in goal setting is highly regarded at a strategic level in health care and is considered a clinical standard within the health system (Department of Health, 1997). It is generally accepted that sharing in decision making improves commitment to the decisions that are made (Gwyn & Elwyn, 1999); however, even when the will to ensure this practice is present, professionals might lack the insight needed to facilitate patients making self-determined decisions (Zoffmann, Harder, & Kirkevold, 2008).

Studies of patient participation or involvement, or collaboration between professionals and patients, have yielded the following findings: (a) therapists might be more positive about the process of collaboration than patients (McAndrew, McDermott, Vitzakovitch, Warunek, & Holm, 1999); (b) patients sometimes perceive collaboration to have occurred even when there is little evidence of it (Baker, Marshak, Rice, & Zimmerman, 2001); and (c) collaboration often involves strategies of persuasion (Karhila, Kettunen, Poskiparta, & Liimatainen, 2003), especially when participants (e.g., doctors and patients) do not share a common perception about the nature of the problem (e.g., Pilnick & Coleman, 2003). A study of professionals' perspectives revealed that rehabilitation clinicians have varying interpretations of the concept of goal, and there were varied purposes for undertaking goal planning, some of which conflicted (Levack, Dean, McPherson, & Siegert, 2006).

Previous studies of goal setting have investigated participation in relation to predetermined items (e.g., Baker et al., 2001, McAndrew et al., 1999) and generated rich data about how people experience participation (Holliday, Ballinger, & Playford, 2007; Lawler, Dowsell, Hearn, Forster, & Young, 1999; Wressle, Oberg, & Henriksson 1999), but have not attempted to answer questions about how participation happens. To better understand what influences participation within the context of what is essentially an unequally balanced relationship in health care, it is necessary to draw on studies utilizing detailed analyses of interaction (e.g., Robinson, 2003). By

looking closely at the interaction as it unfolds, it is possible to answer questions about how decisions are made between professionals and patients, and to begin to unpack the complexity and skill involved in achieving collaboration (Parry, 2004). Conversation analysis, a method for analyzing the turn-by-turn construction of meaning between parties in a conversation (Sacks, Schegloff, & Jefferson, 1974), has been favored by researchers to explore patient medical interactions and strategy use. Previous research illustrates that medical encounters are typically characterized by doctors setting the agenda and restricting patient response options (ten Have, 1991). Doctors use strategies to coimplicate patients in medically led decisions—for example, by seeking patient perspective in such a way that they can confirm it—thereby easing the delivery of unwelcome diagnoses (Maynard, 1991). Just as social conversation is constructed by all the participants, so is the medical encounter (Heritage & Maynard, 2006). Patients can be seen to utilize strategies toward clinicians, such as silence or a noncommittal response when an affirmative response is expected (Jones, 2003), hinting at issues of concern rather than stating them directly (Kettunen, Poskiparta, Liimatainen, Sjögren, & Karhila, 2001), deferring to medical judgment while at the same time using strategies to continue holding the floor (Kettunen, Poskiparta, & Gerlander, 2002), and using humor to soften the act of dissent (Mallett & Ahern, 1996). Interactions between health care professionals and patients are also influenced by the structures and systems of the health care organization itself. Professionals are accountable to their training and their organization in ways that are not transparent to the patient, and are also likely to have goals differing from those of their patients (Drew & Heritage, 1992). The pressure of time is a factor common to most health care settings, which also influences doctor–patient interactions.

The majority of the literature discussed above reported on dyadic studies, typically concerning doctors and patients. Our study broadens the evidence base by exploring interaction between and among a team of health care professionals and a patient within a rehabilitation setting. These patients entered into a meeting in which the explicit aim was to develop a series of goals. The aim of the study was to increase understanding of how a team of professionals and a patient work together to create a set of written goals during the first interdisciplinary, goal-setting meeting, and thus this study extends the work of Parry (2004), who investigated episodes of goal setting as they arose during individual treatment sessions with a clinician. Achieving this aim requires an understanding of the impact of task and topic control (ten Have, 1991), the sequential implications of turn design by clinicians, and the strategies used by all parties to achieve their objectives in the encounter; therefore, conversation analysis was selected as the research method for the study.

Method

We carried out the study at a neurological rehabilitation unit in a large metropolitan hospital in London, England, which is an 18-bed unit specializing in relatively short-stay, individually tailored rehabilitation. We collected data during the increased participation phase of a larger study, which compared interdisciplinary goal setting during two conditions: one with the patient present and participating, and one without the patient being present (Holliday, Cano, et al., 2007). The increased participation phase included a goal-setting information pack provided to the patient on admission, a key worker interview with the patient at the start of admission week, and a mid-week meeting with the key worker to prepare for an end-of-week goal-setting meeting. Key workers could be from any professional background; they adopted a representational and coordinating role.

Fourteen different members of staff participated in the study across six goal-setting meetings: 4 physiotherapists, 4 occupational therapists, 4 nurses, a speech and language therapist, and a neuropsychologist. Three of the therapists were involved in two different goal-setting meetings. Each meeting included a core team comprising the patient, a nurse, a physiotherapist, and an occupational therapist. The speech and language therapist and the neuropsychologist formed part of the team when the patient was on their caseload. Staff had been qualified for an average of 10.5 years (range 2.5 to 27 years), and had an average of 2.5 years of experience working on the rehabilitation unit (range 3 months to 9 years).

We used nonprobability quota sampling (Robson, 1993) to identify patients for inclusion in the study. The aim was to broadly reflect the case mix of the unit with regard to age, diagnosis, and gender to widen the interest of the research findings to other units with a similar case mix. Participants included 3 people with multiple sclerosis, 2 with spinal cord lesions, and 1 with stroke. This is broadly consistent with the diagnostic intake of the unit, per audit data at that time. Patients ranged in age from 33 years to 60 years, with a mean of 47 years (rehabilitation unit mean, 49 years). There were 4 women and 2 men (rehabilitation unit mean, 53% women, 47% men). Four patients were in paid employment, 1 was on long-term sick leave, and 1 was a homemaker. Two of the patients lived alone, 3 lived with a partner, and 1 lived with her parents. Patients were excluded from the study if they did not meet the criteria for inclusion in the larger, goal-setting study (significant cognitive or language difficulties), and if they had not been assigned an experienced key worker (experienced was defined as having previously key-worked one patient from admission through to discharge). Ethical approval was granted for the study by the relevant research ethics

committees at the hospital and university in London, England. All participants provided written consent to participate and for the meeting to be recorded.

Data Collection and Analysis

We recorded six goal-setting meetings using audio and video equipment. A videotape recorder and an audiotape recorder were set up at a discrete distance from the participants, and a microphone was centrally positioned on the table. The researcher set up the equipment before the patient came into the meeting and then left the room. The presence of audio and video recorders in the room posed a potential threat to validity. Participants sometimes referred to the equipment at the start of the meeting, and it is possible that the team members managed their presentation to concord with their perceptions of a good goal-setting meeting. It has been argued that research participants tend to forget the presence of recording equipment while engaged in interaction (Bottorff, 1994).

The primary transcription was made from the audio recordings, and we used the video recordings to clarify who was speaking and to identify actions important to the proceedings, such as the location of paperwork. Conversation analysis is based on an open approach to the data without predetermined expectations; therefore, the researcher repeatedly listened to and analyzed 233 minutes of recorded data. We transcribed the data using the adaptation of the standardized Jeffersonian transcription method suggested by ten Have (1991; see Appendix A for transcription conventions utilized in this article). The transcripts were scrutinized by the first author for instances of conversational phenomenon and coded to aid management of the data. When interesting phenomena were identified as being potentially part of a pattern, we completed a more thorough transcription of the relevant interaction segments and searched the corpus for other examples and deviant cases (Drew, Chatwin, & Collins, 2001). An independent researcher experienced in conversation analysis checked the accuracy of a selection of the transcripts in the early stages of interpretation of the data. He assumed a consultancy role and influenced us to ask more questions of the data; for example, to scrutinize more deeply the role that responses such as “okay” were playing in the interaction. An important issue in qualitative research is reflexivity, which refers to the impact of the researchers on the phenomenon they are investigating (Hammersley & Atkinson, 1995). Two of the authors were employed by the health care organization. The first author was a clinician on the unit, with a collegial relationship with the professionals in the study. Her insider perspective provided insight into the processes of the meeting and its place within the wider organization, but also involved a conflict of loyalty. The second author was separate from the organization, and challenged for inclusion of findings that could be perceived as critical, for example sequences in

which the talk of the professionals was particularly dominant in the interaction. The excerpts selected for publication were drawn from a huge corpus to illustrate key points as succinctly as possible. However, it is possible that this impacted on the segments of interaction selected for inclusion in the article and on the presentation of findings

Findings and Analysis

The most notable finding in the data was that there was rarely a straightforward translation of patient wishes into agreed-upon written goals. This was despite the fact that the patients had undertaken some preparation prior to the goal-setting meeting. Modification of goals was strongly led by the treating team. This was seen in two main ways: first in relation to the requirement that goals should be achievable, and second in relation to the treating team's assertion that goals should be worded in ways considered acceptable according to the quality standards of good goal setting.

Sequences of interaction concerned with achievability tended to result in change to the essence of the goal—for example the difference between walking to the shops and walking a few steps inside the house—whereas sequences concerned with quality added specific and measurable components to the goal. The findings relating to the quality of goals will be the subject of a later article. The findings presented here relate only to achievability of goals. The eight extracts that follow were selected to illustrate the strategies used by the treating team to encourage patients to accept goals that had the potential to be achieved, and strategies used by patients when resisting goals proposed and reformulated by staff.

A great deal of interactional effort was expended when the treating team felt unable to offer what the patient wanted. This was influenced to some extent by the way in which the sequence was opened. In Extract 1, the physiotherapist introduces the patient's goal on her behalf, by reading from the sheet Alice[1] has prepared with her key worker summarizing her priority goal areas. (See Appendix A for transcription conventions utilized in the article.)

Extract 1: Alice

1	PT: um and so (.2) I'm looking at number one
2	(1.4) walking and thinking that that's more (.) long
3	long (1)
4	P: yeh
5	PT: and you need a lot more (.2) trunk strength in
6	order to achieve that as a goal (1) um: but looking
7	at number two and number three (.2) are (.6)

8 more a realistic (1) um sort of goal for (.4) the
9 given the period of time that we could (.6) we
10 could work with you in hospital ⌈during this
11 P: ⌊°uh hmm°
12 PT: admission
13 (.8)
14 P: °okay°
15 (1)
16 PT: erm
17 (3)
18 KW/SLT: so getting greater trunk strength is
19 fundamental
20 (.8)
21 PT: yeh
22 KW/SLT: to all of this
23 PT: yeh absolutely um (.2) we've been standing
24 haven't we
25 PT: yeh
26 PT: um (.4) having experienced standing and how
27 (.8) much trunk control you need to stand at
28 present (1.2) I think we just really need to focus
29 on your trunk (1.2) on your bottom and get
30 you a lot more a lot stronger ⌈in your seated
31 P: ⌊yeh
32 PT: positions before we (.4) sort of um (.4) delve
33 into (1) getting you up (.2) more
34 (.4)
35 PT: °okay°

PT = physiotherapist; P = patient; KW = key worker; SLT = speech and language therapist

By opening the sequence the physiotherapist is required to construct her argument without first hearing how strongly Alice presents her aim. Through her pause before "walking" (line 2) she signals to Alice that her goal might be problematic and suggests that it is a goal for the longer term (lines 2-3). In lines 7-9 she frames her prognosis around the goals for this admission, restricting the discussion to "what we can do for you here" and avoiding a more tricky, long-term prognostic discussion. References to a time frame for potential change appear to function both to soften unwelcome news and to enable the discussion to move forward without compromise. The physiotherapist indicates by implication that Alice's goal to walk is not realistic, through reference to priority areas two and three (line 11), which are judged to be realistic. Alice gives a minimal response (line 21), and the long pause (line 24) following the physiotherapist's filler. "erm." communicates a trouble spot to all present. Although the patient has not been specifically selected as the next speaker, her nonresponse is open to interpretation as dissent. The key worker helps the interaction over a hurdle by reframing Alice's aim to walk in relation to trunk strength (lines 25-27). The physiotherapist then proceeds with more confidence. She presents her clinical reasoning in a manner that is designed to elicit agreement (line 32), coimplicating Alice in acceptance of a potentially unpalatable,

reformulated goal (Maynard, 1991). Alice does not respond to the reformulated goal (line 48) and the sequence is concluded with a quiet "okay" (line 49) from the physiotherapist, which could be seen as an acknowledgement of her dissent. Alice's goal to walk has been significantly downgraded to a goal around transfers. However, Alice has not been as passive as she might at first appear, because her nonresponse or minimal response formats have resulted in a great deal of interactional work by the treating team in communicating their clinical reasoning for the downgraded goal.

Extract 2 illustrates a very different sequence of interaction, when the treating team considers a patient goal to be achievable.

Extract 2: Veronica

1	P: well I .hh I mean I wrote walking 'cos it was
2	(heh) it was o(h)n the list it doesn't seem
3	re(h)a. I mean I mean it's fairly obvious I mean
4	.hh
5	KW/PT: >yeh<
6	P: that I want to be walking yeh
7	KW/PT: okay=
8	P: =um eventually
9	KW/PT: yeh ⌈so
10	P: ⌊an. (.) sorry go ⌈on
11	KW/PT: ⌊shall we shall we pick that one just
12	to st⌈art off with and then
13	P: ⌊uhhmm
14	PT: we'll move on to the other ones in that
15	category

In this extract, the patient introduced her goal and held the preprepared documentation summarizing her goal priorities. Occupying the first position presents both an opportunity and a challenge. She is able to influence the next speaker's discursive choices, but she orients to a requirement to present her wishes in a manner that is commensurate with what the organization can provide, and that does not make her look unreasonable. She constructs her turn in a very tentative manner (lines 1-6): she describes her aim to walk as being both obvious and unrealistic, her speech is hesitant, and she uses devices to distance herself from her words. These devices include laughter and implicating the organization itself through reference to walking as being one of the items on the list provided to her (line 3). The key worker responds without hesitation, indicating that this is not a problematic goal and promptly accepts it as a topic for discussion (lines 15-17). Here we can see that it is not only the treating team

that orients to achievability when setting goals, as Veronica seems to construct her turn with regard to achievability to save face (Goffman, as cited in Hutchby & Wooffit, 1998).

This desire to show oneself as a reasonable patient is also seen in Extract 3: Jerry presents quite a strong indication of his dissatisfaction with the proposed goal, which is to walk outdoors with sticks. At the same time, he uses strategies to indicate that he knows what is expected of him as a patient.

Extract 3: Jerry

PT: to walk (.2) I've I've still put (.) to walk
outdoors with 2 sticks (.2) with improved (.2)
posture and (.2) improved confidence in your
mobility and balance
(2.2)
P: er (.4) I'd really like to push it yeah I know I
I
⌈can disagree
PT: ⌊you you can
P: as much ⌈as I want until
PT: ⌊yeh
P: I'm sick but=
PT: =you can over achieve
P: The real⌈ity
PT: ⌊you can over achieve
P: Yeh
OT: you can do ⌈better
PT: ⌊I'm trying to sort of think=
P: =yeh ok think pos think think realistically=
PT: =yeh
P: yeh (.) yeh
PT: I mean the the whole point of us (.2)
setting
goals i i it's something to work to it's
something
that should challenge you (.2) but it should
they
should (.2) be
P: yeah
PT: realistic⌈ (.2) as well
P: ⌊realistic (.) yeh I can appreciate that °I
can appreciate that° you're the professionals
its
just er

[Over the subsequent 18 turns the physiotherapist presents her clinical reasoning for why walking outdoors is problematic.]

PT: I won't stop (.2) ⌈working when ⌈we get to
P: ⌊yeh ⌊no
PT: this (.6) you ⌈know

33 P: ⌊yeh yeh
34 PT: if we got to this level at the end of next
35 week I won't say right you've achieved ⌈that's it
36 you
37 KW/PY: ⌊no
38 P: ⌊yeh
39 PT: know we'll=
40 P: =yeh (.2) ⌈no I appreciate
41 KW/PY: ⌊what does it say to have improved
42 PT: bed mobility

OT = occupational therapist; NP = neuropsychologist

The treating team uses strategies to indicate that the goal is essentially nonnegotiable. First, the goal is presented in its final written form: "I've still put" (lines 1-2). Writing down a goal acted as an important marker in the discourse of the goal-setting meetings, typically signaling that agreement had been reached. Second, it is suggested that the goal can be overachieved (lines 15, 17, 20). This is a strategy that presents the patient with only two choices: accept the goal as it is, or go beyond it and prove the team wrong. Jerry understands that there is no possibility of reformulating the goal and asserts his dissent in a manner that recognizes the futility of it: "until I'm sick" (lines 12-14). He presents himself as a competent patient by referring to the expectation that goals should be realistic (lines 24, 36). He also orients to his position as the person without the knowledge: "you're the professionals." Although there is essentially no compromise, the physiotherapist recognizes the distance between Jerry's aim and the agreed-upon goal, and later in the discourse assures him that she will keep his aim in mind (lines 41-44**]**). The key worker then closes the discussion by moving onto the next topic (lines 54-55).

There was only one example in the full corpus of data of a patient achieving substantial change to the core content of a goal. In Extract 4, the patient indicates that a proposed goal concerning supervised toilet use is impractical because she is alone in the day and her mother, who lives upstairs, is unable to help. The difficulty is swiftly resolved by the intervention of the physiotherapist, who asserts that the goal can be upgraded without impacting on its achievability (lines 3-4). The key worker immediately accepts the reformulation, moving directly to write down the goal (lines 5-8).

Extract 4: Evelyn

1 P: =no she just can't lift ⌈me
2 PT: ⌊I think we should be able ⌈to
3 KW/OT: ⌊yeh (.) yeh be able to get on and off
4 the toilet and pull up my lower garments

5 *(writing)*
6 P: yeh
7 KW/OT: independently

It was more common for the treating team to respond to patient initiatives for reformulation by presenting uni- or multiprofessional justifications for keeping the goal unchanged. Extract 5 illustrates this. The extracted sequence followed a sequence in which the occupational therapist was encouraging the patient to use the bus independently.

Extract 5: Audrey

1 KW/PT: shall I put (.4) I'll put accessing local
2 facilities (1) independently
3 P: mm ((skeptical tone))
4 OT: or d: (.2) is that not what you want to do
5 KW/PT: how d'you feel what d'you ⌈feel
6 P: ⌊maybe to go with someone not by mys:
7 (.2) not by myself initially
8 KW/PT: hmm yeh I mean if you want to make
9 this this would be a lo:ng term goal so we
10 won't say (.4) on Monday okay here's a bus
11 ticket ⌈go on
12 OT: ⌊yeh go no
13 KW/PT: the bus but that over the next two
14 weeks we would work towards you being
able
15 to get on and off the ⌈bus on
16 P: ⌊yeah
17 KW/PT: your own so that (.2) would mean
18 you could access the facilities on your own
19 when you get home yeh
20 P: yeah
21 OT: because I mean if you want to go to the
22 gym then you're gonna have to wait for a
23 friend to come go to the gym with you
24 P: but that what I've been doing
25 OT: yeah (.)so that
26 P: so (.2) I have to break out of of that
pattern
27 KW/PT: uh hmm
28 P: yeah
29 (5)
30 KW/PT: okay so I've put accessing local
31 facilities independently using public transport
32 P: uh hmm ((skeptical tone))
33 KW/PT: ok
34 ( )
35 KW/PT: so we're on to the next priority card
36 which was looking after yourself

Audrey's dissent (line 4 **[**) immediately follows the key worker's statement that she is about to write something down: "I'll put" (lines1-2). The timing is important, as once committed to paper goals were seldom reformulated. The minimal response format she selects powerfully but temporarily derails the process of goal acceptance. The occupational therapist and the key worker collaboratively rationalize the goal (lines 12-33), and the occupational therapist appeals to the real-life world of the patient (lines 29-33), who initially resists ("but that's what I've been doing"; lines 34-35), but later orients to the expectation that as a patient it is her duty to try to get better (Stivers, 2005): "I have to break out of that pattern" (lines 37-38). The key worker takes Audrey's voicing of perspective as assent and moves on to the next topic (lines 49-51).

Despite the interactional difficulties presented, patients can be quite persistent in indicating their resistance to goals they do not think they are able to achieve. In the following sequence, Evelyn makes three different attempts to communicate her skepticism about a goal to incorporate her right arm more in activities. Prior to this sequence, Evelyn agreed to the first part of the goal, which was to prepare light snacks and hot drinks; however, the requirement that she do this using her hemiplegic arm had not previously been discussed.

Extract 6.1: Evelyn

1	KW/OT: so maybe we could put it (.2) able to
2	(2.8) m.make prepare=
3	PT: =hmm=
4	KW/OT: =light snacks
5	P: yeh
6	(1)
7	KW/OT: and hot drinks
8	(1)
9	SN:( )
10	*(gestures right hand movement)*
11	KW/OT: yes (.6) incorporating that I think
12	(.6) the right hand
13	P: heh
14	SN: you can forget it (heh)
15	KW/OT: yeh (heh)
16	PT: able to >prepare light snacks and hot
17	drinks using both hands<
18	KW/OT: <u>yes</u>
19	P: heh heh
20	KW/OT: very good (.) <u>very</u> <u>very</u> good
21	P: heh heh

SN = staff nurse

The team introduces the use of both hands as a component of the goal (lines 11-15). Their collaborative approach communicates to Evelyn their commitment to this aspect of the goal, which is reinforced by strong evaluative language in lines 24-25, and by the way the physiotherapist utilizes the language in which the agreed-upon goal will appear in print when she summarizes the preceding talk (lines 19-21). Collaborative formulations allows the treating team to indicate both to each other and to the patient that they will fight for the goal. They present a strongly unified message that patients have to work hard to resist. Evelyn indicates her dissent through laughter (lines 16, 23, 26). Her dissent is acknowledged through the shared joking and laughter of the team (lines 17-18), but the goal remains unchanged. Ten minutes further into the discussion, the physiotherapist reintroduces Evelyn's right arm as a topic:

Extract 6.2: Evelyn

1	PT: um (1.6) I think probably you'll have a
2	little bit of help to keep your right hand on the
3	frame (.4) with ↑assistance
4	*(dictating to KW, who is writing)*
5	(4)
6	P: yeh
7	PT: to keep my right hand
8	P: yeh
9	(.6)
10	PT: on ⌈my
11	P: ⌊it was really hard (.2) to keep it on my (.2)
12	on my (.4) right hand it just
13	PT: pulls up
14	P: comes away
15	(2)
16	PT: and my right <u>hip</u> (.6) forwards (.4) rather
17	than back

On this occasion, Evelyn verbalizes the difficulty she experiences in keeping her right hand on the frame (lines 14-17). The physiotherapist acknowledges the nature of the difficulty (line 18), but does not accept it as a topic for discussion and continues with the next component of the goal. Evelyn has a final opportunity to indicate her resistance 7 minutes later. Here, the key worker adopts an emphatic tone to encourage her to accept the use of her right arm in activity as a goal:

Extract 6.3: Evelyn

1	KW/OT: incorporating some standing but
2	<u>definitely</u> (.) <u>definitely</u> *(emphatic gesture with*
3	*hands)* incorporating that right hand as much

as
we can *(gazes at PT)*
(1)
(Evelyn is out of shot of video—researcher unable
to see facial expression)
KW/OT: heh heh I⌈knew Evelyn
SN: ⌊( )
KW/OT: was going to raise her eyebrows
KW/OT: does that sound
P: mm
KW/OT: what d'you think .hh
(.6)
P: um (1) well if it works
SN: ( )
KW/OT: heh heh
P: I'm not sure that's gonna happen but
KW/OT: as much at maybe starting to
incorporate it a bit because at the moment
(1) you are <u>just</u> (.6) <u>not</u> (.4) you're just not
even (.) paying attention to it within tasks
P: cause its ea⌈sier or it
KW/OT: ⌊I KNOW it is
P: was ⌈it was easier to
KW/OT: ⌊I <u>know</u> I know
P: to use all this side

The key worker makes a very strong assertion of what is expected of her ("definitely"; lines 2-3), which, surmising from the comment in lines 11-14, Evelyn apparently resists nonverbally (lines 8-10). When Evelyn's response is first sought (line 15) she gives a minimal response ("mm"; line 16), then reasserts her skepticism (line 19) when her opinion is directly requested (line 17), again using a stronger formulation in lines 22-23. The outcome of this sequence on the agreed-upon goal is a modification by her key worker: "maybe starting to incorporate it a bit." She continues with a judgment of how Evelyn is failing to perform in the manner expected (lines 26-30**]**), and when Evelyn explains her reasoning in terms of ease (line 31), her key worker concludes using the powerful professional voice (line 32). The essence of this final line in the data does not transcribe easily, but might reasonably represent a shortened version of, "I know it's easier for you but you won't improve if you don't challenge yourself" (researcher's interpretation).

Discussion

This study demonstrates that the process of setting goals collaboratively between patients and professionals is complex and can be challenging. Both patients and members of the treating team demonstrated an orientation to the maxim that goals should be achievable. For the treating team, this arose out of their professional judgment as to

what they were able to deliver within the context of a defined period of inpatient rehabilitation, and it was a fairly stable feature that was common to all recordings. The treating team used six key strategies to ensure that goals were achievable:

1. Framing a goal around the admission rather than the long term, thus enabling modification of a goal without denying the possibility of its eventual achievement, and also softening unwelcome news and enabling the discussion to move forward
2. Presenting information in a step-wise fashion, designed to elicit agreement; thus, patients demonstrating resistance are complicated in acceptance of the goal and the team are able to progress quickly through the business of the meeting
3. Indicating that the goal is essentially nonnegotiable; for example, by writing down the goal, or by indicating that if the therapist's assessment of what is achievable is wrong, the patient can exceed the performance level specified in the goal
4. Collaborating with other team members to formulate the goals to indicate both to each other and to the patient that they will fight for the goal
5. Using the authority implicit in the professional role
6. Moving on to the next goal, despite signs of patient resistance—thus closing down a difficult discussion and preventing further challenges

There were two significant ways in which patients demonstrated concerns with achievability: first when attempting to resist goals for which they lacked self-efficacy, and second, when moderating requests for ambitious goals they suspected might be considered unrealistic by the treating team. Patients expressed these using minimal responses or nonresponses, and used face-saving devices such as humor to raise potentially conflicting perspectives. Patient goals deemed unachievable by the treating team were never agreed upon; however, expressions of dissent by patients were seen to influence the interaction in two main ways: by stimulating the provision of clinical reasoning, and less frequently, by achieving very minor modifications to the goal. Patients also demonstrated influence on the interaction by maintaining control of the premeeting documentation and by directly raising practical difficulties with proposed goals. The following discussion is structured around professional and patient influences on the interaction, with a foreword on participation in goal setting.

Participation in Goal Setting

This research was undertaken during the increased participation phase of a larger goal-setting project; however, the sequences of talk presented demonstrate that the concept of participation is actually rather loose. Although the very act of holding the meeting represented a kind of participation when contrasted with the usual practice of goal setting in the rehabilitation unit, patients' physical presence did not necessarily influence the end-point goals. Gwyn and Elwyn (1999) argued that professional expertise will inevitably override patient choices in circumstances in which the doctor considers the patient's preferences to be counter to her or his own best interests. Patients themselves expect professionals to exercise their medical expertise, and recognize the disparity with their own knowledge as being the reason they are seeking help (Heath, 1992). Patient presence, though, did result in increased dialogue about goals and required the treating team to explain their clinical reasoning for proposed goals, which might have been of benefit to patients in their later treatment.

Professional Influences on the Interaction

The finding that professionals expended a great deal of interactional effort on goal reformulation is consistent with Parry's research (2004). Most notably, the treating team never agreed to goals they did not consider achievable within the time frame of the admission. The treating team remained oriented to the participation agenda and used strategies to reframe goals in such a way that maintained the appearance of shared decision making (Maynard, 1991). However, the professional need for achievability took precedence over mutuality, reinforcing the asymmetrical relationship. Strategies in pursuit of this professional agenda included reference to the time frame for intervention, the offer of overachieving as a possibility, the use of language indicating that agreement had been reached, and collaborative work among the treating team to communicate their position as a cohesive unit (Sacks, 1992) in support of the proposed goal. Patients were seen to orient to power differential directly in their language; for example, Jerry, in Extract 3: "you're the professionals." This is consistent with much of the literature in the field of patient–care provider interaction (e.g., ten Have, 1991). On occasions on which patients questioned their ability to undertake a goal, the usual response was for the professional to use persuasive strategies (Karhila et al., 2003) to pursue the goal in an unchanged format.

Control of topic was typically professionally led, with transition from discussion of one goal to the next always initiated by a member of the treating team. This occurred as working through the agenda of the meeting, but it was sometimes used more strategically as a means of communicating to a patient that the discussion was closed

and agreement was considered to have been reached. Professionals also attempted to discourage further discussion by presenting goals as if they were already agreed upon, and this was achieved via the interplay between what was being said and what was being written.

An additional method for control of topic was the handling of the premeeting documentation. The patient normally entered the room carrying this documentation, and the key worker usually took physical control of it during the meeting, leading the patient through the priority areas. This can be illustrated by contrasting Extract one with Extract two. In Extract one, the professional introduced the topic, placing the patient in the position of responding to the professional reformulation of her goal. In Extract two, Veronica retained control of the documentation and was the one to introduce the goal. She did so in a way that communicated to the team that she was open to reformulation. In the latter approach, the patient is more explicitly implicated in the outcome of the interaction, and the team enters into the discussion with increased knowledge of the patient perspective. It has been previously reported in the literature that by opening the sequence (taking the first position) the professional is in an advantaged position because she or he can control the response options for the person in the second position (Jones, 2003). These findings indicate that it might be mutually beneficial in a goal-setting meeting for the patient to have control of topic.

Patient Influences on the Interaction

There was evidence that the patients were aware that there was an imbalance of power within the interaction (Heath, 1992). They were seen to act in accordance with what they considered to be acceptable behavior within a patient–care professional encounter; for example (a) agreeing that one is in an unhelpful patient pattern that one needs to break out of; (b) orienting to the expectation that patients should make changes to their behavior in the pursuit of getting better (Pilnick & Coleman, 2003); (c) using linguistic and paralinguistic features to communicate preparedness for rejection; (d) presenting oneself as a reasonable patient by deferring to professional expertise; and (e) sharing the language of the treating team.

The most notable strategies used by patients to actively shape the interaction were devices signaling resistance. It was uncommon for patients to communicate their dissatisfaction with goals proposed by the treating team using direct language, although this did occur. It was much more usual for dissent to be communicated indirectly through minimal responses and through humor. Minimal response formats were common in the data, and their purpose was often simply to signal that the speaker had been heard or to show that agreement had been

reached. However, minimal responses were also interpreted as communicating dissent, and this occurred when the response was uttered quietly or in a skeptical manner, or when there was no response at all at a point when one was expected—referred to here as negative minimal responses. On these occasions the minimal response was often quite powerful in the interaction. The most notable effect of a negative minimal response was that it often resulted in further dialogue. This enriched the discourse through the provision of explanations and clinical reasoning by members of the treating team. It is important to note, however, that the treating team did not always allow a negative minimal response to influence the course of the discussion.

Patients sometimes used laughter when they were communicating a potentially conflicting perspective, using it as a face-saving device to communicate resistance to the proposed goal in a nonchallenging way. Mallet and Ahern (1996) suggested that using humor in this way increases the social acceptability as well as the efficiency of the act of disagreeing. Resistance might have been acknowledged by the treating team; however, the treating team continued to push forward through the goal-setting agenda, making only minimal concessions. There was evidence, however, to suggest that the treating team did remain conscious of patient power messages throughout the discourse, and this might extend beyond the goal-setting meeting into subsequent treatment sessions. Further research might help determine whether these areas of contention are revisited in subsequent conversations outside of the meeting.

In summary, in accordance with recent research (e.g., Kettunen et al., 2002), these patients were active participants in the interaction despite the constraints imposed by the medical context. However, the professionals retained a dominant voice throughout the interaction and the choices they made in their talk directly impacted on the options available to patients for subsequent discourse.

Limitations

The main limitation of this study is its small, localized scale, which makes it difficult to make generalizations beyond this particular rehabilitation unit, and indeed, findings might only be relevant to this particular set of participants. The status of the first author as a clinician on the unit is likely to have resulted in some bias in the selection of sections of the transcripts considered worthy of further exploration, and will have impacted on her openness to the data. Future research in the area could be strengthened by distancing the researcher from the setting observed. Finally, a criticism that has been leveled at conversation analysis is that the methodology requires a large amount of attention to be focused on local context at a potential cost in terms of appreciating the wider context (Wodak, 1996). Different findings might have been generated if goal-review meetings occurring at a later stage of

the patients' stay on the unit had been selected. Later goal-setting meetings might be characterized by a reduction in asymmetry as a consequence of patients acquiring familiarity with the process and the goal-setting language (Pilnick & Coleman, 2003).

Clinical Implications

Findings of the current study increase our understanding of precisely how decisions were being made within the increased-participation phase of the larger study (Holliday, Cano, et al., 2007), and make explicit the strategies used by participants during the interaction. Professionals within the rehabilitation team received some training in the processes of the two goal-setting conditions; however, the current study suggests that a deeper level of training is required to increase understanding of how the decision-making environment is actively created by the strategies used by all the participants in the meeting (Heritage & Maynard, 2006). Professional training might involve reflecting on the extent of participation that is being sought, means of sharing topic control such as ownership of the premeeting documentation, means of equalizing knowledge, and discussion regarding circumstances in which professionals might agree to goals they do not consider to be achievable. Recent research also suggests that professionals might benefit from developing a team consensus on the interpretation of the concept of goals in rehabilitation and their purpose (Levack, Dean, et al., 2006).

The richest opportunity for adjusting the balance of power in the interaction might arise out of understanding what is happening on the patient side of the table. Of particular interest are the strategies used to communicate resistance. Patients were very skilled at dissenting in nonconfrontational ways, and it was clear that subsequent interaction was influenced by the strategies they used. It would be beneficial for professionals to learn how to recognize these as they occur; for example, Alice's minimal response in Extract 1 (line 21) could be treated as an opportunity to directly seek her perspective, which might result in stronger commitment to the rehabilitation plan.

In addition to training professional staff, it would be beneficial for the rehabilitation unit to investigate ways of educating patients in how to achieve their objectives within the goal-setting meeting. This is a more complex area, as patients come to goal setting with varied experiences of both illness and the concept of goal setting (Holliday, Ballinger, et al., 2007), as well as different levels of expectation (and desire) for being involved in decisions about their care (Robinson, 2003). However, there is scope for patients to receive more specific preparation via the premeeting documentation and key worker discussions.

Implications for Future Research

A number of areas for future research have arisen out of the current study. These include exploring:

- The impact of goals that are agreed upon, despite patient resistance (particularly goal achievement, clinical reasoning during treatment sessions, and patients' perceptions of ownership);
- The impact of self-efficacy and risk taking in relation to goal achievement;
- The control of the premeeting documentation by the patient or treating team, and the impact on subsequent interactions as well as patient perceptions of control and involvement;
- The impact of later data collection during admission on patient and treating-team participation;
- The participants' nonverbal communication observed in video-recorded data to reveal more of the strategies used by participants during the discussion (particularly at contentious points).

The above possibilities sit within a broader framework of research priorities for goal setting in rehabilitation. A recent conference report (Playford, Siegert, Levack, & Freeman, 2009) highlighted that experts in the field are still seeking answers to fundamental questions, such as what the components of goal setting actually are. Constructs in this field are clearly still in their developmental stage, and there is a role for further exploratory work.

Concluding Remarks

In this article we have attempted to unravel some of the complexities involved in a decision-making activity involving multiple participants. We have shown that the talk of all participants influenced the outcomes of the goal-setting meeting, although the interaction was heavily shaped by professional influences. Participants were not confined to playing predetermined roles within the interaction, and there is the potential to use this information to create a decision-making environment that reflects the values of the organization. Both staff training and patient education are implicated to achieve authentic participation of all participants.

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1. All participant names are pseudonyms.

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Appendix A

Transcription Conventions

(1.2)	Intervals in the stream and between utterances of talk in tenths of a second
(.)	Short untimed utterance
underline	Emphasized word
LOUD	Word/s spoken louder than surrounding talk
°quiet°	Word/s spoken more quietly than surrounding talk
>quick<	Word/s spoken faster than surrounding talk
⌈	The point where the talk of a speaker is overlapped by the subsequent speaker
⌊	The point where the subsequent speaker commenced overlap
	(Note: The end point of the overlap was not transcribed to avoid interfering with the fluidity of the written text for the reader)
=	Where there was no interval between adjacent utterances
.hh	Audible inspiration
((whispered))	Characteristics of the mode of delivery
(actions)	Physical actions observed on videotape
( )	Utterances which were undecipherable by the transcriber
(unsure)	Utterances of which the transcription was in doubt
(heh)	Laughter between words or utterances
ta(h)ble	Laughter with a word
:	Extension of sound or syllable
↑	Marked rising intonation immediately prior to the rise
cle.	Word cut short