Risk talk: rhetorical strategies in consultations on hormone replacement therapy

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Abstract When analysing risk discussions in medical settings it is important to consider the specific activity type. In this qualitative study 20 first-time consultations by healthy women regarding hormone replacement therapy (HRT) in the menopause the risk discussion is asymmetrical with the doctors dominating. Despite being set up as a specific opportunity for women in the menopause to discuss problems and risks, it comes forth as a decision-making activity in a traditional medical setting. The consultations fulfil to a high extent the demands for informed decision making, but the risk discussions are recontextualised into a cost-benefit discourse with a typical implicit quantitative bias. The doctors use several different rhetorical strategies such as positive introduction of HRT, embedding drawbacks in positive introductions and/or exits thereby diminishing them. The word risk is avoided to a considerable extent and the term ‘drawbacks’ is used instead. The most obvious strategy is to move from the woman’s symptoms to aspects of prevention, thus changing the discussion from the menopause and different strategies to cope with menopausal problems into a medically oriented discussion of pharmacological treatment alternatives. The ‘change of life’ in these talks is entirely conceptualised within a ‘medical model’.

Key words: risk, communication, menopause, hormone replacement therapy, physician-patient relations

Introduction

Explicit and implicit orientation to risk in medical contexts

There are many complexities in risk talk in medical contexts. To these belong the discrepancies between risk as individually perceived, and risk as understood as a statistical concept when seen from a professional epidemiological point-of-view, Lupton (1999) and Reventlow et al. (2001). Experts have access to sophisticated information of the latter kind, but
it is clients who must make sense of it and act upon it within their lives. Risks can be talked about more or less directly and explicitly, or indirectly and implicitly. Operationally, explicit talk can be defined as the use of the word ‘risk’ (plus its compounds, such as ‘risk factor’, ‘risk organ’, ‘cancer risk’, etc.) and/or talk about probabilities, i.e. incidences talked about as increasing or decreasing, in the most explicit cases with numerical specifications. Linell et al. (2002) used data from five medical contexts when dealing with the socio-pragmatic variation in the discursive management of ‘risks’ in medical talk: genetic information talks, health information talks (about high cholesterol values), booking interviews in maternal health care, medical testing situations during pregnancy (midwives), and talk between nurses and patient during urography and kidney radiography. The present paper is in some ways a continuation of the research presented in Linell et al. (2002).

According to Linell et al. explicitness vs. implicitness in talk about risk can be related to at least seven different factors, see Table 1.

In addition, there are of course other factors, including the ideological difference between a traditional, paternalistic bio-medical model and the philosophy of partnered care that implies informed decision-making.

Just like talk in other institutional or mundane settings, risk talk in medical contexts varies with the activity types involved Linell et al. (2002 op. cit.). As for the notion of ‘activity type’, we draw upon characterisations by Levinson (1979), Sarangi (2000), and others; an activity type is a special kind of encounter designed to solve particular communicative problems in particular ways. In the present paper, we are concerned with an activity type which we will call ‘hormone replacement therapy (HRT) talks’. These are special appointments between gynaecologists and women in the menopause, in which HRT is to be discussed and decisions on therapy possibly taken. However, as we will see, parties entertain goals and perspectives that are only partially shared.

With regard to risk talk, these information- and advice-giving talks about menopausal symptoms and hormone replacement therapy are interesting on several counts. First and foremost, they concern a trade-off situation involving risks of two kinds, risks associated with

<table>
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<th>Explicitness is probable if:</th>
<th>The place of the risk talk within the whole activity type (encounter): Are risks predetermined agenda points?</th>
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<td>The medical status of the individual patient: Is (s)he at ‘high risk’ or not?</td>
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<td>The patient’s distance in time from the potential negative outcome (and distance from the medical intervention)</td>
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<td>The patient’s responsibility for decision and risk reduction</td>
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<td>Professionals’ responsibilities and entitlements with regard to determining and communicating (individual) risk</td>
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<td>The time frame of the talk exchange (consultation) itself</td>
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<td>The topic of risks is an agenda point rather than something which is more incidentally brought up</td>
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<td>The individual patient is known to be at high risk</td>
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<td>The patient is in the process of being informed rather than already being under medical treatment</td>
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<td>Patients can, in and through their own conduct (lifestyle), influence future risks</td>
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<td></td>
<td>The professional has the legitimised right to issue medical (predictive or diagnostic) information</td>
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<td>Plenty of time available</td>
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Table 1. According to Linell et al. (2002) analysis of the socio-pragmatic variation in the discursive management of ‘risks’ in medical talk led to a number of tentative hypotheses claiming that explicitness vs. implicitness in talk about risk can be related to at least seven different factors. Implicitness or avoidance are chosen as professional strategies in cases where the opposite conditions to explicitness are at hand.
the menopause and risks related to the therapy as such. Secondly, they are first-time visits on this subject by women, who, compared to the average patient, are well informed about the medical subject. As such, they represent a rare situation in Swedish public health care with comparatively rich opportunities for an expanded risk discussion.

The complexity of the situation will call for analysis of both social-communicative aspects of framing (of the activity) and types of cognitive framings (parties’ understandings of problems discussed). Against this background we will particularly focus on doctors’ rhetorical strategies.

Data corpus

Our corpus of data consists of 20 HRT talks, collected at three different outpatient clinics of gynaecology in Sweden in 1999–2000. Twenty-one women, aged 45–59 years, were consecutively identified through manual search of the appointment lists for five gynaecologists (two male, three female) who agreed to participate in the study. The physicians were selected through convenience sampling and were informed about the research objective of studying risk discussions but were asked to use their usual strategy. Women who had a scheduled consultation for a first-time visit for discussion of climacteric discomfort and/or HRT were identified consecutively and invited by letter to participate in a study about risk communication. Before the consultation, the study was explained and the patient’s consent was asked for. The study protocol was reviewed and approved by a local ethics committee. The consultations were audio taped, except during the gynaecological examination. They were then transcribed in a broad transcription format capturing pauses and listener support items. Three investigators then validated the transcriptions independently. The total audio taped speaking time varied between 15 and 25 min, with two exceptions lasting 32 and 43 min respectively. The original spoken data are Swedish, and our analyses reported here and elsewhere were carried out on the originals (which are available from the authors). Here, we present data in approximate English translations, and our discussion refers to points in the translated data.

In all, 26 women were contacted. One woman declined to participate. Four of the women who were willing to participate could not participate since a suitable time for the consultation, including audio taping and interview, could not be arranged. One consultation could not be analysed due to technical reasons. The remaining 20 HRT talks constitute our data corpus. One of the included women had tried HRT for a short period during a blind clinical trial 3 years before the consultation.

As we noted above, the talks may topicalise two kinds of risks:

1. risks associated with the menopause, i.e. (increased) risks of future diseases and inconveniences facing women during, or as a sequel to, the menopause, e.g.: cardiovascular disease (increased risk of myocardial infarction and/or stroke), osteoporosis (increased risk of fractures, especially of the cervical spine and the femoral neck), and inconveniences such as flushes and vaginal dryness.

2. risks induced or increased through the medical treatment (HRT) itself: e.g. increased risk of breast cancer and deep venous thrombosis.

Results

HRT talks as an activity type

It is an empirical issue to explore the actual enactment of any activity type. In this section, only a few findings will be reported, which we will then use as a background for our main focus, the rhetorical strategies used in HRT talks.
The general phase structure of the HRT talks in our corpus is as follows:

1. Gynaecological history taking.
2. Introduction of HRT as a treatment option.
3. Discussion of risks, costs and benefits with treatment options.
4. Gynaecological examination.
5. Closing (in which every patient gets a prescription of HRT).

However, the chronology of the different phases varies slightly between the consultations and this is further analysed in Hoffmann et al. (2002b). The first and second phases start out with the woman’s current menopausal problems. However, the third phase, which will provide us with most of the excerpts in this paper and which is also the core phase of the encounter, is geared more to long-term medical problems and is dominated by the doctor’s information giving and recommendations, with some questions asked by (some) patients.

Although the HRT talk, as an activity type, is a ‘risk context’ (in the sense that risks are explicitly talked about and that risks are a main agenda point), the word ‘risk’ itself, or in compounds such as ‘risk factor’, is avoided to a considerable extent. The word ‘risk’ plus its compounds is used 102 times in a physician/patient ratio of 12:1, or in average five times per consultation. Instead, the discourse tends to be about ‘benefits’ (‘advantages’) (i.e. reducing risks associated with the menopause) vs. ‘drawbacks’ (or ‘disadvantages’) (i.e. risks induced by taking HRT) (see below for a discussion of the word choices). When the word ‘risk’ is actually used, it is about risks with HRT, where it alternates with ‘drawbacks’.

With respect to which aspects are topicalised, Hoffmann et al. (2002a) discussed four possible ways of talking about risks in patient–physician encounters of the HRT type: discussion of (only) risks associated with (only) one treatment alternative in isolation (‘assigned risk’); the same but discussed with regard to possible benefits (‘balanced risk’); discussion of risks associated with two or several alternatives (‘compared risk’); and finally, risks associated with several alternatives and discussed with regard to possible benefits (‘risk difference’). In addition, there might of course be a total lack of risk discussion. In actual fact, the consultations turned out to fall into three categories:

- Encounters without discussion of risks with HRT ($n = 2$).
- Encounters with discussion of benefits/risks with only HRT ($n = 14$), balanced risk.
- Encounters with discussion of benefits/risks with several therapy options, including HRT ($n = 4$), risk difference.

The encounters tend to focus on medication. There are only four cases (4/20) in which alternatives to pharmacological treatment (e.g. lifestyle-related options such as diet and physical exercise) are introduced and/or discussed. The activity type therefore appears to be quite biased. There is a premise in the very positive attitude to pharmacological treatment (HRT), i.e. the presumption is that HRT is the self-evident (as it were, only) option. This may also explain why explicit risk talk turns out to be completely avoided in two cases (2/20); the desirability of HRT is simply taken for granted. Indeed, HRT is introduced (in 19/20 cases) by the physician, and most often, in positive terms at an early stage of the talk (phase 2), i.e. before risks, drawbacks and benefits have been discussed at all. On the whole, the decision-making process is strongly governed by the physicians.

Doctor–patient interactions in general are, just like most other institutional talk activity types, relatively asymmetrical. In Linell’s (1990) terms, doctors dominate strategically (structuring the encounter, initiating and concluding all the phases and most of the topics/episodes), tactically (governing interaction and topic progression on the turn-to-turn level),
and quantitatively (talking more in terms of number of words). The HRT talks are also dominated by expert talk by the doctors, which, in Foucaultian terms, subordinates other discourses. But there are also some moments of resistance, such as women avoiding being totally subjected to surveillance. In fact, the talks score high in the terms of the criteria for patient–centredness developed by Braddock III et al. (1999) for determining the involvement of patients in consultation talk; patients are given slots for talk, and some utilise these slots, patients’ concerns are taken up and seriously responded to, etc. In this sense, the talks are therefore relatively patient–centred, despite the professionals’ above-mentioned dominance.

Rhetorical strategies

The HRT talks can be adequately characterised in terms of what we will call ‘rhetorical strategies’. These can be understood as recurrent patterns of argumentation, largely controlled by the doctors, which constitute solutions to the communicative tasks and dilemmas involved in dealing with risks of the two types and in advising women to take HRT. We will discuss eight such strategies, using data and excerpts primarily from the risk discussion phase (phase 3).

1. Recontextualising risks in terms of drawbacks and benefits.
2. Simplifying calculations.
3. Embedding drawbacks in positive environments.
4. Asking for the patient’s perspective first.
5. Ending with positive aspects.
6. Warding off objections.
7. Selling the option of HRT.
8. Moving from menopausal problems to long-term medical risks.

Recontextualising risks in terms of drawbacks and benefits

The most salient feature of the HRT talks is perhaps that risk talk becomes recontextualised into, and reformulated in terms of a drawback-benefit discourse. When ideas and concepts are placed in a new context (‘recontextualised’), their meanings will also become modified, Linell (1998). Here, the professional/institutional framing of the talks lead to a dispreference for risk talk and a preference for simplified drawback-benefit calculations. Doctors talk about ‘drawbacks’ (Swedish ‘nackdelar’) and ‘benefits/advantages’ (‘fördelar’), rather than ‘risks’ (‘risker’). We will use the word ‘drawback’ rather than ‘cost’, since this approximates the meaning of the Swedish term ‘nackdel’ best.

Instead of discussing risks and risk reductions with HRT (e.g. using probabilities and/or consequences), the risk discussions are reduced into simple enumerations of drawbacks and advantages. Excerpt [1] is a short version of such a risk-benefit discussion:

[Excerpt 1] (HRT 2: 167ff.) (Dr1m, P2)
1 D do you know anything about this thing with oestrogen therapy?
2 P nothing
3 D no
4 P only what one hears on the radio and newspapers and
telly. and the on one day it’s so super and next
day it’s life-threatening you know and
5 D mm. and it is like this, it’s got its benefits and
drawbacks

> the biggest drawback is that there is a little bigger risk than in other non-treated women to get breast cancer

(p)

> the benefits are that one decreases risks of cardiac infarction, ulcer, calcium reduction in the skeleton

> with fractures, broken legs as a consequence.

plus that there will be an effect (p)

on those inconveniences [that one may find it > > ]

[p]

difficult to live with

(p)

> and if one puts the drawbacks in one scale and the benefits in another one, then it’s the benefits that will clearly carry the weight. there is a small increase of the risk of breast cancer, in those who get therapy. but that breast cancer doesn’t seem to be a dangerous cancer. so there is no increase of mortality in those who get the oestrogen [in breast > > ]

[p]

cancer

(p)

that’s how matters stand

I see

mm-mm

Here, we find what is in effect an enumeration of risks (lines 15ff.). There are several features in [1] which we will see recurring in other examples below. This include the order of presentation with drawback(s) mentioned before benefits, the difference in number of drawbacks and benefits (here one drawback (lines 11ff.), four benefits (lines 15ff.)), the downsizing of risks (lines 25ff.), and the summary in terms of balancing drawbacks and benefits (lines 23–24). The doctor asks for the patient’s perspective (line 1) (see also below), which makes her associate to the media’s extreme messages (lines 6–7: ‘super’ vs. ‘life-threatening’). Characteristically, the doctor picks up the most frightening prospect, which is always (in this corpus) that of breast cancer. He then mitigates the risk at several levels, quantitatively (‘line 25: ‘small increase’) and otherwise (lines 28–29: ‘no increase of mortality’), i.e. it is not really life threatening.

The drawbacks-benefits discussions are often much longer than in [1]. Excerpt [2] is a long version, which has been abbreviated considerably here:

[HRT 4: 77ff.] (Dr3f, P4)

OK, then one can say, then you feel relatively well

[now but then we don’t know what will happen to you]

[p]

no

but it’s probably that it will come again

yes

and if you are – then one can – then there are two
different philosophies so to speak. we who are
gynaecologists are often very positive to oestrogen
cos we – one thing is that we notice that many women
feel well with this y’know, and another thing is
that we know that it has many benefits
but it’s always you who must decide. for a certain
drawback is there too, it’s always you who must
decide
– > P yes, what sort of drawbacks are there that–
you’re asking about what drawbacks there are?
mm-mm
shall we take the drawbacks first?
yes
the drawbacks are that after a long-term therapy with
oestrogen then there is a small small increase of risk
of breast cancer. all of us have unfortunately a high
base risk, so that all women run y’know a fairly high
risk through their life time to get breast cancer. and
then I usually say that if it is a life time then
seven out of a hundred women get breast cancer,
without oestrogen. and if you take oestrogen for seven
to ten years then seven-and-a-half get breast cancer,
so a little longer time of oestrogen therapy yields a
somewhat increased risk of breast cancer.
then it has as a second drawback is that precisely
when one starts with oestrogen we believe that it
leads to a little increase in risk of clots (i.e. thrombosis) in the leg
and it is fairly, probably fairly small.

the third drawback which one can think is troublesome
in taking oestrogen. then one must – oestrogen which
is then good for people then one also gets a thick
mucous membrane inside the uterus, and if you take
just oestrogen then you can get small bleedings so
in the worst case you can get a bit of cell
degenerations in the uterus
(etc; about 50 lines omitted)
towards the end of a long turn) bleedings one may
have to accept, a small small increase of risk for
clots (i.e. thrombosis)

yes
so – mm
yes, clots – I’ve had such superficial clots
yes
but that’s perhaps not–
(10 lines omitted)
that’s perhaps a little bit little bit – may I state
this in terms of facts for and against, it swings all
the time a little bit. cos I have such a long list,
have a super-long list of benefits of oestrogen.

D and it varies a little bit too y'know, one can say, so
the most important thing I think is y'know than one
should feel that one is well [cos then –

D this thing that if there’s an increase of risk of
thrombosis or not, then they think that it’s fairly
small, there’s perhaps a small small increase if you
have very superficial varicose veins, though not much –
we can say. so this is not anything that we regard
as particularly dangerous

the benefits, those I have such a super list of, which
you may know about.

D yes. the biggest benefit of course is that one should
feel better, but now you feel already fairly well to
start with (laughs) well, anyway so that you won’t
start sweating again then.

D and then we know of course that they have a – that
they are good against osteoporosis. and osteoporosis
increases when you lose your periods. now it protects
against – then we believe lots of things. we believe
that this can be good for your heart, that it can
protect against cardiac infarction, and certain
cardiovascular diseases. then we believe a lot of
other things too, this thing with it increasing blood
circulation in the brain so it may be good for the
short-term memory, it may protect against Alzheimer’s.
it may be good for your balance, less wrinkles, good
against loosening of the teeth. that is, many things
that increase blood circulation in the body. so the
plus list is much y’know much higher than on the minus
list.

Here, we find, before any risk discussion, a declaration of positive attitude towards HRT on the part of the doctor (lines 8–9). The topic of drawbacks is initiated at the patient’s initiative (line 17), although the doctor provided the opportunity, mentioning the issue of drawbacks already in line 15. Again, drawbacks precede benefits, and there is a clear difference in number: first three drawbacks, then a ‘super-long list’ (line 57) (‘super list’, line 71), which then appears to contain seven different items (lines 75, 80, 83, 88, 89, 90). The doctor not only presents the list of benefits and drawbacks, she actually spells out the conclusion that the former outweigh the latter (line 92; cf. excerpt 1: lines 23–24). The drawbacks are discursively diminished: ‘small small’ (lines 23, 47, 65), ‘a little longer’ (line 31), ‘somewhat increased’ (line 32), ‘little increase’ (line 36), ‘a bit of’ (line 44), etc. The risk of thrombosis is successively characterised as ‘fairly, probably fairly
small’ (lines 36–37), later again as ‘fairly small’ (line 64), and as ‘small, small increase’ (line 65).

Excerpt [2] also displays the typical tension between individual concerns and risk talk at the population level. While the doctor points out the individual responsibility for therapy choice (‘you must decide’, line 14), she naturally has to base her lengthy account of the breast cancer risks (lines 22–32) (and similarly for thrombosis) on statistical data.

Simplifying calculations

The discussions exhibit a typical implicit quantitative bias. The trade-off between drawbacks and benefits is implicitly based on a simple calculation; doctors count the number of drawbacks (at most three) and benefits (usually more than three). The number of drawbacks mentioned is always smaller than that of benefits (in a few cases there is an equal number); some doctors mention three drawbacks and 7–10 benefits (Excerpt 2), others mention one drawback (which is always the increased incidence of breast cancer) and 2–3 benefits (Excerpt 1).

Interestingly, these discussions disregard the weightings of benefits and drawbacks; fewer wrinkles (a benefit) seem to count just as much as cardiovascular diseases (a drawback). A serious risk discussion could of course hardly avoid considering risks in terms of their relative weights, neither in terms of their probabilities, nor in terms of gains or losses. The simple calculation used here could be interpreted as doctors’ coming closer to a presumed lay or mundane logic, Tversky and Kahneman (1974): how many arguments are there for HRT, and how many against?

Changes in risk levels are discussed in absolute rather than relative terms. For example, on lines 29–30 in [3], the increased risk of breast cancer is given as 0.5% (going from 7 to 7.5%) rather than as 7% (if you go from 7 to 7.5, the relative increase is 7%). Absolute risk reduction is the recommended way of presenting risk level, but it is also arguably a format that serves to diminish the possible threat of breast cancer as a consequence of HRT, Edwards et al. (2002).

Embedding drawbacks in positive environments

We have already pointed out that doctors give the whole talk a bias that clearly favours the alternative of prescribing HRT, by (quite often) mentioning their positive attitude to oestrogen therapy before any discussion of risks, drawbacks and benefits has started. This happens in 15 out of 20 talks (cf. Excerpt 3: lines 8–9). In other words, the risk discussion proper (phase 3) is preceded by a short summary of the message of ‘there are more benefits; (in phase 2). There are, in addition, other ways in which drawbacks are embedded in positive introductions and/or exits.

After this introduction, there is some variation in the linear orders of the risk discussions. Some doctors (e.g. Excerpts 1, 2) first mention risks, then downsize them (i.e. verbally presenting them as relatively small), then discuss benefits (in a larger number). Other talks start with benefits first, and take drawbacks later (Excerpt 3):

[3] (HRT 5: 55ff; Dr3f, P5)
1 D what is completely certain, you will get rid of your
2 hot flashes, sweatings. perhaps a little better with
3 your joint pains, but not so much with swellings.
4 P no
5 D that you can gain.
6 P mm
and then one should know then that it’s often good for your well being, it’s good for the skeleton. have you got a mummy or sisters who have broken a lot or–

P no

(more talk about various conditions, smoking etc; about 25 lines omitted)

D then, what more benefits are there with oestrogen?

D we believe a lot of things. we believe that it can probably be good for the brain, that it may protect against Alzheimer’s, we believe in this thing that it may be good for the short-term memory

P mm-hm

D and it may be good for the balance, in a study up at the hospital. one has observed that the loosening of teeth get less, and less wrinkles

P mm-hm

D French women take it because of that, and it is all about increasing blood circulation in different organs, but this we cannot promise, we believe it.

P mm

D the most important thing I think one should do is that one feels well, that is the most important thing.

(p)

D the drawback with oestrogen is above all three things (D goes on to talk about three drawbacks at some length)

Here, we first get seven or eight advantages, followed by three drawbacks. The former are mentioned as indisputable (no discussion needed), although half of them are presented as things one ‘believes’ rather than ‘knows’. The drawbacks, by contrast, seem to need a long discussion in order to be diminished or neutralised (though this is not shown here).

Asking for the patient’s perspective first

Another variant of the preferred orders of presentation is for the doctor to first ask about the patient’s understanding, concerns and expectations (asking for patient’s perspective first, cf. Maynard (1991), on ‘perspective-display series’ in delivery of diagnosis). This is usually done by a very simple introductory question, of the type ‘what do you know about HRT?’ (Excerpt 1: line 1). This regularly makes the patient ask about one particular risk, namely, breast cancer. The doctor topicalises this ‘risk’, then diminishes it, and then expands on benefits, which will thereafter dominate his/her expert’s account. By first topicalising one (or several) worries by the patient (or on the patient’s behalf), the doctor talks him/herself into a position where (s)he can then give a positive message after the negative aspects have been dealt with.

Ending with positive aspects

Summarising the point of order of presentation, we can say that there is a tendency to start by a declaration of positive attitude, and to finish on positive aspects (‘Pollyanna strategy’: ‘always end on a happy note’ Adelswärd (1999)). Talk about drawbacks is not only embedded within talk about positive aspects. When patients bring up additional questions, counter-questions, objections or reservations, these are often emphatically refuted, and the argument is ended with a positive statement. Excerpt [4] is a clear case:
(from the very end of the consultation)

1 P and this thing with risk of cancer in the genitals or
2 so, there is then [hardly anything
3 D [no no no no
4 D no no.
5 P now since [it is gone
6 D [no but it's not connected
7 D NO BUT, it's not connected with the oestrogen
8 P no, I just thought about it anyway [I mean
9 D [yes but you have
10 just your ovaries left
11 P yes
12 D no, no!
13 P and there [there is nothing of the kind, no.
14 D [NO, no no
15 D the only, so the only – there’s SUCH a heap
16 (demonstrates with a gesture) with benefits with
17 oestrogen [and so (gesture) with drawbacks [and > >
18 P [yes [yes
19 D in the small bag of drawbacks there was the uterus,
20 but the uterus is gone now.
21 P mm
22 D yes. and what still lies there is this thing with
23 the breasts
24 P mm
26 D and with 5 years of therapy you won’t have any
27 increased risk. but the same risk as your women-
28 friends, but you have no increased risk.
29 P no
30 D and that one once in a month that one palpates the
31 breasts properly
32 P mm
33 D but the most important thing I think is to try and
34 feel good. you must feel as well as possible.
35 P yes
36 D that I think is good
37 P OK, it sounds good, all this.

This patient has had her uterus surgically removed, a fact alluded to in lines 10, 20. In lines 2–
3, 7, 12, 14 etc., the doctor emphatically denies the risk of gynaecological cancer. One notices
the extreme version of the balance metaphor in favour of benefits (lines 15–17), and the
somewhat misplaced metaphor with the ‘bag of drawbacks’ (line 19), which would normally
involve the uterus, but in this case only contains ‘this thing with the breasts’ (lines 22–23). This
discussion ends with the patient somewhat reluctantly (line 37) accepting a prescription.

Warding off objections

A minority of patients raise questions, objections, and reservations, which tend to be warded
off by strategies of diminishing risk and of adding new benefits. If the patient mentions worries,
there is often a cascade of mitigations from the doctor, combined with a massive enumeration of benefits. A reason for being sceptical about HRT often expressed by the women is their reluctance to take any drugs at all:

[5] (HRT7; Dr2f, P7)
(towards the end)
1 D OK, what is it that makes you hesitant to taking
2 anything?
3 P I’m hesitant to taking medicines on the whole
4 D mm-hm
5 P I’d prefer not to take any medicine.
6 D mm
7 P cos it’s, I feel that this thing of putting something
8 alien into my body, it’s difficult for me.
9 D mm. mm. now there’s a difference between medicines and
10 medicines. these hormones are after all such hormones
11 that one has in one’s body.
12 P that’s it.
13 D so it’s more of a substitution then, than like adding
14 something, well, one does add something from outside
15 but it is nevertheless not anything entirely alien to
16 the body.
17 P no:. no:. so therefore I can then-can think of it
18 (laughs) mm-mm (laughs)
19 D (laughs) mm. mm-mm.

Here we find the female doctor refuting, in lines 9–16, the patient’s argument, which is based on her general reluctance to take drugs (‘medicines’). The patient takes the doctor’s argument (line 17).

**Selling the option of HRT**

Doctors employ a selling strategy: don’t force anything on the customer, but invite her strongly to try the goods offered. Excerpt [6] occurs somewhat later in the same consultation as [5]:

[6] (HRT5: Dr3f, P5)
(towards the end, after many tentative objections from the patient)
1 D but it sounds like you are a bit curious after all
2 or do you wish to wait?
3 P (sighs) well, I don’t know cos I’m one of those that
4 I’m not very much in favour of tablets, but at the
5 same time then–I was thinking of this with the
6 joints and such like, such things could get better.
7 cos the sweatings –
8 D those are not so big you think?
9 P I don’t suffer that [enormously from [I should say
10 D [no: [no: no:
11 P it can get worse of course [but it’s not that–
12 D [yes
13 P [I’m suffering
14 D [it’s mainly the joint pains as you see it?]
15 P yes
16 D yes
17 (p)
18 D one variant is to test it for 3 months, and if
19 one thinks this is good, then one continues—and if
20 one doesn’t feel well then one can start again in a
21 couple of years if that would be needed.
22 P so it does no harm to quit then, in other words?
23 D no.
24 P no.
25 D it’s not dangerous to have a try.
   (discussion goes on; patient finally agrees to have a try)

According to the doctors, hormonal treatment is clearly desirable; they try to ‘sell’ this
(pharmacological) treatment, discussing it in cost-benefit terms (‘health benefits (profits)’);
in these consultations the doctors never discourage patients from undergoing HRT (the
only issue is the mode of administration). If patients are reluctant, doctors offer a
compromise: Test HRT for a period of time, then evaluate it and decide to quit or
continue (Excerpt 6: lines 18ff.). At least, patients should take a prescription home, just in
case (cf. Excerpt 7 below). Indeed, all the women left the consultations with a prescription
for HRT.

Counselling in medical contexts is often presented as information giving (as for example, in
HIV counselling as described by Silverman (1997)). The HRT talks have a somewhat more
ambiguous character in that they have an information giving or counselling character on the
surface (the patient should decide), yet they always lead to prescription (as if an illness had
been diagnosed). The selling strategy may be said to involve more explicit advice-giving, not
just ‘advising-by-informing’ (Silverman’s term). In excerpt [7], the doctors make it explicit
that she can only ‘recommend’, while the patient ‘has to decide’ (lines 3–4):

[7] (HRT5; Dr3f, P5)
(towards the end, about 5 min after [6])
1 P and as a physician you think one ought to start with
2 it or should I rather wait? what—
3 D well, it depends on who one is. it depends—I can
4 recommend and you have to decide.
5 P yes
6 D is it like that that one doesn’t want to tolerate one
7 single little side effect so to speak, then it’s
8 better to wait until you get really a lot of troubles,
9 cos then you’ll be much more motivated to take your
10 medicine
11 P mm-hm
12 D is it so that one feels that—no phew! I can’t have
13 one single little sweating, this I think is tough,
14 then one should of course start early
15 P mm-hm
16 D but if one feels that one is a bit sceptical, then
17 then perhaps one should wait a little while.
18 P mm-hm
In [7], as in [6], the patient is somewhat reluctant to HRT (line 20). When she asks the doctor for advice (lines 1–2), the doctor concedes that she can ‘recommend’ something but that it is up to the patient to ‘decide’ (line 4). Yet, the female doctor minimises the patient’s reason to turn down the HRT offer (cf. line 7: ‘one single little side-effect’). Doctors in virtually all the HRT talks ‘recommend’ HRT. This is their overall, global message; yet, some of them go on record in emphasising the patient’s obligation to decide by herself (especially when facing counter-questions from patients), often formulated as ‘we only inform’. There is a discrepancy between the aim only to inform and recommend, expressed in line 19 as ‘we try to listen to what you are saying’, and the very strong selling strategy used by the doctor. This discussion ends with that the patient somewhat reluctantly accepts the doctor’s insistent suggestion that she ought to take home a prescription, after all (lines 23, 27). The HRT talk is an arena for joint decision-making; patients are requested to decide, but in many cases, doctors may still be said to decide in the patient’s place (and, perhaps, in the patient’s best interest).

**Moving from menopausal problems to long-term medical risks**

The HRT talks are arranged because the women have experienced menopausal problems. Thus, this is the premise and starting-point of the appointments. In excerpt [7], we saw (lines12ff) that the doctor returns to menopausal problems, when she adopts the patient’s perspective as a starting-point for her argument. But the whole corpus (cf. other excerpts) shows that menopausal problems are no more than precisely a starting-point for the argumentations which then move over to long-term medical risks. In excerpt [3], the doctor uses the elimination of menopausal problems as the very first argument in favour of HRT (lines 1ff.). But then she goes over to the long-term effects (lines 8, 11ff.), the reduction of risks related to increased age. There is a move from the patient’s (current) problems to prevention issues, in itself a reframing of the encounter and a recontextualisation of its main topic; the climacteric is reframed from a period of inconveniences to the starting-point of a period of increased medical risks.

**Discussion**

Linell et al. (2002) discussed the issue of orientation to risk as being dependent on contexts of various kinds. A few of the situations studied by Linell et al. i.e. genetic information talks, are ‘risk contexts’ in that the discussion of risks is the mutually acknowledged purpose of the encounter and risks are indeed explicitly talked about there. Considering our HRT talks as an activity context, they constitute a ‘risk context’ in this sense. There is more explicit orientation to ‘risk’ in these talks than in any other talk activities studied by Linell et al. except the genetic
information talks. In terms of the dimensions discussed there, see Table 1, the HRT talks score approximately as follows (yes = favouring explicitness in the sense defined above):

(a) agenda point: yes.
(b) medical status of patient: yes/no.
(c) distance to negative outcome: yes?
(d) attribution of risks: yes?
(e) professional rights: yes.
(f) patient’s responsibility: yes.
(g) time frame: yes?

However, the orientation to risk in our HRT talks is embedded, recontextualised, within a drawback-advantage framing. This results in downplaying its risk character. In fact, the very word ‘risk’ (and its compounds) is not particularly frequent. This makes the talks similar to prevention talks on risks related to hypertension as studied by Kjellgren et al. (1998, 2000). As has sometimes been pointed out, ‘risk’ is a sensitive ‘medico-moral concept’, Harris (1989). The word itself seems to evoke unpleasant feelings of danger, uncertainties, worries, and distress. While the media are in general prone to use ‘risk’ in order to evoke feelings (as shown by patients’ remarks in our data corpus of interviews; cf. also excerpt 2), there is, in the HRT and other talks, Kjellgren et al. (2000), a strong tendency to ward off feelings. Doctors’ rhetorical strategies, including those of under-using the word ‘risk’ and of ending on a happy note, seem to be designed to induce reassurance and confidence in patients, thereby possibly increasing compliance (cf. also informing without worrying in Bredmar and Linell (1999)).

The situation in the HRT talks involves some types of incongruent agendas, or mismatches of parties’ expectations. Patients come to see the doctor because of their menopausal symptoms (this is why they have been advised to, or themselves decided to, see the gynaecologist in this specialised talk). Doctors listen to the accounts of these symptoms in the history-taking phase, but then they use their time to discuss something else—long-time risks and prevention issues. Patients and doctors bring up partly different sets of problems or fears; the women sometimes broach topics such as (the fear of) weight increase, pregnancy or tense breasts, issues that are topicalised only when patients bring them up. Irrespective of what exactly is taken up in the specific encounter, there is a strong tendency by the doctors to move from patient’s symptoms to prevention aspects. The talk is not primarily about the subjective experiences of menopausal symptoms, or the climacteric, but about the projected or foreseeable problems of aging. Despite the focus on the clinical treatment of individual women’s health, there is of course a public health dimension lurking behind this; a hidden concern is about limiting future suffering and societal costs for older people’s health care.

The cognitive framings governing expectations on this kind of talk activity include the idea that menopausal problems are to be discursively treated as analogous to symptoms of disease; they should be treated medically and possibly cured. This understanding is shared by both parties. For example, pre-empting fractures is transformed into a medication issue rather than a life-style issue. The women too seem to know more about oestrogen treatment than about the menopause as such, i.e. there is a focus on medical treatment more than on the natural process. In the terms of Coupland and Williams (2002), the ‘change of life’ is in these talks entirely conceptualised within a ‘medical model’.

In the activity type studied here, risks are partly disguised as something else, i.e. as costs and benefits. Furthermore, there are discrepancies between parties about which risks are most relevant to talk about. Despite being set up as a specific opportunity for women in the menopause to discuss problems and risks, the activity type presents itself, in the end, as a decision-making activity led by the doctors.
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References


