Patient Education and Counseling 121 (2024) 108134

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.journals.elsevier.com/patient-education-and-counseling

Conceptualizing negotiation in the clinical encounter – A scoping review using principles from critical interpretive synthesis

Freja Ekstrøm Nilou [a,1], Nanna Bjørnbak Christoffersen [a], Olaug S. Lian [b], Ann Dorrit Guassora [c], Marie Broholm-Jørgensen [a,*]

[a] National Institute of Public Health, University of Southern Denmark, Copenhagen, Denmark
[b] Department of Community Medicine, UiT—The Arctic University of Norway, Tromsø, Norway
[c] Section and Research Unit of General Practice, University of Copenhagen, Denmark

ARTICLE INFO

Keywords:
Negotiation
Patient-Professional Interaction
Clinical Encounter
Scoping Review

ABSTRACT

Objective: Negotiation as an analytical concept in research about clinical encounters is vague. We aim to provide a conceptual synthesis of key characteristics of the process of negotiation in clinical encounters based on a scoping review.
Methods: We conducted a scoping review of relevant literature in Embase, Psych Info, Global Health and SCOPUS. We included 25 studies from 1737 citations reviewed.
Results: We found that the process of negotiation is socially situated depending on the individual patient and professional, a dynamic element of the interaction that may occur both tacitly and explicitly at all stages of the encounter and is not necessarily tied to a specific health problem. Hence, negotiation is complex and influenced by both social, biomedical, and temporal contexts.
Conclusions: We found that negotiation between patient and health professional occurs at all stages of the clinical encounter. Negotiation is influenced by social, temporal, and biomedical contexts that encompass the social meeting between patient and health professional.
We suggest that health professionals strive to be attentive to patients' tacit negotiation practices. This will strengthen the recognition of the patients' actual wishes for their course of treatment which can thus guide the health professionals' recommendations and treatment.

1. Introduction

Negotiation is associated with concepts such as agenda setting, finding common ground and Shared Decision-Making (SDM) in the clinical encounter [1–3]. Negotiation is often associated with bargaining in the legal system or industrial disputes, and thus with outspoken conflicts. Despite the negative ring to the word, the definition of negotiation aligns with core elements of the clinical encounter [4–6] and is considered to be of crucial importance for establishing collaboration and patient participation in health care [1–3]. According to the Cambridge dictionary, negotiation is the process of *having formal discussions with someone in order to reach an agreement with them* - a comprehension of the term that seems widespread in the literature about clinical encounters. Within SDM, negotiation is seen as a communicative strategy of shifting perspectives with the aim of reaching decisions together with the patient [7,8]. In the patient-centered clinical method, negotiation is defined as the result of a conflict followed by an agreement [9]. Negotiation is furthermore described as an integral part of motivational interviewing by Miller and Rollnick [10], although the concept is not further defined.

Because negotiation is assumed to be an essential part of the clinical encounter, it is important to fully understand the meaning of the concept and how it can be explored. However, negotiation as an analytical concept in research about clinical encounters is vague, and there is a lack of consensus on the definition of the concept. Moreover, empirical studies exploring negotiation in the clinical encounter rarely present a definition of the term. The term is often used implicitly to illustrate a conflict, disagreement, or opposition, however, in this study, we comprehend the term as a neutral discussion with the purpose of reaching an agreement. The simplified outlines of the process of negotiation do not do justice to the complexities of shifting perspectives and

* Correspondence to: National Institute of Public Health, University of Southern Denmark, Studiestræde 6, 1455 Copenhagen K, Denmark.
E-mail address: mbro@sdu.dk (M. Broholm-Jørgensen).
[1] Shared first author

https://doi.org/10.1016/j.pec.2024.108134
Received 31 August 2023; Received in revised form 20 December 2023; Accepted 1 January 2024
Available online 4 January 2024

reaching an agreement in the clinical encounter between patient and professional. Hence, based on a scoping review, we aim to provide a conceptual synthesis of key characteristics of the process of negotiation in clinical encounters.

For this scoping review, we consider the clinical encounter as a social meeting that entails assessments and adjustments of different perspectives on health and risk: the patient's lay perspective and the health professional's medical perspective [11–13]. According to Philosopher Harald Grimen [11], different perspectives of health and risk are pivotal in the clinical encounter as assessment of risk concerns everything from prognosis to treatment, and thus, negotiations in the clinical encounter bear consequences for behaviour beyond the clinical encounter, such as treatment options and preventive initiatives.

2. Methods

With the exploratory nature of aiming to identify key characteristics or factors related to the concept of negotiation in clinical encounters, we opted for conducting a scoping review of relevant literature. We conducted the scoping review following the framework of Arksey and O'Malley [14], which includes the stages of 1) Identifying the research question, 2) Identifying relevant studies, 3) Study selection, 4) Charting the data and 5) Collating, summarizing and reporting the results. The refinement of the framework by Levac,Colquhoun and O'Brien [15] allowed for an iterative and collective study selection process and a qualitative thematic analysis approach to data charting. We adhered to the Preferred Reporting Items for Systematic Reviews and Meta-analysis extension for Scoping Reviews (PRISMA-ScR) checklist (Appendix A) [16,17]. A protocol with a pre-specified objective and research questions was developed prior to the scoping review, though this protocol has not been published.

2.1. Identifying the research question

The scoping review approach facilitates an exploration of the terminological and conceptual discrepancies in the research field concerned with negotiation in clinical encounters including research articles that do not take negotiation as their main focus. To accommodate for variations and nuances in the literature, we were intentionally broad in our conception of "negotiation" and to how it occurs in the clinical encounter and therefore applied synonyms such as shared decision-making, patient involvement and risk communication in the search string.

We developed a set of research questions that reflected different definitions and characteristics to guide the scoping review: 1) How is negotiation in clinical encounters defined in the existing literature? And 2) what factors have been found to characterize the process of negotiation in the clinical encounter?

2.2. Identifying relevant studies

We conducted the literature search across four databases (Embase, Psych Info, Global Health and SCOPUS). We created a list of search terms combining different versions of the terms; 'negotiation', 'primary health care', 'clinical encounter' and 'qualitative research'. The search strings were tailored to each database. In consultation with a university librarian with expertise within systematic reviews, we applied Bolean operator "AND" to connect these groups of terms together, and "OR" to connect sub-terms. As a quality measure for whether the individual search strings were sufficient, we carried out a MESH search in Embase on the potential search terms before performing the searches. The primary search was conducted in July 2021. Five articles were added after the screening drawing on expert network and references from identified relevant articles. One supplementary search was performed to include recently published articles in January 2023. See Appendix B for an example of our search string.

2.3. Study selection

The initial search yielded 1737 articles (See Fig. 1). All identified articles were uploaded to the Covidence™ Software to identify duplicates, title/abstract screening, data extraction and to avoid risk of assessment bias. After 45 duplicates were removed, the remaining 1692 articles were screened in three rounds. In the first round we screened the articles on title/abstract based on the following criteria: 1) peer-reviewed published studies presenting qualitative empirical material, 2) studies published in English, and 3) studies addressing communication in the clinical encounter. We had no limits on date of publication. We excluded articles that addressed clinical encounters with children and their parents. 1622 articles did not meet the inclusion criteria and were thus removed. 70 articles were subsequently full text screened. 25 articles that included a definition of negotiation in the text and/or presented negotiation in relation to the findings were included.

Three researchers (NBC, FEN & MBJ) independently read and screened the articles. Disagreements were resolved by MBJ, an experienced researcher within doctor-patient relationship research.

2.4. Data charting process and data synthesis

We organized and analyzed the remaining articles using the qualitative data analysis software NVivo. The data was categorized in a data charting form developed for this review as follows: author, year of publication, aim, data origin, study design, clinical setting, definition of negotiation in the text. The study characteristics were entered into a standardized form in NVivo and converted into Table 1: Study characteristics.

To adopt a critical and reflexive approach to the literature, we chose to carry out a qualitative analysis of the literature [15,18]. We conducted a thematic analysis and initially, by means of cross-sectional indexing, MBJ (an associate professor and Ph.D. in qualitative research) coded and organized the various factors considered characterizing the process of negotiation in the clinical encounter across the articles into scoping themes [19]. The codes were organized using NVivo. The data material was analyzed in an iterative inductive process of reading and coding in several rounds. After several analytical readings of the material, where the codes were compiled into groups of similar items of interest, the author group conjointly compared, contrasted, and integrated the groups into higher-order patterns. The initial 23 codes (Appendix C) were organized into the following four overall themes that characterize negotiation in the clinical encounter*:* 1) *Negotiation occurs both tacitly and explicitly in the patient-professional interaction,* 2) *Negotiation is dominated by the power of biomedicine, 3) Negotiation is socially embedded* and 4) *Negotiation is framed by different dimensions of time.* We present the data in a narrative summary to show how the results relate to the descriptive aim of the scoping review.

3. Results

A total of 1737 articles were identified in the initial database search. After removing duplicates, 1692 studies remained and were hereafter screened for eligibility (see Fig. 1). 25 studies met the inclusion criteria and were included for data extraction.

3.1. Included studies and study characteristics

In four studies, a biomedical well-defined diagnosis was singled out as part of the research object, such as cancer [20,21], Type 2 Diabetes [22], and Hepatitis C [23]. In 11 studies, more complex problems were under study, such as Medically Unexplained Symptoms (MUS) [24,25], prevention of chronic disease [26–30], multimorbidity [31], sick leave [32,33], chronic pain [34] and emotional concerns [35]. Nine studies did not state a specific diagnosis or treatment as part of the research aim, but focused on a setting, such a general practice. The studies originated

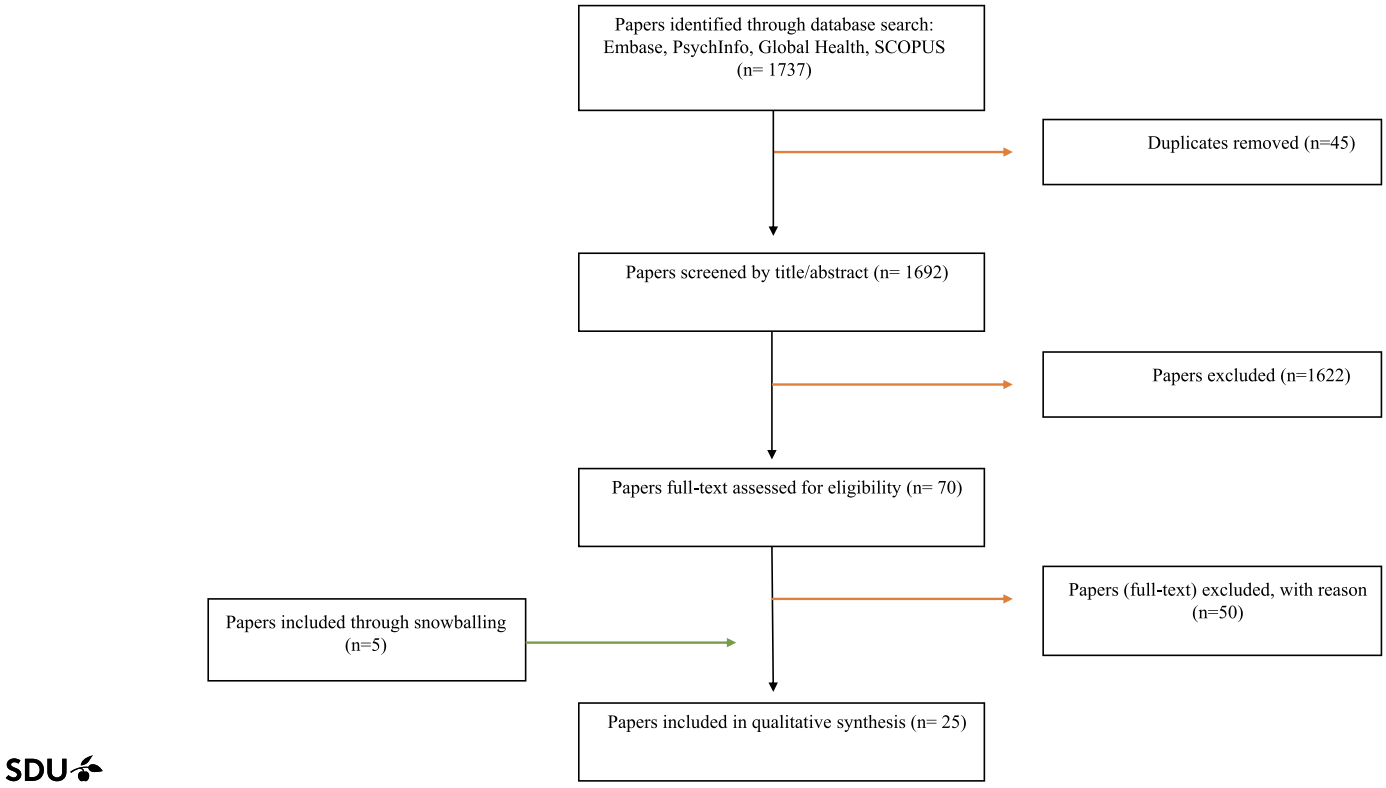

Fig. 1. Study selection flow diagram *here*.

from England [26,27,30,32,34–39], Denmark [20,25,28,40,41], United States of America [42–44], Sweden [21,29], Norway [33], Holland [24], Finland [22], Australia [23] and Ireland [31]. Included methods in the studies comprised interviews [23,25,30–32,34,36,39,43], observations [21–24,27–29,37,38,42], a combination of interviews and observations [20,40,41], and workshops [33,35,44]. Study characteristics are described in Table 1.

3.2. Definition of negotiation in the included studies

15 of the included studies stated a definition of negotiation in the clinical encounter in the text or a definition of the interaction in the clinical encounter which included negotiation [21–23,25,28,29,31,33–35,37,38,40,42,44]. The definitions of negotiation found in the 15 studies gathered around one or more central aspects, for instance social action [22,25,28,29,34,38,42], exchange of different positions, values and perceptions of health and illness [28,35,37,40,42], affected by structural constraints and the organizational context [23,25,33,34], temporally embedded [21,40,44] and aiming to reach a mutually satisfying agreement [21,22,29,31,38,44].

In the included studies negotiation in the clinical encounter is overall defined as an active and social interchange of different, sometimes oppositional, perspectives and values of health and the good life that end up as a joint decision. The process of negotiation is temporally embedded and may take place over several encounters.

In the synthesis of the 25 articles, we found four themes that characterize the process of negotiation between health professionals and patients: 1) *Negotiation occurs both tacitly and explicitly in the patient-professional interaction;* 2) *Negotiation is dominated by the power of biomedicine; 3) Negotiation is socially embedded;* and 4) *Negotiation is framed by different dimensions of time.* In the following, we will elaborate on the themes in a summative analysis.

3.3. Negotiation occurs both tacitly and explicitly in the patient-professional interaction

The patient and the health professional are mutually reliant on each other throughout the interaction in the clinical encounter, which makes negotiation in the clinical encounter relational [22,37].

Based on the studies for this scoping review, we find that negotiation occurs in every consultation more or less explicitly. An active part of the interaction is when professionals elicit patients' perceptions of the health problem. Understanding the patient's situation and presentation of the problem is considered to be a necessary starting point for negotiation [33]. The negotiation process is thus found to depend on the patient's presentations of health problems as well as the professional's reactions to the problems, such as active listening and recognizing the problem [30].

Exploring interactional modes in general practice consultations, Lian, Nettleton, Wifstad and Dowrick [38] identifies five modes: 1) question and answer (Q&A) mode, 2) lecture mode, 3) probabilistic mode, 4) competition mode, and 5) narrative mode. Of the five modes, three (1−3) are led by the general practitioner (GP) as well as the three modes most dominating in the interactions observed [38]. Hence, patients are left with a narrow dialogic space in general practice, as GPs initiate the interaction and controls the course of the interaction by asking closed questions not inviting patients to express themselves nor engaging them in the dialogue [24,38].

Several studies illustrate how negotiation in the clinical encounter occurs when patients present new health problems, express worries or ask questions about the professionals' assessments of the problem and solution to the problem [28,29,40,43]. Studies show how patients claim control of the dialogue, e.g., by asking reciprocal questions [28,29]. Hultberg & Rudebeck argue that with the use of reciprocal questioning, patients actively participate in the negotiation process, by withholding acceptance of and question the professional perspective [29]. Patients can tacitly show resistance to the professionals' assessment of the problem or solution by e.g., minimal response or silence [22,38]. The

Table 1
Study characteristics.

Nr.	Author	Year of publication	Aim	Data origin	Study design	Clinical setting	Definition of negotiation
1	Andersen RS, Tørring ML & Vedsted P	2014	To examine how the discourses on health care–seeking practices in biomedicine are negotiated and manifest themselves in local clinical settings.	Denmark	Observations and interviews	Cancer	N/A
2	Broholm-Jørgensen M, Kamstrup-Larsen NK, Guassora AD, Reventlow S, Daloton SO & Tjørnhøj-Thomsen T	2019	To contextualize the clinical encounter by connecting the social meeting between general practitioners (GPs) and patients with the organisational, physical and temporal contexts of general practice, to account for the conditions and possibilities of negotiation.	Denmark	Observations and interviews	Preventive health checks	We define negotiation as the combination of tacit or explicit adjustments of different perspectives of health and risk. Negotiation between GP and patient is, in our view, a temporally embedded social action that has the possibility of shaping, maintaining and altering the clinical encounter.
3	Broholm-Jørgensen M, Langkilde SM, Tjørnhøj-Thomsen T & Pedersen PV	2020	To provide in-depth insight into the unfolding of preventive health dialogues in general practice from perspectives of both GPs and patients.	Denmark	Observations and interviews	Preventive Health checks	N/A
4	Chappall P, Toerien M, Jackson C & Reuber M	2018	To identify two key practices whereby clinicians might invite patients to contribute, actively, to decision-making about treatment, investigation or referral options.	England	Observation	Neurology outpatient consultations	N/A
5	Davey A, Asprey A, Carter M & Campell JL	2013	To explore young adults' needs and experiences of primary healthcare with a view to identifying the reasons for lower satisfaction with regard to services, in addition to understanding why young adults are less likely to respond to patient experience questionnaires.	England	Interview	N/A	N/A
6	den Boeft M, Huisman D, Morton L, Lucassen P, van der Wouden JC, Westerman MJ, van der Horst HE & Burton CD	2016	To examine how symptom explanations were negotiated between GPs and patients with MUPS, we carried out detailed analysis of the dialogue structure of symptom explanations.	The Netherlands	Observation	Medically Unexplained Physical Symptoms (MUPS)	N/A
7	Drass KA	1982	To present an empirically grounded model of medical negotiation developed through an analysis of medical practitioner-patient discourse.	USA	Observation	N/A	Conceptualizes negotiation as a process in which mid-level providers and patients introduce their perspectives on the definition and treatment of medical problems by linking together units of discourse (acts, turns, sequences and phases).
8	Griffiths F, Green E & Tsouroufli M	2005	To examine how health professionals talk to patients about this uncertainty, and provide a framework for reflecting on how they handle the dilemma of applying clinical evidence to particular patients	England	Observation	Hormone replacement therapy, bone densitometry, and breast screening	N/A
9	Guassora AD, Reventlow S & Malterud K	2014	To explore how patients enact presentations of self in general practice consultations addressing lifestyle.	Denmark	Observation	Lifestyle consultations	Regards medical communication as a negotiation between agents holding different, sometimes oppositional, positions.
10	Haidet P, Kroll TL & Sharf BF	2006	To examine patients' illness stories and describe the meaning of active participation from the patient's perspective.	USA	Interview	Primary care consultations	N/A
11	Hultberg & Rudebeck	2017	To describe and explore patient agency through resistance in decision-making about cardiovascular preventive drugs.	Sweden	Observation	cardiovascular prevention	When a treatment proposal is not readily followed by uptake from the patient, the interaction takes on the form of a negotiation with collaborative efforts from the participants to reach a mutually agreed decision.

(*continued on next page*)

Table 1 (*continued*)

Nr.	Author	Year of publication	Aim	Data origin	Study design	Clinical setting	Definition of negotiation
12	Hultstrand C, Coe AB, Lilja M & Hajdarevic S	2020	To explore how presentation of bodily sensations were constructed and legitimized in primary care encounters within the context of Standardized Cancer Patient Pathways (CPPs).	Sweden	Observation	Cancer care encounters	Negotiation can be understood as an ongoing process whereby individuals engage in interactions aimed to attain a certain outcome attainable only through the other party. Negotiation further encompasses development of shared meanings, understandings and agreements, "getting things accomplished" based on joint interest and balance of power. One goal of negotiating is to reach a mutual solution through the combination of expertise, power, understanding and compassion.
13	Karhila P, Kettunen T, Poskiparta M & Liimatainen L	2003	To describe how negotiation focused on lifestyle changes was produced using participants' speech in type 2 diabetes counselling during nurse-patient encounters in Finland.	Finland	Observation	Type 2 Diabetes	Negotiation requires contributions from both participants. Negotiation is fundamentally associated with solving conflicts of interest or problems between the negotiating participants or parties, who with their incompatible motives pursue a mutually satisfying agreement through this social interaction process
14	Körner H	2010	To examine how people on hepatitis C treatment experience and describe clinical interactions about treatment with their physicians	Australia	Interview	Hepatitis C	Patients' accounts of negotiating hepatitis C treatment with their clinicians are constructed against a diverse heteroglossic backdrop which encompasses voices and values from the field of biomedicine as well as from the patients' social worlds.
15	Lian OS, Nettleton S, Wifstad Å & Dowrick C	2021	To study naturally occurring talk between GPs and patients to (a) capture the manner and style in which the medical encounters are mutually conducted, (b) generate a model of modes of interaction that may have general applicability, (c) explore how interactional modes vary within and between consultations, and (d) explore how mode shifts come about within each consultation, including who initiates them.	England	Observation	General practice consultations	Negotiations are performed through a verbal exchange of speech acts between individuals who build on and respond to each other's utterances. Successful negotiation, defined as mutual agreement on a definition of a situation and a common course of action, often requires a cooperative spirit, mutual respect, shared goals, and shared decision making. It also requires that all participants provide each other with a "dialogic space" where they freely can speak their minds.
16	Lian OS, Nettleton S, Wifstad Å & Dowrick C	2021	To explore how patients and general practitioners (GPs) negotiate medical and existential uncertainty in clinical encounters.	England	Observation	General practice consultations	Negotiating uncertainty involves seeking, obtaining and exchanging information, interpreting it, and deciding how to deal with it.
17	Lown BA, Clark WD & Hanson JL	2009	To explore how patients and physicians describe attitudes and behaviours that facilitate shared decision making.	USA	Workshop	N/A	Negotiation is described as part of shared decision making. Negotiation may occur within a single encounter, or a shared decision may take place over several visits.
18	Mik-Meyer N	2015	To examine how patients with MUS affect the role of the doctor by exclusively analysing interviews with doctors on the problematic situation of patients with MUS.	Denmark	Interview	Medically Unexplained Symptoms (MUS)	Classifications of illness and health are results of social negotiations conditioned by societal institutions and norms.
19	Money A, Hussey L, Thorley K, Turner S & Agius R	2010	To explore sickness absence negotiations between GPs and patients; the initiation of certification; occupational health training on interactions;	England	Interview	Sickness absence certification	N/A

(*continued on next page*)

Table 1 (*continued*)

Nr.	Author	Year of publication	Aim	Data origin	Study design	Clinical setting	Definition of negotiation
			and GPs' role in the certification process and the doctor–patient relationship; and to identify other key issues arising from sickness absence certification due to work-related ill-health				
20	Nilsen S, Malterud K, Werner EL, Maeland S & Magnussen LH	2015	To explore GPs' specific strategies for negotiation regarding sick-leave issues with patients suffering from subjective health complaints.	Norway	Workshop	Sick leave	Doctors negotiating sick leave seek to find a balance between compassion and flexibility on one side, and impartiality and strict rule-application on the other, facing the dialectic dilemma of all public services
21	Parker D, Byng R, Dickens C & McCabe R	2020	To explore GPs' experiences of providing care for patients experiencing emotional concerns, focusing on the research questions: (a) what are GPs' experiences of providing care for patients with emotional concerns? (b) what approaches do GPs use that may differ from the guidance, and (c) how do GPs provide care within the constraints of busy clinical practice?	England	Workshop	Emotional concerns	How patients' emotional concerns are understood and managed is the result of a negotiation between patient and GP belief models and the availability of treatments.
22	Sinnott C, Hugh SM, Boyce MB & Bradley CP	2015	To explore how and why GPs make decisions when prescribing for multimorbid patients, with a view to informing the design interventions to assist prescribing and multimorbidity care.	Ireland	Interview	Multimorbidity	Negotiation is described as part of shared decision making
23	Wainwright E, Wainwright D, Keogh E & Eccleston C	2015	To explore how the structural tensions between the interests of chronic pain patients and the government's objective of reducing sickness certification are played out at the micro-level of the GP consultation.	England	Interview	Chronic pain	Complex process of social negotiation in which each party attempts to navigate the structural constraints and imperatives that their contradictory locations give rise to.
24	Walter A, Chew-Graham C & Harrison S.	2012	To explore GPs' accounts of refusing patient requests in routine, day-to-day practice and the negotiation strategies they employ.	England	Interview	N/A	N/A
25	Wilson A, Agarwal S, Bonas S, Murtagh G, Coleman T, Taub N & Chernova J	2010	To explore how the decision to treat and/or refer motivated smokers is negotiated from the perspective of the patient and doctor	England	Interview	Smoking	N/A

practice of tacit negotiation is moreover found among the professionals [40]. Among other things, Walter, Chew-Graham and Harrison [39] argue that experienced doctors strategically chose whether or not to challenge patients in certain encounters and that the strategies of tacit negotiation generally aim to avoid conflict. Along these lines, the study of Lian, Nettleton, Wifstad and Dowrick [38] shows that explicit scepticism toward the different parties' perspectives on diagnostic and etiological issue is rare in the clinical encounter.

3.4. Negotiation is dominated by the power of biomedicine

Overall, the studies in this synthesis show how the dialogue in the clinical encounter is primarily influenced by the biomedical paradigm [20,23,37,38,40–42]. Lian and colleagues describe negotiation as a dynamic interaction between two different territories of knowledge positioned in the biomedical system and show how the authority of the medicalized perspective in the social interaction in the clinical encounter is shaped, maintained, recognized and acknowledged by both the professionals and patients [38]. Hence, patients are aware that the legitimacy of their perspectives in the negotiation process depends on how they present their symptoms or concerns within the biomedical paradigm [34,38]. Andersen, Tørring and Vedsted [20] show how the patients' often complex illness narratives are summarized to suit the logic of clinical encounters in Danish general practice. Merely presenting worries is not sufficient, instead the patients have to present reasons and arguments for care-seeking and justify embodied sensations within the biomedical knowledge perspective in order to legitimize access to further care [20,21]. Patients attempt to obscure uncertainties of their problems by presenting short and well-defined illness experiences and in this way follow the biomedical logic [20].

As a way to demonstrate certainty in the clinical encounter, health professionals employ biomedical knowledge, including estimates of risk based on medical evidence for risks and benefits [27]. Exploring negotiation of medical and existential uncertainty, Lian, Nettleton, Wifstad and Dowrick [37] show how GPs mainly conceptualize uncertainty indirectly and in a depersonalized manner, and thereby safeguard against clinical errors without compromising their authority and credibility. In a similar vein, a study exploring preventive health checks in

general practice illustrates how patients divert the interaction to focus on biomedical well-defined problems by bringing other health problems into the preventive health check or follow-up conversation, such as birthmarks and eczema [41]. However, references to biomedical test-results and numeric standards are found to lessens negotiation in the clinical encounter [41].

The character of the health problem presented in the clinical encounter influences whether and how negotiations between patients and health professionals are carried out. For instance, uncertainty about the nature and the severity of a health problem can give rise to a negotiation revolving around the recognition of the health problem as well as a negotiation about possible solutions to the problem [22,34,37,38]. By contrast, negotiations rarely occur in encounters regarding simple acute conditions, such as hay fever, tonsilitis, a deviant skin lesion and ear infections [21]. In encounters where symptoms are easy to define and verify, the health professionals put less attention towards patients verbal presentations, which can explain the absence of negotiation [21]. However, at the same time, health professionals have been found to be more likely to include the patient and the patient's preferences in decision making about treatment when there is certainty about the diagnosis [26].

3.5. Negotiation is socially embedded

Based on the studies for this scoping review, we find that the conditions for negotiation depend on the character of the professional-patient-relationship [31,40]. Overall, the studies in this scoping review indicate that not only medical symptoms, diagnosis, treatment options and health perspectives are negotiated in clinical encounters. The clinical encounter is a social encounter that includes negotiations about identity, knowledge, values, and trust [25,28].

This scoping review shows that negotiation takes place on different levels. For example, a meta-communication, where the participants negotiate who is the decision maker and how the decision is going to get made, exists before the "real" negotiation process [29,38,44]. This negotiation among other things, concerns patients and professionals' preferred interaction style [38,43].

The character of the professional-patient relationship influence how negotiation occurs in the individual clinical encounter [34,40]. Exploring negotiation in general practice encounters, Broholm-Jørgensen et al. finds that GPs prioritize between the patient's health problem in relation to 1) the length of the consultation, 2) knowledge about the patient's illness history, and 3) knowledge about the patient's everyday life [40]. The fact that professionals draw on their previous knowledge about the patient and considers the patient's social life shows how negotiations in the clinical encounter are socially situated [23,34,40]. In line with the Broholm-Jørgensen et al. study, Mik-Meyer shows that symptoms are negotiated in relation to societal institutions and dominating norms, such as government policies [25]. Thus, in encounters concerning complex health problems, such as sick leave and sickness certificates, the professionals bring the political context into the negotiation process because the outcome of these consultations usually will be used and translated within a political context [25,32,33]. Dilemmas of balancing maintenance of the professional-patients relationship and keeping up to the demands of the welfare state can complicate the negotiation process even further [25,32].

This scoping review shows that the professionals' actions to preserve the professional-patient relationship influence whether and how they chose to engage in negotiation with the patient [31]. Uncertainties about the nature and the severity of a problem presented in the clinical encounter can give rise to mistrust and conflicts as both patient and professional struggle to negotiate their own definition of the situation [34]. With complex health problems professionals fear corroding trust, due to troubles aligning the medical examinations with the patients' description of their symptoms and thus not being able to meet the patient's expectations of the outcome of the clinical encounter, such as providing MUS patients with a medical diagnosis [25,34]. Strategies to avoid conflict and protect the professional-patient relationship, such as avoid using the word "no", is found in several of the studies [33,39].

3.6. Negotiation is framed by different dimensions of time

Several dimensions of time influence negotiation in the clinical encounter, for instance the length of the individual encounter, continuity in the professional-patient relationship and the course of a disease [20,31,35,36,40].

The length of the clinical encounter frames the possibilities for negotiation for both professional and patient [20,31,33,35,40]. Having relatively short time, often 10–20 min, to elicit the patient's health problem, perform an examination of the problem, and discuss the problem and potential solutions, limit the amount of health problems to be discussed in the individual clinical encounter. While discussing and prioritizing (often diffuse) symptoms and treatment options is time consuming, lack of time was found to push professionals to abstain from involving patients in decision making in complex encounters, such as encounters with patients with multimorbidity [31]. Time constraints of the individual encounter may also explain why GP-led dialogues were the most dominating in general practice encounters [24,38].

Studies in our sample show how negotiations of clinical decisions can be postponed [29] or take place over several encounters [44]. In a study exploring GPs' strategies for negotiation sick-leave issues, the authors show how GPs in a stepwise process over several encounters move towards a decision of terminating the sick leave [33]. In another study, where this process is defined as provisional decisions, the authors show that the use of time fits well in encounters characterized by uncertainty, where the test results, treatment options and patient's level of risk are changing over time [27]. Correspondingly, Sinnott et al. find that the opportunity to re-evaluate a decision in a return consultation can give clarity on the best approach to take in cases with multiple competing demands, such as multimorbidity [31].

Continuity in the patient-professional relationship provides important information and awareness to the professionals about changes in the patient's everyday life that may affect the patient's treatment adherence or lead to detection of abnormal health behavior [30,40]. In general practice this information can be achieved through the medical record, which supplies the health professionals with information about the patient's everyday life and medical history that covers a significant amount of time [40], information that is inaccessible for professionals who may see the patient only once or at infrequent intervals [27]. In this way, the interaction in the clinical encounter is specific to the individual and the situation.

Findings in this scoping review thus shows that the presented health problem in the clinical encounter is negotiated by an orientation into the patient's past experiences with health and illness and influenced by length of the encounter and continuity of the patient-professional relationship.

4. Discussion and conclusion

4.1. Discussion

It is evident from the scoping review that the concept of negotiation in the clinical encounter is an incoherent and complex concept. In this scoping review, we find that literature drawing on the concept of negotiation often refers to it as a process that is socially situated depending on the individual patient and professional, a dynamic element of the interaction that may occur both tacitly and explicitly at all stages of the encounter and is not necessarily tied to a specific health problem. Hence, this scoping review indicates that the concept of negotiation, as presented in the literature, does not thoroughly capture the social dynamics of reaching a decision in the clinical encounter.

Among other things, the finding of tacit negotiation opposes the comprehension of negotiation as a 'formal discussion'. Due to this important finding, we suggest more research to fully comprehend the different elements of the process of negotiation, which may include narrowing down negotiation as an analytical concept and adding new concepts such as 'tacit negotiation'.

While research of traditional consultations (e.g. Heritage and Clayman [45], Neighbour [46]) show that negotiation is typically linked to setting the agenda, and in the formulation of further investigations and/or treatment at the end of the consultation, the findings in this scoping review point out that negotiation occurs in several phases of the clinical encounter. Among other things, we find negotiation of interaction styles in the *opening* [47] or *connecting* [46] phase. Similar to Rapley [48], this scoping of literature demonstrates that negotiation of decisions can take place over multiple encounters. Thus, negotiation transcends the phases of the clinical encounter and even the immediate space of a single clinical encounter.

Another central finding of this scoping review is that negotiation occurs in every consultation more or less explicitly. Specifically, negotiation in most cases occurs tacitly (e.g., silence or indirect talk) and we find that explicit discussions of perspectives are rare. Generally, research within the clinical encounter and professional-patient communication have paid attention to the explicit negotiation, such as interruptions [49] and potential conflicts when denying patients' requests [50,51]. However, based on the findings in this scoping review, we recommend further research and attention to the tacit negotiation, such as indirect talk, silence, and minimal response from both the patient and professional when exploring negotiation in the clinical encounter.

As anticipated, the scoping review showed that the process of negotiation is dependent on the different knowledge paradigms present in the individual encounter. However, although the view of patient-doctor interaction has gone from paternalistic doctor-centered to patient-centered, emphasizing a more egalitarian style of interaction, several studies in our sample show that the social interaction in the clinical encounter rarely deviates from the traditional asymmetric paternalistic doctor-patient dialogue [20,23,37,38,41]. Asymmetry in the patient-professional conversation and the fact that the patient-professional interaction operates within the biomedical frame is not new [52,53]. Scholars argue that the institutional context of the clinical encounter, characterized by unwritten rules and practices for the communicative framework, challenges the health professional's translation of the biomedical logic to the patients, which may explain this finding [53,54]. Grimen argues that trust and power in the clinical encounter is interdependent and transactional because the patient transfers power by trusting the doctor and the bio-medical knowledge paradigm [11]. Unlike other theorists exploring power in the clinical encounter [55], the doctor's power is malleable because it cannot be exercised unless the patients trust the doctor [11]. In this line of thought, the uneven power distribution is legitimate and thus does not need to come to zero [56]. Conversely, the biomedical influence on the clinical encounter presents a well-known risk for those not willing or capable of arguing for their needs within the biomedical knowledge paradigm. In a recent study, Lian, Nettleton, Grange, and Dowrick [57] argue that patients, due to their vulnerable position, in which they need the doctor's help, tend to hesitate to take responsibility for clinical decisions and the potential consequences. Thus, attention to patients' social and cultural capital to talk to doctors is needed [53,54,56].

4.2. Strengths and weaknesses

With the aim of capturing the breadth and depth of negotiation in the clinical encounter in the literature, we completed a comprehensive literature search without limits in relation to year and publication type. Due to this methodological decision, we ended up including both observation and interview-based studies as well as studies applying both observations and interviews in the study design. We opted to include all three study types in one complete dataset because the findings, precisely due to the outcomes' diverse characteristics, pointed to different aspects and provided nuance to the conceptualization of negotiation.

We did not conduct a formal quality appraisal of the included studies and outcomes, other than demanding that the studies be peer-reviewed and indexed in the four chosen databases. This is because we were interested in the studies' definitions of negotiation and not the results of the studies. Methodological quality may have influenced how negotiation was interpreted in this review.

Despite using an array of keywords to maximize the identification of studies, some relevant keywords may have been missed, and our search strategy may not have detected all relevant studies. Similarly, we limited the scoping review to include studies that either presented a definition of negotiation in the text and/or presented the term negotiation in relation to the findings, with the limitation of not capturing other relevant characteristics of the process of reaching an agreement in the clinical encounter.

We chose only to include studies from primary care. Primary care is characterized by continuity in the patient-professional relationship, undifferentiated symptoms, and the care of families and populations. Contrary to acute care, the patient is responsible for implementing the decisions taken in primary care in their own social setting [8]. Further work is needed to understand the influence of the setting on the nature of negotiation, for example, to demonstrate the role of prior relationship with the professional and other forms of care.

Furthermore, in our thematic analysis we grouped together studies about different professional-patient interactions and different health problems presented in the clinical encounter. While we did find variations in the negotiation process depending on whether the health problem was easy to define or characterized by uncertainty, the results did not indicate fundamentally differences in negotiations with different professions.

4.3. Conclusion

We find that negotiation in the clinical encounter is a complex and incoherent concept. Based on the sample of literature, we find that the process of negotiation is socially situated depending on the individual patient and professional, a dynamic element of the interaction that may occur both tacitly and explicitly at all stages of the encounter and is not necessarily tied to a specific health problem. Hence, the process of having a formal discussion with someone in order to reach an agreement is complex and influenced by both social, biomedical, temporal contexts.

In this scoping review, we found that the process of negotiation in the clinical encounter occurs at all stages of the encounter, and is influenced by social, temporal, and biomedical contexts that encompass the social meeting between patient and health professional. We also found that negotiations in most cases occur tacitly and that patients claim control over proposed clinical decisions by asking reciprocal questions, minimal response, or mere silence. For this reason, we suggest future research should investigate the role of tacit negotiation in the clinical encounter.

4.4. Practice implications

Health professionals need to be aware that negotiation concerns more than reaching decisions about diagnosis and treatment; it also includes negotiations about how decisions are made and depends on the character of the health problem as well as the social relationship between the patient and the health professional. And as such, negotiation may occur in all phases of the clinical encounter, especially in complex encounters characterized by uncertainty.

Acknowledging patients' right to actively engaging in clinical decision-making has been an important international ambition for a long time [58]. Guidelines of SDM, of which negotiation is often considered to be a central part [7,59], work under the premise that patients can and will actively participate in asking informed questions

and express personal values and opinions about their conditions and treatment options. Moreover, SDM is subject to the proviso that health professionals respect patients' goals and preferences and use these to guide recommendations and treatments. Thus, both parties are considered to play an active role in the interaction. However, this scoping review shows that patients tend to engage in the clinical encounter in an indirect way. Based on this scoping review, we argue that because minimal response, reciprocal questioning, and silence might be strategies of resistance of a clinical decision making, health professionals need to be attentive to patients' tacit negotiation strategies in order to recognize patients' actual wishes for their course of treatment and thus, use them to guide recommendations and treatment.

Although, negotiation is described as an integral part of SDM, Motivational Interviewing and patient-centered care, the findings show that negotiation does not draw on a philosophical perspective of equality and symmetry in the professional-patient relationship. Rather, this scoping review indicates that the power of biomedicine can act to curb and influence the process of negotiation. A new study indicates that there is little resemblance between how the different participants in the clinical encounter experience how power relates to the process of negotiation and that power dynamics are largely absent from physicians' perspectives of negotiation [60]. The findings in this scoping review, though, indicate that physicians need to be aware of how the communication in the clinical encounter is laden with power, which may potentially limit or foreclose the process of reaching a decision.

CRediT authorship contribution statement

Nilou Freja Ekstrøm: Writing – review & editing, Writing – original draft, Formal analysis, Data curation. **Guassora Ann Dorrit:** Writing – review & editing, Supervision. **Lian Olaug S.:** Writing – review & editing, Supervision. **Christoffersen Nanna Bjørnbak:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation. **Broholm-Jørgensen Marie:** Writing – review & editing, Writing – original draft, Project administration, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Marie Broholm-Jørgensen reports financial support was provided by The Health Foundation (Helsefonden).

Acknowledgements

This work was supported by The Health Foundation (Helsefonden). [grant numbers 19-B-0255].

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.pec.2024.108134.

References

[1] Cali DD, Estrada C. The medical interview as rhetorical counterpart of the case presentation. Health Commun 1999;11:355–73.
[2] Larsen JH, Risør O, Putnam S. P-R-A-C-T-I-C-A-L: a step-by-step model for conducting the consultation in general practice. Fam Pract 1997;14:295–301. https://doi.org/10.1093/fampra/14.4.295.
[3] Rollnick S, Miller WR, Butler CC, Aloia MS. Motivational interviewing in health care: helping patients change behavior. COPD: J Chronic Obstr 2008;5. https://doi.org/10.1080/15412550802093108.
[4] Baker LH. "What else?" Setting the agenda for the clinical interview. Ann Intern Med 2005;143:766–70.
[5] Gwyn R, Elwyn G. When is a shared decision not (quite) a shared decision? Negotiating preferences in a general practice encounter. Soc Sci Med 1999;49 (1982):437–47. https://doi.org/10.1016/s0277-9536(99)00067-2.
[6] Stewart M., Brown J., Weston W., McWhinney I.R., McWilliam C.L., Freeman T.R. Patient-Centered Medicine: Transforming the Clinical Method. Publishing R, editor. Abingdon, UK2003.
[7] Hargraves IG, Montori VM, Brito JP, Kunneman M, Shaw K, LaVecchia C, et al. Purposeful SDM: a problem-based approach to caring for patients with shared decision making. Patient Educ Couns 2019;102:1786–92. https://doi.org/10.1016/j.pec.2019.07.020.
[8] Murray E, Charles C, Gafni A. Shared decision-making in primary care: Tailoring the Charles et al. model to fit the context of general practice. Patient Educ Couns 2006;62:205–11. https://doi.org/10.1016/j.pec.2005.07.003.
[9] Levenstein JH, McCracken EC, McWhinney IR, Stewart MA, Brown JB. The patient-centred clinical method. 1. A model for the doctor-patient interaction in family medicine. Fam Pract 1986;3:24–30. https://doi.org/10.1093/fampra/3.1.24.
[10] Motivational interviewing: Preparing people to change addictive behavior. New York, NY, US: The Guilford Press; 1991. Motivational interviewing: Preparing people to change addictive behavior; p. xvii, 348-xvii,.
[11] Grimen H. Power, trust, and risk: some reflections on an absent issue. Med Anthr Q 2009;23:16–33.
[12] May C, Allison G, Chapple A, Chew-Graham C, Dixon C, Gask L, et al. Framing the doctor-patient relationship in chronic illness: a comparative study of general practitioners' accounts. Sociol 2004;26:135–58. https://doi.org/10.1111/j.1467-9566.2004.00384.x.
[13] Tjørnhøj-Thomsen T. Framing the clinical encounter for greater understanding, empathy, and success. Hear J 2009;26.
[14] Arksey H, O'Malley L. Scoping studies: towards a methodological framework. Int J Soc Res Method: Theory Pract 2005;8:19–32. https://doi.org/10.1080/1364557032000119616.
[15] Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. Implement Sci 2010;5:69. https://doi.org/10.1186/1748-5908-5-69.
[16] Peters M., Godfrey C., McInerney P., Munn Z., Trico A., Khalil H. Chapter 11: Scoping Reviews.10.46658/JBIMES-20–122020.
[17] Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Ann Intern Med 2018;169:467–73. https://doi.org/10.7326/m18-0850.
[18] Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J, et al. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. BMC Med Res Method 2006;6:35. https://doi.org/10.1186/1471-2288-6-35.
[19] Mason J. Qualitative researching. 3. ed. London, UK: Sage Publications; 2018.
[20] Andersen RS, Tørring ML, Vedsted P. Global health care-seeking discourses facing local clinical realities: exploring the case of cancer. Med Anthr Q 2015;29:237–55. https://doi.org/10.1111/maq.12148.
[21] Hultstrand C, Coe AB, Lilja M, Hajdarevic S. Negotiating bodily sensations between patients and GPs in the context of standardized cancer patient pathways - an observational study in primary care. BMC Health Serv Res 2020;20:46. https://doi.org/10.1186/s12913-020-4893-4.
[22] Karhila P, Kettunen T, Poskiparta M, Liimatainen L. Negotiation in type 2 diabetes counseling: from problem recognition to mutual acceptance during lifestyle counseling. Qual Health Res 2003;13:1205–24. https://doi.org/10.1177/1049732303257153.
[23] Körner H. Negotiating treatment for hepatitis C: interpersonal alignment in the clinical encounter. Health 2010;14:272–91. https://doi.org/10.1177/1363459309358597.
[24] den Boeft M, Huisman D, Morton L, Lucassen P, van der Wouden JC, Westerman MJ, et al. Negotiating explanations: doctor-patient communication with patients with medically unexplained symptoms-a qualitative analysis. Fam Pract 2017;34:107–13. https://doi.org/10.1093/fampra/cmw113.
[25] Mik-Meyer N. The social negotiation of illness: doctors' role as clinical or political in diagnosing patients with medically unexplained symptoms. Soc Theory Health 2015;13:30–45.
[26] Chappell P, Toerien M, Jackson C, Reuber M. Following the patient's orders? Recommending vs. offering choice in neurology outpatient consultations. Soc Sci Med 2018;205(1982):8–16. https://doi.org/10.1016/j.socscimed.2018.03.036.
[27] Griffiths F, Green E, Tsouroufli M. The nature of medical evidence and its inherent uncertainty for the clinical consultation: qualitative study. BMJ 2005;330:511. https://doi.org/10.1136/bmj.38336.482720.8F.
[28] Guassora AD, Reventlow S, Malterud K. Shame, honor and responsibility in clinical dialog about lifestyle issues: a qualitative study about patients' presentations of self. Patient Educ Couns 2014;97:195–9. https://doi.org/10.1016/j.pec.2014.08.003.
[29] Hultberg J, Rudebeck CE. Patient participation in decision-making about cardiovascular preventive drugs - resistance as agency. Scand J Prim Health Care 2017;35:231–9. https://doi.org/10.1080/02813432.2017.1288814.
[30] Wilson A, Agarwal S, Bonas S, Murtagh G, Coleman T, Taub N, et al. Management of smokers motivated to quit: a qualitative study of smokers and GPs. Fam Pract 2010;27:404–9. https://doi.org/10.1093/fampra/cmq027.
[31] Sinnott C, Hugh SM, Boyce MB, Bradley CP. What to give the patient who has everything? A qualitative study of prescribing for multimorbidity in primary care. BJGP: J R Coll Gen Pract 2015;65:e184–91. https://doi.org/10.3399/bjgp15X684001.
[32] Money A, Hussey L, Thorley K, Turner S, Agius R. Work-related sickness absence negotiations: GPs' qualitative perspectives. BJGP: J R Coll Gen Pract 2010;60:721–8. https://doi.org/10.3399/bjgp10X532350.
[33] Nilsen S, Malterud K, Werner EL, Maeland S, Magnussen LH. GPs' negotiation strategies regarding sick leave for subjective health complaints. Scand J Prim Health Care 2015;33:40–6. https://doi.org/10.3109/02813432.2015.1001943.

[34] Wainwright E, Wainwright D, Keogh E, Eccleston C. The social negotiation of fitness for work: tensions in doctor-patient relationships over medical certification of chronic pain. Health 2015;19:17–33. https://doi.org/10.1177/1363459314530738.
[35] Parker D, Byng R, Dickens C, McCabe R. Every structure we're taught goes out the window": general practitioners' experiences of providing help for patients with emotional concerns. Health Soc Care Community 2020;28:260–9. https://doi.org/10.1111/hsc.12860.
[36] Davey A, Asprey A, Carter M, Campbell JL. Trust, negotiation, and communication: young adults' experiences of primary care services. BMC Fam Pract 2013;14:202. https://doi.org/10.1186/1471-2296-14-202.
[37] Lian OS, Nettleton S, Wifstad Å, Dowrick C. Negotiating uncertainty in clinical encounters: a narrative exploration of naturally occurring primary care consultations. Soc Sci Med 2021;291(1982):114467. https://doi.org/10.1016/j.socscimed.2021.114467.
[38] Lian OS, Nettleton S, Wifstad Å, Dowrick C. Modes of interaction in naturally occurring medical encounters with general practitioners: the "one in a million" study. Qual Health Res 2021;31:1129–43. https://doi.org/10.1177/1049732321993790.
[39] Walter A, Chew-Graham C, Harrison S. Negotiating refusal in primary care consultations: a qualitative study. Fam Pract 2012;29:488–96. https://doi.org/10.1093/fampra/cmr128.
[40] Broholm-Jørgensen M, Kamstrup-Larsen N, Guassora AD, Reventlow S, Dalton SO, Tjornhoj-Thomsen T. Negotiation, temporality and context – a qualitative study of the clinical encounter. Eur J Person Centered Healthcare 2019;7:334–43.
[41] Broholm-Jørgensen M, Langkilde SM, Tjørnhøj-Thomsen T, Pedersen PV. Motivational work': a qualitative study of preventive health dialogues in general practice. BMC Fam Pract 2020;21:185. https://doi.org/10.1186/s12875-020-01249-z.
[42] Drass KA. Negotiation and the structure of discourse in medical consultation. Sociol 1982;4:320–41. https://doi.org/10.1111/1467-9566.ep10487982.
[43] Haidet P, Kroll TL, Sharf BF. The complexity of patient participation: lessons learned from patients' illness narratives. Patient Educ Couns 2006;62:323–9. https://doi.org/10.1016/j.pec.2006.06.005.
[44] Lown BA, Clark WD, Hanson JL. Mutual influence in shared decision making: a collaborative study of patients and physicians. Health Expect J 2009;12:160–74. https://doi.org/10.1111/j.1369-7625.2008.00525.x.
[45] Heritage J., Clayman S. Patients' Presentations of Medical Issues: The Doctor's Problem. In: Heritage J, Clayman S, editors. Talk in Action: interactions, identities, and institutions;https://doi.org/10.1002/9781444318135.ch8: Chichester Malden: Wiley-Blackwell; 2010. p. 101–18.
[46] Neighbour R. The Inner Consultation: How to Develop an Effective and Intuitive Consulting Style. Second edition ed: CRC Press; 2005.
[47] Byrne P., Long B. Doctors Talking to Patients. London: HMSO; 1976.
[48] Rapley T. Distributed decision making: the anatomy of decisions-in-action. Sociol 2008;30:429–44. https://doi.org/10.1111/j.1467-9566.2007.01064.x.
[49] Coyle AC, Yen RW, Elwyn G. Interrupted opening statements in clinical encounters: a scoping review. Patient Educ Couns 2022;105:2653–63. https://doi.org/10.1016/j.pec.2022.03.026.
[50] Breivold J, Rø KI, Hjörleifsson S. Conditions for gatekeeping when GPs consider patient requests unreasonable: a focus group study. Fam Pract 2022;39:125–9. https://doi.org/10.1093/fampra/cmab072.
[51] Nilsen S, Malterud K. What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway. Scand J Prim Health Care 2017;35:201–7. https://doi.org/10.1080/02813432.2017.1333309.
[52] Coupland J, Robinson JD, Coupland N. Frame negotiation in doctor-elderly patient consultations. Discourse Soc 1994;5:89–124. https://doi.org/10.1177/0957926594005001005.
[53] Pilnick A, Dingwall R. On the remarkable persistence of asymmetry in doctor/patient interaction: a critical review. Soc Sci Med 2011;72(1982):1374–82. https://doi.org/10.1016/j.socscimed.2011.02.033.
[54] Schneider-Kamp A, Askegaard S. Putting patients into the centre: patient empowerment in everyday health practices. Health 2020;24:625–45. https://doi.org/10.1177/1363459319831343.
[55] Foucault M. The history of sexulaity. New York: Vintage; 1980.
[56] Timmermans S. The engaged patient: the relevance of patient-physician communication for twenty-first-century health. J Health Soc Behav 2020;61:259–73. https://doi.org/10.1177/0022146520943514.
[57] Lian OS, Nettleton S, Grange H, Dowrick C. I'm not the doctor; I'm just the patient": patient agency and shared decision-making in naturally occurring primary care consultations. Patient Educ Couns 2022;105:1996–2004. https://doi.org/10.1016/j.pec.2021.10.031.
[58] World Health O. WHO global strategy on people-centred and integrated health services: interim report. Geneva: World Health Organization; 2015 2015. Contract No.: WHO/HIS/SDS/2015.6.
[59] Stiggelbout AM, Pieterse AH, De Haes JC. Shared decision making: concepts, evidence, and practice. Patient Educ Couns 2015;98:1172–9. https://doi.org/10.1016/j.pec.2015.06.022.
[60] Macdonald G, Asgarova S, Hartford W, Berger M, Cristancho S, Nimmon L. What do you mean, 'negotiating?' Patient, physician, and healthcare professional experiences of navigating hierarchy in networks of interprofessional care (ahead-of-print) J Inter Care 2023:1–12. https://doi.org/10.1080/13561820.2023.2203722.