USING CONVERSATION ANALYSIS TO REVIEW AND IMPROVE BRIEF WEIGHT LOSS INTERVENTIONS IN PRIMARY CARE



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Abstract

Using conversation analysis to review and improve brief weight loss interventions in primary care

National guidelines exhort GPs to give brief opportunistic interventions for weight loss which incorporate the offer of referral to an effective behavioural programme, such as a commercial weight management service (CWMS). These brief interventions have been shown to be effective. However, GPs rarely deliver these interventions, and have requested more support to facilitate delivery. Current guidelines provide little detail to support GPs because there is sparse evidence regarding how to deliver effective opportunistic interventions.

In this thesis I aimed to understand what conversational strategies used by GPs are likely to result in patient agreement-to-attend, and actual attendance at a CWMS referral, and use the findings to develop an information resource to support primary care clinicians. I used a mixed methods approach including: a systematic review of evidence from conversation and discourse analytic studies; conversation analysis of audio recorded data from the brief interventions for weight loss (BWeL) trial; and statistical analysis of BWeL patient outcome data.

In a systematic review to identify how healthcare professionals can best communicate with patients about health behaviour change I found ten papers. Results demonstrated a series of specific conversational practices which clinicians use when talking about health behaviour change, and how patients respond to these. Results largely complemented clinical guidelines, providing further detail on how they can best be delivered in practice. However, one recommended practice -linking a patient's health concerns and their health behaviours - was identified as potentially problematic.

In three studies using conversation and statistical analyses to examine data from the BWeL trial I examined how referrals to CWMS were structured, delivered, and received. In the first study I found that referrals were formatted as 'news deliveries'. I identified three news delivery formats, and found that use of a 'good news' delivery format showed evidence of motivating patient agreement-to-attend, and actual attendance.

In the second study I focussed on patient responses to the announcement of news. I found that patients displayed positive or negative reception of the referral early in the sequence, before they had been explicitly asked if they would like to attend. I found that positive and negative reception displays following the announcement of news were associated with subsequent attendance (or not) at the referral. Additionally, orienting to these patient responses which were produced early in the consultation, showed evidence of maintaining the brevity of the intervention.

In the third study I examined when and how GPs articulated an association between a patient's weight and their health, and how patients responded. I found that, although this strategy is recommended by guidelines, linking was no more effective than not-linking, but did seem likely to generate displays of resistance in many cases, and was associated with longer consultations.

This thesis demonstrates associations between conversational practices and longer-term patient action. This provides specific evidence for GPs on how to deliver effective opportunistic brief interventions for weight loss. Results from this thesis highlight the importance of careful attention to conversational features to identify effective communication which has potential to improve practice.

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Glossary of Key Terms and Abbreviations

Commercial weight management service (CWMS)	A commercially funded group-based service aimed at motivating weight loss through dietary advice, physical activity advice, and behaviour change components
Conversation analytic role-play method (CARM)	An approach to communication skills training grounded in results from conversation analysis which can be adapted to any institutional encounter
Health behaviours	Behaviours which could influence a person's health or risk of future ill-health. These behaviours would need to be repeated or represent a long-term change that was considered to be within a patient's control
Health behaviour change talk (HBCT)	Talk designed to change health behaviours
Lexical	Words used during talk-in-interaction
News delivery sequence (NDS)	The sequence through which news can be delivered and receipted. This consists of an announcement, announcement response, elaboration of news, and assessment of news
Non-lexical	Vocalisations, which are not words, used during talk in interaction
Patient and public involvement (PPI)	The process of involving patients and members of the public to support research design
Perspective display series (PDS)	The process through which a person's view on a topic is elicited and reported before news about that topic is delivered
Positive reception display (PRD)	Ways through which people display that prior talk has been positively received
Prosody	Patterns of stress and intonation used during talk-in-interaction
Transition relevance place (TRP)	A point in talk where it is relevant for speakership to change
Turn constructional unit (TCU)	A unit of talk-in-interaction which is complete in grammar, action, and prosody
Valence	The emotional lamination ascribed to aspects of talk-in-interaction which ascribes affective orientation

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Chapter 1
Introduction

1.1 Introduction

In this chapter I introduce the evidence gap which I address with this thesis. I first provide a summary of current guidelines which encourage primary care clinicians to opportunistically discuss weight and offer referral to effective behavioural services. I then present an overview of current literature which explores how these guidelines are implemented in practice, and the views of both clinicians and patients on taking part in weight management discussions. I identify gaps in current evidence and highlight areas where further research is needed, presenting my specific aim and objectives for this thesis in the context of these gaps. I finally introduce the data which I use to address my aim and objectives throughout this thesis.

1.2 Clinical guidelines on weight management discussions

Clinical guidelines exhort primary care clinicians to intervene on obesity (1-5). As part of this strategy, guidelines recommend that primary health care clinicians opportunistically discuss weight, and offer referral to effective behavioural services to adults who have a BMI$\geq$30. These services, known as Tier 2 services, provide multi-component lifestyle interventions. To be eligible as an NHS referral site, they should include dietary advice, physical activity advice, and behaviour change components (2, 6, 7).

In the UK, National Institute for Health and Care Excellence (NICE) guidelines recommend that clinicians "Refer overweight and obese adults to a lifestyle weight management programme" (3), and guidelines from Public Health England (PHE) and the Royal College of Physicians (RCP) all provide recommendations consistent with this. In the US "Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral (sic.) interventions" (8),

and Canadian guidelines make similar recommendations (9). An overview of the specific recommendations from each guideline is presented in Table 1.1. These recommendations – to opportunistically discuss weight, and offer referral to patients with a BMI≥30 – are largely consistent across these guidelines. In the UK, NICE guidelines are based on commissioned evidence reviews, which assess available literature in order to formulate recommendations for practice. Whilst these evidence reviews examine the effectiveness of referrals to effective behavioural services in detail (10-13), evidence about how to deliver these referrals in practice is sparse. This is common across guidelines, and illustrated in Table 1.1. Both the U.S. Preventive Services Task Force and Canadian Task Force on Preventive Health Care offer vague, non-specific advice on how to refer patients to these services. Clinicians are advised only to "Offer/provide this service" (8) or to "Have a discussion with your patient, and offer or provide referral…" (9). NICE guidelines are the most specific, comprising of two recommendations which advise clinicians to: Refer overweight and obese adults to Tier 2 weight management services (recommendation 6); and to address the expectations and information needs of adults thinking about attending (recommendation 7).

In contrast to US and Canadian guidelines, NICE guidelines also provide some details for clinicians on how to implement each recommendation. For example, these include to "Raise the issue of weight loss in a respectful and non-judgmental way" and to "Discuss the importance and wider benefits of… making gradual, long-term changes". Although NICE guidelines seem to provide more specific advice which could support GPs to offer referrals, primary care clinicians have articulated a reluctance to follow these current guidelines (14). They have stated that current advice from guidelines is not enough, and articulated a need for more *specific* resources to help them tackle the issue of overweight and to help them to discuss weight management in practice (15).

Table 1.1 Clinical guidelines on delivering weight management referrals

Guideline	Recommendation	Details of how to carry out the recommendation in practice
U.S. Preventive Services Task Force (USPSTF) Recommendation statement on screening for obesity and overweight in adults (8)	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioural interventions (B recommendation).	Offer/provide this service.
Canadian Task Force on Preventive Health Care Obesity in Adults: Recommendations for prevention of weight gain and use of behavioural and pharmacologic interventions to manage overweight and obesity in adults in primary care (9)	Have a discussion with your patient, and offer or provide referral to structured behavioural interventions aimed at weight loss. For adults who are obese (BMI 30–39.9) and are at high risk of diabetes, we recommend that practitioners offer or refer to structured behavioural interventions aimed at weight loss. *(Strong recommendation; moderate-quality evidence)* For adults who are overweight or obese, we recommend that practitioners offer or refer to structured behavioural interventions aimed at weight loss. *(Weak recommendation; moderate-quality evidence)*	Have a discussion with your patient, and offer or provide referral to structured behavioural interventions aimed at weight loss

NICE Guidelines Weight management: lifestyle services for overweight or obese adults Public health guideline [PH53](3) *Several other NICE guidelines also recommend that clinicians refer overweight and obese adults to lifestyle weight management programmes (CG143, PH11, PH27, PH28, PH38, PH42 and PH54). Those presented here are, at the time of writing, the most up-to-date and comprehensive.*	Recommendation 6: Refer overweight and obese adults to a lifestyle weight management programme	GP practices and other health or social care professionals who give advice about, or refer people to, lifestyle weight management programmes (see Who should take action?) should: Raise the issue of weight loss in a respectful and non-judgemental way. Recognise that this may have been raised on numerous occasions and respect someone's choice not to discuss it further on this occasion. Identify people eligible for referral to lifestyle weight management services by measuring their body mass index (BMI). Also measure waist circumference for those with a BMI less than 35 kg/m2. Consider any other locally agreed risk factors. For funded referrals, note that: Programmes may particularly benefit adults who are obese (that is, with a BMI over 30 kg/m2, or lower for those from black and minority ethnic groups) or with

	Recommendation 6 (continued)	other risk factors (comorbidities such as type 2 diabetes). Where there is capacity, access for adults who are overweight should not be restricted (that is, for people with a BMI between 25 to 30 kg/m2, or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes). There should be no upper BMI or upper age limit for referral. Provide information on programmes available locally, where possible, taking people's preferences and previous experiences into account. Be clear that no programme holds the 'magic bullet' or can guarantee long-term success. Refer people to a group rather than an individual programme if they express no preference because, on average, group programmes tend to be more cost effective.

		Ensure people who are overweight or obese who are not referred (for whatever reason) have an opportunity to discuss and reconsider attending a programme in the future. Discuss making a follow-up appointment at an agreed date (for example, in 3 to 6 months). Provide them with sources of information about how to make gradual, long-term changes to their dietary habits and physical activity levels (for example, NHS Choices). Give people the opportunity for a re-referral, as necessary, because weight management is a long-term process. Use clinical judgement, taking into account the person's circumstances, previous experiences of weight management and commitment to change.
	Recommendation 7: Address the expectations and information needs of adults thinking about joining a lifestyle weight management programme	GPs and other health or social care professionals advising or referring adults to lifestyle weight management programmes, and providers advising people who are thinking about joining programmes (see Who should take action) should:

		Discuss the importance and wider benefits of adults who are overweight or obese making gradual, long-term changes to their dietary habits and physical activity levels. Discuss what the programme does and does not involve. Discuss realistic weight-loss goals.
	Recommendation 7 continued	People should be aware that: The more weight they lose, the greater the health benefits, particularly if someone loses more than 5% of their body weight and maintains this for life. On average, people attending a lifestyle weight management programme lose around 3% of their body weight, but this varies a lot. Preventing future weight gain and maintaining a lower weight trajectory leads to health benefits.

		Discuss the effort and commitment needed to lose weight and prevent weight regain, and the benefit of receiving long-term support. Discuss sources of long-term support, such as from the practice nurse, pharmacist, local support group or weight management programme, online groups or networks, and friends or family.
Royal College of Physicians Policy: Public Health Action on obesity: Comprehensive care for all (2)	Patients should be referred to Practice-based weight management intervention (if currently delivered) or Slimming on referral	GPs may refer patients that meet **all** of the following criteria: They have a BMI of >30 or BMI >28 with comorbidities (>28 for Asian patients). There must be documented evidence of Tier 1 intervention for at least 6 months prior to referral and that the patient has not achieved sufficient sustained weight loss. They have not attended a slimming group in the last 3 months. Patients must meet the readiness for change criteria.

The review of available evidence used to create NICE guidelines was derived solely from clinician-reported perceptions of what works best (10) rather than an evidence-base of best practice. As a result, this NICE evidence review on offering referrals identifies a clear dearth of data on how to best do so. This NICE review examined qualitative and quantitative evidence about how Tier 2 multicomponent behavioural weight management programmes are commissioned, run, and viewed by both patients and clinicians. The authors state that the 28 studies reviewed "provide no clear guidance as the *(sic.)* most effective referral process for improving uptake or adherence." (10). This evidence review states that knowledge of *how* to deliver effective referrals is vital for success (10), identifying a clear gap in current research.

1.3 Discussing weight management in primary care

Although guidelines recommend intervening on obesity, evidence indicates primary care clinicians do not commonly intervene on patient weight. A cohort study of 91,413 patients with overweight or obesity showed that most patients do not receive weight management interventions in primary care (16). A systematic review of patients' experiences also reported that discussion of weight management occurred very rarely (17). As a result, patients experience "a lack of access to weight management interventions in primary care" (16). This absence of weight management advice has been reported to evoke a number of negative feelings from patients, including stigmatisation (18, 19) that discussing weight was not worthy of a doctor's time (18, 20, 21); a failure on the doctor's part to address a key heath issue (22); and that their weight was not problematic and did not merit intervention (19). In a survey of 366 people with overweight and obesity, most stated wanting "more help with weight management than they are getting from their primary care physicians" (23).

Patient views and experiences have been explored through interviews (18, 19, 21, 24-26), and focus groups (27-29). In these studies most patients with obesity stated a belief that they should lose weight, and reported feeling positively about discussing their weight with a GP. Patients across existing studies stated that primary care was

the preferred setting for weight management, and weight management discussions (20, 26), and that appropriately delivered discussions would be welcome (20, 24). However, they also reported that this topic is often avoided by primary care clinicians during consultations (23). A systematic review of clinicians' reports of their own practice aligns with evidence from these patient reports and Booth et al's cohort study (30). Booth et al hypothesise that a reason for this is a "lack of clinician awareness or confidence in treating obesity" (16). However, should they deliver such interventions, evidence shows that GPs prefer offering programmes that encourage lifestyle change over more clinical treatments for obesity (31).

I have shown that guidelines encourage clinicians to intervene on patients' weight, and patients often report that they would welcome such discussions. However, evidence shows that primary care clinicians rarely intervene on obesity. The guidelines on the management of obesity I have mentioned above (6) do not appear to have been successfully implemented into practice. Primary care clinicians report a number of barriers to implementing these guideline-recommended practices. I explore below the key barriers clinicians report to delivering brief interventions for weight loss which incorporate the offer of referral to effective behavioural services.

1.3.1 Clinician reported barriers to discussing weight management in primary care

GP opinions on discussing weight management in practice have been researched extensively. Interview (25, 26, 32-38), survey (39, 40), and focus group (14, 40-43) studies have been conducted exploring GP views and thoughts on this subject. These studies generally focus on barriers to discussing weight, rather than on how best to do so. This existing evidence shows that GPs report reluctance to follow guidelines (14) because they say that they are general and unspecific (15). GPs also report other key barriers too, and I now discuss these.

1.3.1.1 Lack of time

A systematic review of qualitative studies found that time limitations are a leading barrier to discussing weight management, and GPs perceived they had insufficient

time to effectively address obesity (30, 37, 44, 45). 'Time famine' in primary care is very real (46, 47). Competing priorities for GPs' tightly limited consultation time can lead them to prioritise presenting concerns over intervening on health behaviours (37, 44). They state "We've got enough to do, in terms of sorting and presenting the complaint and then sorting out the ongoing stuff and sorting out the critical health stuff and that's quite enough for 10 minutes, thank you very much." (25), and "it's the conflict of time for all the other things that we're supposed to do…" (44).

One way to offer these guideline-recommended interventions which incorporate referral that would address the clinician reported barrier of limited time, is to ensure these are kept as brief as possible. 'Brief interventions' involve discussion of a health behaviour, and may also include support, referral, or follow-up. These are typically carried out opportunistically, and take less than two minutes (48). Not only are brief interventions in primary care reported as preferred by clinicians (31), but systematically reviewed evidence of data from randomised controlled trials (RCTs) indicates that brief opportunistic interventions on health behaviours can be effective (49, 50). Up until recently RCTs showed referral to be effective only in people seeking treatment for obesity (51). The Brief Interventions for Weight Loss (BWeL) trial was the first to examine the effect of brief opportunistic weight management referrals in an unmotivated population not seeking help to lose weight, and showed these to be effective in this population (52). Brief interventions incorporating the offer of referral in primary care have been shown to be both acceptable to patients and GPs, and successful in terms of patient weight loss (52). These offer a means to support patients to lose weight within the institutional time constraints of primary care. However, whilst BWeL clinicians were trained to deliver these interventions in 30 seconds, most discussions were far longer, ranging from 8 to 458 seconds, with an average of 95 seconds. There is a lack of evidence on how brief opportunistic weight management interventions which incorporate the offer of referral to an effective behavioural service can be kept appropriately short, and avoid placing significant additional burden on time-poor clinicians.

1.3.1.2 Lack of confidence

As well as reporting a lack of time, another reason GPs stated for feeling reluctant to engage in weight management discussions with patients was lack confidence when talking about weight (39). This includes a lack of confidence that the discussions will be well received, with primary care clinicians reporting concerns that raising the topic of weight management, particularly if it was opportunistically, would offend patients (15). Clinicians state concerns that patients would react with negative emotions, they "may be sensitive about the issue, take offence or feel ''got at'', may object or get angry, or may be tired of hearing the same message" (15). They reported beliefs that these responses from patients could also damage their ongoing relationship (15, 44), and even alienate patients from future care seeking (44). Clinicians also report a lack of confidence that discussions incorporating weight loss interventions are successful, one stating "I just haven't seen it be very successful with very many people*"* (38).

Although clinicians report concern that discussing weight management with patients can cause upset or offence, patients report that they welcome such discussions if they are appropriately delivered. Existing studies provide sparse evidence on patients' reactions to clinicians' advice as I have already stated that discussion of weight management occurs very rarely (17). However, where discussions about weight *did* occur, patients reported the importance of communication techniques in ensuring discussions were well received. Specific words such as 'obese'(22) and 'morbidly obese'(53) were stated to be perceived negatively. The overall 'tone' of the conversation was also important to patients, who emphasised importance of tone of voice (22) and a 'caring manner'(24).

Whilst clinicians express a lack confidence that they are effective in motivating weight loss, patients state that these discussions can indeed motivate them to lose weight, but can also demotivate them. Some tones of voice and language used by clinicians have been reported to create negative feelings in patients (20, 21), and to have undermined motivation to lose weight (18, 22). Whilst patients report that doctors' word choice and tone of voice matter to them when having conversations about weight, and have important implications for what they do next, it is not

currently known *which* words, phrases, or tones these are. This is because existing studies mainly analyse post-consultation reports which explore perceptions and experiences of these conversations, rather than data which shows how conversations were actually carried out.

Because of this lack of evidence on what specific practices used during a weight management conversation are both well received by patients, and likely to motivate patient action on their weight, how GPs can address the barrier of 'lack of confidence' is unknown. Therefore, detailed support cannot be included in guidelines. However, analysing real conversations and exploring how weight-management referrals are really done in practice, and with what response, can address this knowledge gap and provide an evidence base of best practice to support GPs to deliver referrals more acceptably, frequently, and effectively.

1.3.1.3 Lack of knowledge

In the first section of this chapter I showed that GPs are reluctant to follow guidelines which do not provide specific information to support delivery of weight management interventions which incorporate the offer of referral. However, it is not only guidelines that GPs state are inadequate. GPs report a lack of knowledge on how to discuss weight (14, 54), and a need for further training to increase their skills and knowledge in addressing the issue of obesity (15, 39, 44). Blackburn et al. argued that these concerns could be addressed firstly through "providing evidence of effective interventions that are feasible to deliver within consultations" and, secondly, through using this evidence to design and deliver training. Their study concluded that addressing these two factors may lead to "greater practitioner engagement and willingness to raise the topic" (44). I agree with Blackburn that provision of evidence and evidence-based training is important. However, in addition to this, I believe that the strategies imparted through training should be first reviewed by clinicians, patients, and policy makers who are all experienced stakeholders in the process of weight management discussions.

In this chapter so far I have highlighted a mismatch between guidelines and practice.

There is clear lack of evidence underpinning guidelines to support clinicians to refer patients effectively. This is important because clinicians are encouraged to have potentially sensitive conversations about weight without any evidence for the effectiveness of the techniques that are recommended. GPs have stated they find these conversations difficult, and current support is not enough to help them to discuss weight management more frequently. This means many patients who are eligible for a referral, and who could potentially welcome a conversation with their GP, are not being provided with these opportunities. We need to better align guidelines with evidence to support GPs to have these discussions and need more evidence of effective practice to achieve this.

1.4 BWeL Trial

1.4.1 Background:

In this thesis I use existing data from The Brief interventions for Weight Loss (BWeL) trial to address this evidence gap. The BWeL trial was a parallel two-arm, randomised controlled trial assessing the effects of GP-delivered brief weight loss interventions in primary care. In the trial, 137 GPs randomised 1882 consecutively attending patients who were obese to one of two opportunistic interventions to motivate weight loss. These interventions were added at the end of a typical GP consultation, and could be delivered in 30 seconds. In the intervention group, GPs endorsed, offered, and facilitated a referral to an effective behavioural programme – in this case a commercial weight management service (CWMS) – for free for 12 weeks. In the control group, GPs advised weight loss to improve health. Both interventions were reported to be equally well-received in patient post-consultation satisfaction ratings; only 1 in 500 thought it was inappropriate and unhelpful. The population receiving the intervention lost 2.4kg on average at one year, while the control group lost 1kg, a difference of 1.43 kg (95% CI 0.89–1.97, $p<0.0001$). Data collected from the BWeL trial included audio recordings of weight loss interventions; the reactions of patients to the consultation reported immediately afterwards; the actions they took to address their weight; and their weight loss. These

data provide a rich corpus through which to address my research objectives in this thesis.

1.4.2 Role of secondary analysis of BWeL data

I previously identified a clear evidence gap: whilst guidelines recommend GPs offer patient referral to CWMS, they are not underpinned by any evidence of how to do so, therefore they offer little support for GPs. Subsequently, GPs report reluctance to discuss weight in practice and a need for more training and support to do so effectively.

A potential reason for this lack of evidence may be because it is rare for GPs to discuss weight with patients, or to offer weight management referrals. Therefore, recording and analysing these discussions is difficult. A cohort study of 91413 primary care patients found that clinicians do not commonly report intervening on obesity. The authors demonstrated that there was no record of weight management discussion during the 7 years of the study in 60.0% of men and 58.1% of women with morbid obesity. Furthermore, in patients with a BMI between 30 and 34.9 kg/m^2 (non-severe obesity) there was no record of weight management discussion in 84.2% of men and 80.2% of women (16). In contrast to this, GPs in the BWeL trial offered a brief intervention to all adult patients where it was clinically appropriate to do so. The recordings from the support arm of the trial contain 246 instances of offering a brief intervention in which weight management referrals were offered to patients, and therefore provide a good opportunity to identify how different conversational practices are likely to be responded to by patients.

Although the BWeL interventions were broadly successful (52), there was variation in their delivery and reception. The first of these was variation in delivery time. GPs received training showing that interventions could be delivered in 30 seconds. However, in practice the average delivery time was 95 seconds, with a range of 8-458 seconds. Using up to seven and half minutes of a 10-minute consultation to intervene on obesity is unlikely to address GPs articulated need for discussions which fit within the time constraints of the primary care consultation. However,

many GPs did deliver referrals in 30 seconds or less, therefore these data offer the prospect to examine how discussions can be kept brief.

There was also variability in how patients received these referrals. GPs report concern that they will upset patients by discussing their weight. Following referral patients were asked to report how appropriate and helpful they found these conversations. Patients independently reported these outcomes on a scale from 'not at all appropriate' and 'not at all helpful', to 'very appropriate' or 'very helpful'. When reporting appropriateness 4 patients (<1%) reported that it was 'not at all appropriate; 11 patients (1%) stated it was 'not appropriate'; 63 patients (7%) stated it was 'neither appropriate nor inappropriate'; 364 (39%) stated it was appropriate; and 490 (53%) 'very appropriate'. Variability was similar for 'helpfulness'. Consultation recordings show that some patients were audibly upset by these discussions, whist other displayed positivity towards the offer of referral. This variability provides good opportunity to identify how referrals can be delivered in ways which are likely to be received positively, and how clinicians can discuss weight without upsetting patients, which is a leading concern that they report.

Another reason GPs do not intervene on obesity is because they think patients will not act. In the BWeL trial 722 (77%) of 940 participants agreed-to-attend the weight management programme and 379 (40%) attended. Access to recordings where some people agreed, and some did not, and some people attended, and some did not, shows potential to see if any factors of referral delivery influence these outcomes. If so, training clinicians in these aspects of delivery could optimise their success, and increase GP confidence that what they are saying is likely to be both well received and associated with action. Existing work has explored communication practices in clinical settings, and how patients respond (55-57). The BWeL dataset however, provides the rare opportunity to explore associations between communication practices and patient action.

Research using this dataset can contribute to an evidence base of conversational techniques which have been used successfully in practice to facilitate patient agreement to, and attendance at, commercial weight management services. I describe and justify the specific outcome measures used in this thesis in Chapter 2. This

evidence can highlight effective referral processes for improving uptake and adherence (10), addressing the gap in the NICE guidelines and providing evidence to support development of training and support for GPs.

1.5 Summary

To summarise, I have shown that guidelines recommend intervening on obesity in general practice though offering referral to effective behavioural services. However, these guidelines are vague and unspecific, and are not underpinned by evidence. Primary care clinicians report rarely discussing weight management with patients with obesity, and have called for more specific advice on how best to do. They have a series of concerns about these discussions, including a lack of time. Brief interventions for weight loss which incorporate referral to effective behavioural services have been shown to be effective, and broadly acceptable to both patients and clinicians, addressing concerns about limited time. There is, however, variation in their delivery, reception, and effectiveness. There is no current evidence on how these are best delivered in ways which facilitate patient action, and which are well received. Clinicians have stated a need for this specific evidence to better to support them to intervene on weight. The audio recorded weight management discussions and linked patient data from the BWeL trial provide a rich dataset to build an evidence base of effective practice. These data provide good opportunity to address existing knowledge gaps and identify specific conversational patterns and practices GPs use during these conversations. This work can build an evidence base of effective practice that can support GPs to better deliver brief and effective interventions.

1.6 Thesis aims

Aim:

To understand what conversational strategies used by clinicians are likely to result in patient agreement to attend and actual attendance at a weight management referral, and to develop an information resource to support delivery.

Objectives:

1. To identify and synthesise evidence from conversation and discourse analytic studies regarding how health care professionals communicate with their patients about health behaviour change, and how patients respond.
2. To determine the conversational strategies used by GPs in the BWeL trial which were particularly effective or ineffective in producing in-consultation displays of agreement, patient reported satisfaction, and post-consultation attendance at CWMS and post-consultation attendance at CWMS.
3. To identify how brief interventions could be shortened.
4. To work with key stakeholders to formulate successful conversational strategies into a video-based information resource using the conversation analytic role play method (CARM).

1.7 Thesis structure

Chapter 2 – Methods and Methodology

This chapter describes the methods used in this thesis and the methodology which underpinned my approach. I provide information on the BWeL corpus and the patient outcome measures used throughout this thesis.

Chapter 3 - Communicative practices in health behaviour change talk: A systematic review and thematic synthesis

In chapter three I address the first objective of this thesis. I review systematically, and synthesise, existing literature on health behaviour change talk in clinical settings. I examine what is known about how conversations about health behaviour change are delivered in clinical practice, and the responses they are likely to generate from patients. I aggregate similar practices to build a picture of how health behaviour change talk is enacted at each stage of the clinical consultation, and discuss these results in the context of clinical guidelines.

Chapter 4 – The referral sequence in the BWeL trial

This chapter concerns the second, third, and fourth objectives of this thesis. I explore the referral sequence in the BWeL trial. I first explicate the referral sequence itself, uncovering the stable structures behind these discussions. I next detail the actions clinicians undertook as they delivered brief interventions. I then highlight which of these actions produced smooth referral sequences, and which were likely to generate interactional troubles, such as displays of misunderstandings from patients. These results offer comment on what specific aspects of a referral sequence could be best used by clinicians to move swiftly through the referral sequence. I then explore the valence clinicians asserted towards the referral. I take a mixed methods approach to examine relationships between GP-asserted valence and patient outcomes. I finally discuss how results from this chapter contributed to a resource for training clinicians in delivering brief interventions which incorporate referral to effective behavioural services.

Chapter 5 - When to stop a brief intervention: In-consultation responses to GP delivered brief weight loss interventions, and subsequent patient action

Chapter five further concerns the third and fourth objective of this thesis. I take a tight focus on patients' first responses to the announcement of the referral. I examine which responses constitute displays of positive reception or explicit rejection, and how GPs respond. I use these responses to identify interactional cues that referrals could be shortened, and quantify the potential time savings this would offer clinicians. I finally discuss how results from this chapter contributed to a resource for training clinicians in delivering brief interventions which incorporate referral to effective behavioural services.

Chapter 6- The impact of linking weight with health in the BWeL trial

This chapter concerns objectives two, three, and four of this thesis. I analyse a practice for discussing weight which is commonly recommended across guidelines, and preferred by clinicians. I explicate how this practice -linking weight with health- is achieved in practice and its implications for patient responses. I then quantify the effects of this practice on patient outcomes. I finally discuss how results from this

chapter contributed to a resource for training clinicians in delivering brief interventions which incorporate referral to effective behavioural services.

Chapter 7 Discussion and conclusions

In chapter seven I summarise the findings from this thesis and discuss how these build upon current literature. Here I present the complete resource for training to which results from each chapter contributed, and discuss the process of stakeholder involvement in its development. I examine my findings in the context of primary care conversation analytic literature, as well as considering how these results align with, or contradict, clinical guidelines. I discuss the implications of these findings for policy and practice, and make recommendations for further research.

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Chapter 2

Methodology and Methods

2.1 Introduction

In the first chapter of this thesis I highlighted a lack of evidence of effective practice for delivery of brief interventions for weight loss which incorporate the offer of referral to an effective behavioural programme, such as a commercial weight management service (CWMS). I showed that, as a result, guidelines are not evidence-based, and are unspecific. GPs have requested more detailed guidelines on how to have these conversations which they find interactionally difficult, and which patients report have potential to make them feel demotivated or motivated, depending on how clinicians communicate (1-3). In this chapter I detail the methods I used to address this knowledge gap, and to meet the aims and objectives of this thesis. In section 2.2 I discuss which research methods were most appropriate to meet the aims of this thesis. Section 2.3 details the method of my chosen approach, conversation analysis, and how it can be used for applied research in clinical settings. In section 2.4 I provide an overview of approaches to quantification within conversation analysis. In section 2.6.1 I describe the data available in the BWeL corpus, and I then provide a detailed overview of the methods I used in the three conversation analytic results chapters (chapters four, five, and six). Finally, in section 2.6.9, I describe the methods I used to involve key stakeholders in transferring results from conversation analysis into useable recommendations for practice.

2.2 Choosing an Analytic approach

The overarching aim of this thesis is to understand which conversational strategies used by clinicians may facilitate patient uptake and attendance at a CWMS and to use this information to develop a resource to support GPs to do this. Most qualitative methods rely on people's accounts of what they have said or done, collected in the

form of interviews or focus groups. These may include views and reflections that may not be evident in a corpus of recorded consultations. However, they do not provide detail about what people actually do and say during consultations. Post-hoc reports on the details of an interaction are subject to considerable recall and social desirability biases (4, 5). These methods, therefore, were not appropriate to identify detailed conversational features. Approaches to the study of discourse were potentially more appropriate to address my aims and objectives. Methodological approaches which use coding schemes, such as the behaviour change techniques taxonomy (BCT) (6) or the Roter interactional analysis system (RIAS) (7) were also potentially suitable. I will briefly discuss why each of these approaches were not wholly appropriate to answer this research question; and then provide an overview of conversation analysis, which was my chosen approach.

Discourse analysis (DA) is, broadly, the study of social life, understood through analysis of language in its widest sense (including face-to-face talk, non-verbal interaction, images, symbols and documents) (8) . Within the field of 'discourse' analysis there is great diversity. Different studies explore different types of spoken or written data, using varying types of approaches to studying discourse. Silverman outlines the complexities of trying to distinguish between what *is* and *is not* discourse analysis as this term can used to describe a number of different approaches (9-11). He states that its meaning can depend on the researcher's discipline or training p.319 (8). Therefore, here I have followed Shaw in her outline of four broad approaches to *analysing discourse* (12). These are macro-level; meso-level; micro-level; and discursive studies. Macro-level approaches largely investigate "the role of power and knowledge in society" p.415 (12), exploring how the language that is available to us can limit what it is possible to "think, say, and do" p.415 (12). This macro-level approach to analysis did not suit my focus on in-consultation interactional patterns, and patient post-consultation action. Meso-level studies do examine face-to-face talk. However, these approaches to discourse generally explore and emphasise connections between face-to-face conversation and wider social and cultural contexts. They are not appropriate to analyse the details of an interaction, to identify conversational patterns, and how they relate to patient responses and action. Discursive studies are those which identify patterns in talk that correspond with or illuminate particular psychological phenomena (13). A

discursive approach may be used to illuminate how identity as a 'good patient' is produced, or how issues of agency and responsibility are managed (13). Microlevel studies, of which conversation analysis is one, explore in detail how language is used and "tend to be concerned with the techniques and competencies involved in successful and unsuccessful conversation" p.63 (11). To answer my research questions, it was necessary that I take a micro-level focus on the fine-grained detail of interaction, to highlight and differentiate between specific conversational practices.

2.2.1 Coding schemes

In addition to the micro-level approach to language described above, there are qualitative coding schemes which are designed to code clinical conversations. The behaviour change techniques (BCT) taxonomy provides a 93-item taxonomy to code and categorise the 'ingredients' of an intervention (6). Careful consideration of the BWeL data and my research questions showed that this technique was not appropriate for the following reasons. First, BCTs are largely suitable for describing the components of interventions. However, as the BWeL trial was a very *brief* intervention it is unlikely that this method would have been sensitive enough to identify differences between interventions that could be associated with patient action and outcomes. This is because the BWeL corpus contains a series of short, tightly focussed, conversations which all largely do the same in terms of intervention components: clinicians introduce the topic of weight management; offer referral; facilitate referral; and arrange follow up. Secondly, in the BCT taxonomy, the sequence in which intervention components are delivered would not be considered. Thirdly, patient responses are ignored. Finally, the BCT approach would group the data into broad categories. This would mean that the fine-grained detail of word choice, grammatical design, and prosody could not be analysed. This is important because, in the previous chapter, I showed how clinical guidelines already provide non-specific information such as 'set goals' or 'be supportive' (14). Use of the BCT taxonomy would not have provided the detail for which GPs have stated a need, as all conversations would have been reduced to similar statements such as 'monitor behaviour' or 'provide social support', rather than illuminating *which* ways of

providing social support are likely to motivate action, or be well received. Furthermore, I have shown that patients state that word choice and tone of voice are important (3), and this broad approach offered by BCT coding would not examine these aspects of the conversation. I felt that conceiving of these discussions, as a *conversation,* between two (or more) people, rather than a unilaterally delivered *intervention* was important. Therefore, an analytic approach that explored patient responses and could identify micro-level conversational differences was important to answer my research questions, and to meet the need for a more specific evidence base of effective practice. Subsequent BCT analysis of these data by members of the BWeL team have confirmed this reasoning (15). In the forthcoming chapters I demonstrate that conceiving of these as a *co-constructed con*versation was a useful approach.

Whilst the BCT taxonomy does not take patient responses into account, some linguistic coding schemes do (7, 16). They provide tools and framework for researchers to code conversations quantitively. To do so these assume independence of measures, and talk is coded as representing a single meaning or action (7, 16). However, as Robinson (17) states, one communicative device can convey more than one meaning at a time, and most schemes cannot accurately code for these multiple functions. Stivers (18), Heritage (19), and Mangione-Smith (20), for example, have shown that one type of communication strategy used by GPs, called an 'online commentary', can simultaneously reassure a patient, and act to forecast what prescription they will receive at the end of a consultation. This dual function would have been hard to identify using a quantitative coding system. Furthermore, these systems often code talk at its semantic value only. For example, in the RIAS approach 'yeah' is consistently coded as 'agrees', with no observation of the placement or context in which this utterance occurs (21). In chapter five of this thesis, for example, I show how patients use 'yeah' to minimally receipt information, rather than display agreement with the GP. This illustrates that use of a coding system would have restricted my analysis. As with BCT coding, linguistic coding schemes lack attention to the specificities of word choice and tone of voice (7, 16), which patients report are important when talking about weight (1-3). Furthermore, these schemes do not analyse utterances within their sequential context. For example, Stivers has shown that silence in specific sequential contexts, such as

following a question, can be used to display "passive resistance" to a treatment recommendation p.50 (22). However, linguistic coding schemes such as RIAS and the BCT taxonomy would not have been able to place silence within the wider sequential context, and uncover the interactional work this was doing (21).

2.3 Conversation analysis

In this section I briefly describe my chosen method, conversation analysis, and follow this with an account of its application to clinical settings. Comprehensive accounts of conversation analysis are provided by Sacks (23), Sidnell and Stivers (24), and Clift (25), and its clinical application is described by Heritage and Maynard (26, 27), and Barnes (28). In the next sections I briefly summarise this work, highlighting the key aspects of the conversation analytic approach. I then outline current approaches to quantification. Following this I describe how I used conversation analysis when working with a large dataset and I follow these descriptions with details of the steps I took throughout conversation analysis.

Conversation analysis (CA) emerged from the work of Harvey Sacks and Emanuel Schegloff (students of Erving Goffman), and Gail Jefferson. This method is founded on the principle that talk is systematic and orderly (29) and can, therefore, be used as a unit of analysis for empirical scientific research (30). CA is sociological in its origins. Whereas linguistics takes *language* as its primary object, the focus of CA is on *language use* (31). Sacks and Schegloff argued that, from the viewpoint of sociology, the "primary significance of language was as a vehicle for social action" p.660 (31). This grounding of CA in sociology means that its systematic approach to studying and uncovering the details of interactional organisation enables observations to be made about social conduct (31), and the significance of language for social life p.26 (32). Conversation analysts argue that to answer questions about how people do things "requires empirical investigation of how they actually talk together" p.101 (33). This method therefore, traditionally explores recordings of naturally occurring talk (34). The aim of analysis is to "uncover the often tacit reasoning procedures and socio-linguistic competencies underlying the production and interpretation of talk in organised sequences of interaction" p.12 (35). CA

explores the organisation of talk by examining how participants display their understanding of 'what is going on' (35), rather than by imposing exogamous concepts which may not be grounded in the realities of an interaction.

I will briefly present the key features of talk on which CA focusses. A fundamental focus of CA is the organisation of 'turn taking'; how speakers organise and design their turns at talk (30). Sacks observed that, during conversation, one person usually speaks at a time. Although speakers may change regularly, overlap is minimal. Turn taking systematics are accomplished by all interlocutors who engage in an ongoing locally and interactionally managed system of speaker selection (30, 36). These turns at talk are produced through turn constructional units (TCUs) which make up conversation. A turn at talk is hearably complete when an action is achieved (E.g. a request or informing), and it sounds grammatically and prosodically whole. Through their next turn interlocutors "whether intentionally or not, implicitly display their understanding and analysis of what is happening as it happens" p.27(37). This offers what Hutchby and Wooffitt call an "analytic foothold" p.41(35) in understanding the participants' perspectives in the order of talk. This is known as the 'next turn proof procedure'. This was helpful in this thesis to see how patients displayed responses to particular types of turns at talk, supporting one of my objectives to see how well received particular conversational strategies were displayed to be. These turns at talk are sequentially organised, and 'sequence organisation' or how "one thing can lead to another" p.130 (36) is a core principle within CA. One utterance is produced to fill a slot after the one preceding it, and creates slot for another to follow it. The type of utterance that is produced in the slot available may depend on what came before it. For example, if a question is done, an answer, or clarification request become relevant next in the sequence. Question and answer 'go together' as an adjacency pair. Sequences of interaction can be explored though breaking them down into a series of adjacency pairs, and troubles in responding can be another analytic foothold to uncover what is going on. The design of certain first pair parts (FPPs) of an adjacency pair can make certain types of responses (or second pair parts - SPPs) more or less relevant in the next turn. For example, a *question* may require an *answer*, but a question designed in a certain way may 'prefer' an *agreement* over other answer types, such as *disagreement*. Exploring how preference was operationalised in my data allowed me to explore the design of the 'referral question'

(for example, 'Would you like to try Slimming World?'), and the likely responses such designs seemed to prefer.

Sequences, turns at talk, and their adjacency pairs, do not always run smoothly. Troubles may arise that could potentially hinder the ongoing co-construction of talk. Interlocutors can deal with interactional troubles in speaking, hearing, or understanding, by interrupting the ongoing flow of a conversation and attending to these troubles. This is known as initiating 'repair'. Its role is to ensure "the interaction does not freeze in its place when trouble arises, that intersubjectivity is maintained or restored, and that the turn and sequence and activity can progress to possible completion" p.xiv (29). A trouble source may be, but is not limited to "misarticulations, malapropisms, use of a 'wrong' word, unavailability of a word when needed, failure to hear or to be heard, trouble on the part of a recipient in understanding, incorrect understandings by recipients" p.210 (38). This can be initiated by the speaker or another in the conversation (39). Repair is the 'self-righting mechanism' p124 (40) for the organisation of talk-in-interaction. Attending to the uses of repair foregrounds aspects of talk that speakers, and to some extent hearers, orient to as important.

I have shown briefly that conversation analysis orients to both sequence and action, and uncovers the orderliness of talk-in-interaction. I will now discuss how CA can be applied in clinical settings to address clinical problems.

2.3.1 Applying conversation analysis to clinical settings

Conversation analysis has been used to research medical interactions since the late 1970s. The use of CA to study medical interactions includes diverse settings from homes to operating rooms (41-44), and childbirth to end of life care (45-48). CA research has explored numerous facets of healthcare communication, with much focus placed on communication in primary care (17, 18, 49-51). Work in this field has uncovered many of the intricacies and routines of medical interactions (52, 53), providing insights into how consultations work. This involves studies of how clinicians communicate in medical settings (26), including advice-giving (54);

treatment recommendations (55); treatment negotiations (56, 57); and lifestyle discussions (58). Implicit, or explicit, within this body of work studying *how things are done*, is information on *how things can be done*, as these analyses uncover the presence of practices which offer something to practitioners. Stivers' work, for example on how clinicians avoid or generate patient resistance displays (18) shows that if a general practitioner recommended *against* antibiotics (e.g. by saying 'there's *no* point in any antibiotics') patients resisted 17% of the time. This often resulted in unnecessary antibiotic prescribing. Whereas if a doctor recommended *for* something (e.g. I *am* going to give you some cough medicine) only 5% of patients resisted not receiving antibiotics. The potential benefit of application of this to clinical settings is great. Increasingly CA has been applied in clinical settings to explore both clinical talk, and to support application of these results. Kitzinger, for example, collected calls to a childbirth helpline. She explored how the call-takers dealt with multiple troubles, and collaborated with helpline operators to offer support in how the calls could be better handled (59). This approach is called "interventionist applied conversation analysis" p.10 (60) and is the approach I take throughout this thesis. This type of conversation analysis has the following characteristics: It is applied to an interactional 'problem' which needs solving; there is potential for naturalistic data; the analyst will identify interactional practices which may provide solutions to the 'problem', and will present these solutions in such a way they can be implemented (60).

A move towards increasing application of work in CA has been facilitated through a greater focus on translating results from conversation analysis into useable recommendations for practice. This has included using conversation analysis to increase the authenticity of training delivered through role-play by informing the training of actors simulating patients (61); video-based training to be used in face-to-face encounters (62); and showing professionals how certain interactional problems are negated or resolved in practice (63). Each type of training is built from evidence identified through conversation analysis.

I considered carefully what type of training would best address the need clinicians had expressed. Clinicians have stated a need for detailed, specific training, but also identified time as a barrier. Therefore, I decided to tailor training to address these

needs, and determined that very brief video mediated resource would be most appropriate. To design this, I used Stokoe's Conversation Analytic Role Play Method (CARM) approach. This approach aims to improve spoken and written communication between organisations and their users (63), and lends itself well to very brief video-mediated training. In this approach, having first identified an evidence base of effective practice through conversation analysis, anonymised animated clips are used, showing participants interacting under the constraints of their institutional setting, to demonstrate how to improve the effectiveness of conversations. For example, Jenkins identified conversational features of neurologists' talk which expedited diagnosis, and she trained neurologists to use this type of talk. Neurologists showed that following CARM training they were able to adopt these 'trainables' (64, 65). There is no strong evidence that CARM leads to long-term changes in consultation style outside of the training, nor for its impact on patient outcomes. However, there is initial evidence that CARM training of service-providers (business to business sales people, and community mediators) resulted in increase of service uptake (as reported by industry following CARM training). These existing studies, therefore, show the potential of this method to move results from research into practice.

I selected this approach as it shows communication in real-time, and encourages clinicians to reflect on the importance of their talk moment-by-moment. This is important because, as I have shown in chapter one, clinicians report concern that patients would react with negative emotions, that what they say will not motivate change, and they do not have enough time to discuss weight. Showing excerpts from recorded consultations where these discussions were brief and successful has potential to demonstrate that clinicians can discuss weight in ways which are brief, effective, and likely to be well received. I detail in the sections below how I use part of the CARM approach to ensure results from this study are presented in a way that is acceptable to the key stakeholders in the brief intervention for weight loss: patients, clinicians, and policy makers.

In this section I have introduced conversation analysis, and its application to clinical settings. I have highlighted the ways in which this method will enable me to address my research objectives. In the next section I outline established approaches to

quantification within this field. Following this I describe how conversation analysis was used in my forthcoming results chapters, including descriptions of the steps I took throughout conversation analysis during the three conversation analytic chapters.

2.4 Conversation analytic approaches to quantification

A benefit of the trial data which I analyse in chapters four, five, and six was the availability of information about patient in-consultation agreement-to-attend, and their post-consultation action - whether or not they attended the weight management service. This provides opportunity to explore relationships between in-consultation communication and what patients did later. I will now briefly describe the history of quantification in conversation analysis, and how quantification is approached within the field.

Conversation analysis lends itself to quantitative analysis (17). To some extent conversation analysts have always informally quantified their results, describing frequency of occurrence of phenomena as "massively, overwhelmingly, regularly, ordinarily" (66). Whilst there is a traditional conversation analytic reluctance to quantify (66), there is a growing understanding that with the availability of larger datasets, it is possible to draw meaningful conclusions from a mixed methods analysis without sacrificing the granular understanding of context (17). Therefore, recent developments in areas of the field have leant towards more formalised quantification. Studies incorporating quantification largely explore relationships between talk and within-consultation variables, such as time-to-response (67, 68), or the frequency of types of responses likely to be produced following specific first pair parts (69, 70).

Researchers in the field of quantified CA argue for CA grounded coding schemes (71-74). These are where results from initial conversation analyses can become a basis for case-specific coding schemes. These are designed to answer a specific question and are developed from results of detailed conversation analysis (74). These coding schemes take into account sequence, preference, action, prosody etc. thus

removing many of the weaknesses of pre-existing coding schemes (7, 16) which I discussed in section 2.2.1 of this chapter. Although they negate these problems, CA grounded coding schemes do require some compromises. For example, in their study of primary care treatment recommendations (75) Stivers et al took the first treatment recommendation a primary care physician performed as their point of quantification, with an understanding that there were drawbacks of not looking at others (Stivers, personal communication). There may have been a wider sequence of pursuit, reformulation, and so on, which could not be captured in their coding system. Schegloff (66) stated that sequence organisation is not yet ready for quantification, and Stivers' study illustrates that we still are not able to build sequences of action effectively into quantification, and must make some compromises when incorporating numerical data; balancing the benefits of complementary data and the drawbacks of losing some detail of sequence organisation.

Conversation analytic approaches to quantification do explore frequency, but within this framework there is an understanding that frequency of practice is not related to how analytically important it is or, in an applied setting, how *effective* it is. Schegloff emphasises the importance of single case analyses in his review of quantification in CA:

> *"Let me begin, then, by remembering that one is also a number, the single case is also a quantity, and statistical significance is but one form of significance. Indeed, it is significance in only the technical sense that a "finding" in a sample may be taken as indicating the likely presence of an element of order in the larger universe being studied."* p.101 (66)

In the early stages of this thesis I read Beach's book 'Conversations about illness' which was a single case study of a conversation lasting less than 13 minutes between a grandparent and her granddaughter (41). Beach laid out how patterns of pursuit and resistance can be collaboratively built; how ownership of 'weight' can be avoided; and resistance overcome. Beach's findings were no less relevant and important because this was a single case. The patterns identified were true for that participant in that circumstance. Although I did not conduct single case analyses, I considered the value of smaller collections throughout this thesis. For example, one

phenomenon, paraphrasing a patient's prior talk (explored in chapter six of this thesis) occurred only nine times across the corpus, but provided exciting, novel, and valuable insights about how brief interventions for weight loss can be delivered.

This flexible approach to qualitatively ground quantitative analysis is a particular strength of conversation analysis. When placed within applied research, CA can be used to identify specific practices and to transform these into measurable variables p.209 (76). Robinson argues that, in conversation analysis, a "case is neither easily nor convincingly made from qualitative analyses alone" p.28 (17). Although I do not wholly agree with Robinson here, I do feel that in the case of this thesis, the potential of this method to identify conversational patterns and explore associations with patient action after a consultation is exciting, and offers a way to address the current knowledge gap.

I have described and justified my analytic approach for this thesis. I next outline and justify my aims for the next chapter, a systematic review of micro-level analyses of conversations about health behaviour change. Following this I outline the detailed analytic methods I use in chapters four, five and six, and how results from conversation analysis are presented in this thesis.

2.5 Chapter 3 - Communication practices for delivering health behaviour change conversations in primary care: A systematic review and thematic synthesis

In the next chapter, I systematically review literature to examine how health care professionals initiate, transact, and finish talk which aims to support health behaviour change in their patients. Before conducting my own investigation into how GPs talk about weight-loss with patients it was appropriate to identify what is currently known on this topic, map the extent of the evidence, and identify knowledge gaps, to help inform my own analysis. I aim to identify how discussions about behaviour change are carried out, including how patients react, and to begin to provide health professionals with techniques that are well-received by patients, and may be effective. Consequently, I chose to review literature that took a micro-level

approach to the actualities of conversation, rather than post-hoc reports. I did not limit this review to conversation analysis only, but included any literature "concerned with the techniques and competencies involved in successful and unsuccessful conversation" p.415 (11). In line with usual reporting of systematic reviews, detailed methods, and further justification for my approach are provided in the next chapter.

2.6 Analytic methods for chapters four, five, and six - Using conversation analysis with an applied focus

In this section I detail my approach to analysing the BWeL data. During conversation analysis I remained blinded to patients' next actions. This is because I wanted to remain grounded in the conversational data, and to minimise risk of unconsciously biasing the analysis of the conversation with knowledge of patient actions. Once I had identified conversational practices that seemed to produce or display in-consultation agreement-to-attend, I then coded for the presence or absence of each phenomena in a particular sequential placement. I next conducted statistical analysis to explore associations between each phenomenon, and subsequent attendance at the weight management service. Therefore, statistical analyses were used to corroborate, or not, results from conversation analysis.

The sections below outline my data (the BWeL corpus), the detailed methods, and the outcome measures which I used through analysis. First, in section 2.6.1, I describe the data available from the BWeL trial, including trial procedures used during data collection and clinician training. In section 2.6.2 I outline my approaches to data handling and storage of these data. I next detail how I handled the large amounts of qualitative data from the BWeL corpus (section 2.6.3), including my approach to transcription (section 2.6.4), and the role of data sessions in the initial stages of this work (section 2.6.5). I then, in section 2.6.6, outline the steps I followed during conversation analysis including my approach to consultation mapping, and building and refining collections. I also outline how results from conversation analysis are presented in order to maintain the applied focus of this

thesis. I finally describe my approach to quantification (section 2.6.7). This includes description of the outcome measures used throughout chapters four five and six, and detailed description of the quantitative methods used in each of these chapters.

2.6.1 The BWeL Corpus

In chapter one, I introduced the BWeL corpus which provided data for my analysis in chapters four, five, and six of this thesis. The BWeL trial was a parallel two-arm, randomised controlled trial assessing the effects of GP-delivered brief weight loss interventions in primary care. I analysed in-consultation audio recordings and post consultation satisfaction, and attendance data. I will now detail the aspects of the BWeL trial which are relevant for this thesis including: trial procedures (section 2.6.1.1); audio recording processes, and the number of recordings available for my analysis (section 2.6.1.2); patient follow-up by the trial team (section 2.6.1.3); and clinician training in intervention delivery (section 2.6.1.4).

2.6.1.1 Trial procedures:

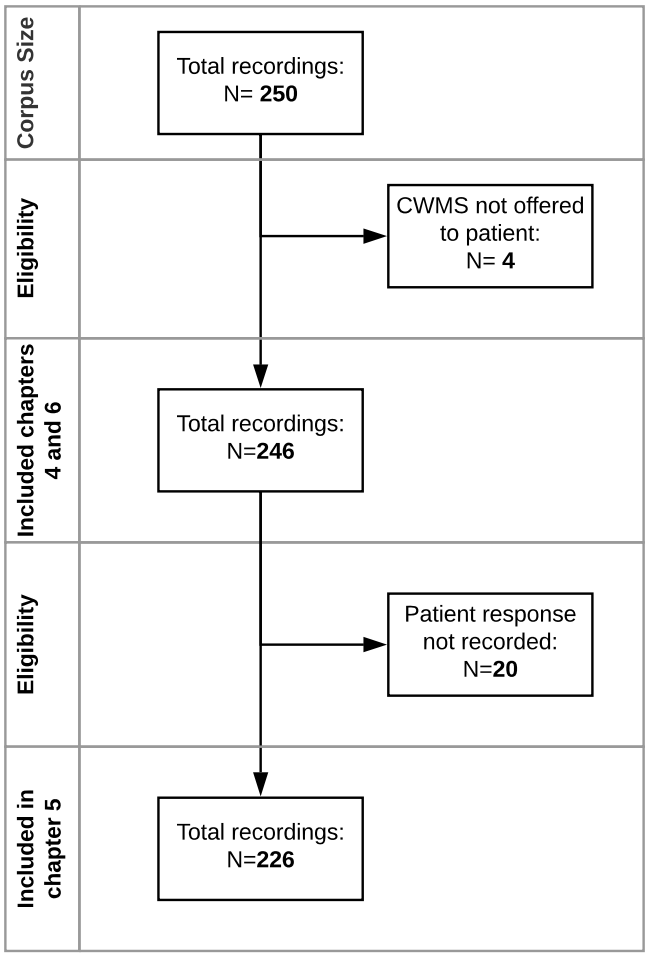
Trial researchers asked to weigh, measure, and estimate the body fat of every patient waiting to see their GP. They screened 8403 patients, and sought to enrol people who were aged ≥18 years; who had a body mass index (BMI) ≥30kg/m2 (or 25kg/m2 if Asian) and had a raised percentage of body fat (2728 patients, 32% of those screened). Patients excluded from the study were: pregnant women (or women who were planning pregnancy); people who had experienced or were scheduled for bariatric surgery; people who had completed a weight management programme within the 3 months before recruitment; people seeing their GP to discuss weight; and people who did not speak English. Of those potentially eligible 2256 (83%) agreed to participate. Of these, 1882 (83%) were eligible and enrolled. The trial team gave a randomisation envelope to patients to give to their GP. This envelope contained details of the patient's BMI, and allocation to trial arm. Of the 1882 eligible and enrolled patients, 940 were assigned to this support arm, whilst 942 were randomised to receive advice only. GPs could exclude patients during the

consultations if opportunistic intervention was clinically inappropriate (e.g. history of eating disorder); inappropriate (e.g., the consultation had been upsetting); or for other exceptional reasons. GPs excluded 122 patients (5%) at this stage. At the end of the consultation, GPs in the support arm made an opportunistic brief intervention where they endorsed, offered, and facilitated a referral to a weight management service (either Slimming World or Rosemary Conley).

2.6.1.2 Audio recording processes:

Half of patients in each arm were randomly selected for audio recording. Patients had the option to participate in the trial but decline audio recording, or to request deletion after the intervention had been delivered. Some GPs did not record, although prompted; some participants did not consent to be recorded; some recordings were rendered unusable for technical reasons; and many of these recordings were not uploaded by the research team as they did not consider it a priority. Therefore, of 940 patients in the support arm, 250 recordings (27%) were available. Of these 250 recordings, GPs in four consultations did not make a referral. Instead they delivered brief *advice* for weight loss, which they were instructed to do in the control arm of the trial only. Therefore, these were excluded from all analyses. This provided 246 recordings for my analysis. In 30 of these recordings the GP turned off the recorder following the announcement of the news of referral. Chapter five specifically focusses on patient responses to news, so these 30 were excluded, providing 226 recordings for analysis. Chapters four and six take a broader view of interactional practices across placements, and so these 30 were included in analysis in both of these chapters (N=246), with an understanding that these provided lower quality data which would not form part of core collections. Figure 2.1 illustrates the recordings available in the BWeL corpus, and the number of recordings used in each analysis. The recorder was visible to the GP and patient. The GP started the recorder after the main business of the consultation was complete and before they opened the randomisation envelope and initiated intervention delivery.

Figure 2.1 Recordings from the BWeL corpus used for analysis



2.6.1.3 Follow-up

Participants reported how 'appropriate' and 'helpful' they found the consultation on a survey immediately after their consultation. They were telephoned at three months and seen in-person at 12 months where the research team ascertained whether they had tried to lose weight, and the means by which they had done this, including using the commercial weight management service (CWMS). The CWMS provided the research team with patient attendance data, which I use in my analyses.

2.6.1.4 Training in intervention delivery

GPs received 90 minutes of online video-mediated training prior to intervention delivery. The training comprised of eight modules which introduced the following topics:

a) The rationale of the trial
b) Evidence for the medical benefits of weight loss and the effectiveness of behavioural support to enhance weight loss
c) Details of the mechanics and logistics of running the trial
d) Details of how to carry out the interventions in practice

These consisted of filmed consultations with a commentary. The aim was to support GPs to assimilate the skills necessary to deliver interventions confidently and to follow appropriate procedures. GPs were not provided with a standardised script and were encouraged to deliver the intervention in their own words. They did not receive top-up training during their participation in the trial. GPs were trained to deliver these interventions in 30 seconds, and many GPs in the BWeL trial achieved this. However, there was some variation in consultation time (8-458 seconds, mean 95 seconds). Table 2.1 demonstrates the specific training components for intervention delivery, highlighting what GPs were explicitly asked to do, and also what they were asked not do.

I have described, above, the aspects of the BWeL trial which are relevant for this thesis, as data provided by the trial are analysed here. Further details on the BWeL trial procedures, including recruitment and follow-up, are available in the trial report (77). The BWeL trial was registered with the ISRCTN Registry, number ISRCTN26563137. Next, in section 2.6.2, I describe how I handled and stored data from the BWeL trial. Following this I outline in detail my analytical processes for chapters four, five, and six.

Table 2.1 BWeL training Components: How GPs were trained to deliver a brief intervention in practice

Consultation Phase	Do	Reason Provided	Do Not	Reason Provided	Example
Referral delivery	Give some information about the best way to lose weight	Patients will be informed of the effectiveness of commercial weight management services	Give medical advice on the benefits of weight loss	This is best left for a dedicated weight loss consultation	"*The best way to lose weight is to join a commercial weight management group like Weight Watchers or Rosemary Conley…"*
	Ask if the patients want to accepts an offer of *support* to lose weight		Ask if a patient wants to lose weight	This may bring to mind previous failed diets and is likely to deter patients from trying again	
	Ask patient to commit to agree in the consultation	Patients are more likely to act when a specific plan has been made			*"How would it be if I referred you to one of the groups today?"*
Possible response 1: A patient accepts the referral	Ask patients to see the researcher after their appointment	Patients will receive referral details and fill out questionnaires necessary for the trial			*"I'll ask you to go and see the researcher outside and she'll talk to you about the details."*
	Make an appointment to check their progress at a month	This is to show you think weight is important and that you're keen to help			*"I know it can be quite hard to lose weight, so do you want to come and see me in a month to see how you're getting on?"*
Possible response 2: A patient may want to lose weight by themselves	State this is okay, and encourage patients to come back in a month for a review	This is to show you think weight is important and that you're keen to help			*"If that's what you think is right for you, that is okay, but I do know that it can be hard. Come and see me in a month's time anyway and we can see how you're getting on."*
Possible response 3: A patient does not want to lose weight	Accept their decision		Try and change their minds if they have said they do not want to lose weight		*"Okay, sure."*
Possible response 4: A patient has concerns and questions about attendance	Arrange a dedicated appointment to discuss these queries and concerns, or of you think it is appropriate discuss them in this consultation	There is more time in a dedicated appointment to address these concerns			*"I'm here to support you. Why don't you book an appointment with the receptionist for a dedicated chat? You can come back and we can address any concerns or answer any questions that you've got. How does that sound?"*

2.6.2 Data handling and storage

Data handling and storage of BWeL data used in this thesis followed Nuffield Department of Primary Care Health Sciences and University of Oxford policy. These methods are outlined in the ethics application for the BWeL trial (reference 13/SC/0028).

2.6.2.1 Audio recorded data

All audio data were stored on the secure departmental drive. Access was restricted for use by those with permissions to work on these data. Data were anonymous, and code numbers were entered by the trial team to enable audio files, anonymous post-consultation satisfaction scores, and anonymous patient attendance data to be linked.

2.6.2.2 Transcribed data

Anonymous transcripts were copied into the NVivo 11 for Mac software programme, and were kept in a password protected file. This was stored on a secured encrypted departmental laptop, and copies were kept on secure departmental drives. Where first names or place names were used, these were replaced on all transcripts.

2.6.3 Working with a large dataset

There were 246 audio recordings in the BWeL corpus. Therefore, it was important that data were managed and sorted in a systematic way to ensure effective handling of a relatively large database. I used NVivo 11, a Computer Assisted Qualitative Data Analysis Software (CAQDAS) package to facilitate data handling and analysis. This software allows: provision for localised file structures;

one transcript to appear across multiple collections; transcript mark-up; links between transcripts and notes where references or thoughts on analytical processes can be recorded; fast data searching and retrieval. The initial stages of working with a large data set necessitated designing methods to systematically order unstructured information in transcript form, before making initial insights and building collections. NVivo "helps people to *manage*, *shape* and *make sense* of unstructured information" (78). NVivo provided me with the workspace and tools to structure, organise, and work through information (78). This facilitated subsequent analyses.

When working with these data I required both closeness and distance (79). I required closeness to: develop thorough knowledge; conduct in-depth fine grained analysis; undertake detailed examination of particular cases (80); and to support effective recall of data (79, 80). I also required distance to consider the wider applicability of this work, and view general similarities across collections and the wider corpus (80). Richards states that analysis can be a process of zooming in and out, sometimes close, sometimes distant depending on the stage of analysis (79), and NVivo supported this. It provided as much closeness as using manual methods, but was assisted by enlarged screen display with three sections, which gave me the ability to view transcripts and wider collections simultaneously; improved management of and access to multiple sources and types of data; rapid retrieval of coded text; and easy ability to view retrieved segments of text in their original context (81).

2.6.4 Approach to transcription

Conversation analysis uses specialised transcription conventions, known as Jeffersonian transcription (82, 83) to represent recordings. Whilst standard verbatim transcription may show what people say, it does not provide a visual representation of *how* people talk. In contrast to this, a Jeffersonian transcript represents "timing, overlap, intonation, emphasis, volume and many other features that interaction analysts now recognise as central to understanding ongoing activities in talk" p.10(82). Following this convention, unique symbols are used

within a text to indicate prosody, gaps or pauses in talk, overlap between speakers, changes in speed or volume and where emphasis is placed. These allow fine-grained observations to be made and provide more 'close-up' access to the delivery of talk-in-interaction. I was keen to conduct Jeffersonian transcription on all audio recordings myself as, following Ten Have (36), I believe this to be the first stage of analysis and to facilitate closeness to the data. To achieve this within the time available I sent all transcripts for professional verbatim transcription, and then used these as a basis for conducting Jeffersonian transcription. Jeffersonian transcripts provided visual representations of the talk and quick access to the conversations. I was aware throughout this work that, whilst a transcription aids in analysis of audio data, it is not the data itself. I used the audio data in conjunction with transcripts during analysis, particularly in the earlier stages of unmotivated looking (see section 2.6.6), and building and refining collections (see section 2.6.6.2 and 2.6.6.4). This facilitated constant grounding and closeness to the original conversations. From a personal perspective, use of audio data reminded me of my applied focus. I could hear GPs and patients talking, and listen to how difficult some of these conversations could become. Regularly listening to the emotion conveyed through these conversations kept me driven to develop work which would smooth out these conversations and support GPs and patients to discuss weight in a helpful way.

I used Audacity version 2.1.1, a multi-track audio editor, to facilitate transcription and transcribed using Microsoft Word. Audacity displays talk as a waveform. Working with this combination of audio and visual display allowed me to identify exact timings of pauses and gaps in talk; identify many initially inaudible sections of talk; and to slow down or speed up data during initial transcription. There have been updates to Jefferson's original transcription conventions (83), and transcriptions throughout this thesis follow Hepburn and Bolden (82). A list of transcription symbols used in this thesis is provided in appendix 1.

2.6.5 Data sessions

As is conventional in CA, I presented the BWeL data at a number of data sessions during different stages of the analytic process (36). I took a few transcripts of full referral sequences to discuss with colleagues at Loughborough University when I was in the initial stages of analysis. This allowed me to begin to conceive of the wider referral sequence.

It is common in qualitative research for researchers to engage in reflexive practice acknowledging the co-construction of interview data, and critiquing their own biases during the research process. However, rather than being grounded in the researcher's own interpretation of the data, conversation analysis is an empirical method which aims to uncover systematic and orderly patterns of communication. Attending and participating in data sessions, acted as a way to ensure that my findings were grounded in observable features of the available data, rather than on subjective interpretations, or my own "individual assessments of actions" p.141 (36). This enhanced the rigour of these analyses. Furthermore, presenting data to varied groups of students and experts meant I received suggestions for references to published literature, allowing me to develop the theoretical points supporting my analyses. The data sessions I attended and insights gained are presented in Table 2.2.

Table 2.2 Data sessions focussing on data from the BWeL corpus

Data Session	**Type of Data**	**Insights gained**
Loughborough University	Full BWeL referral sequence	Suggestions to map typical sequences Discussions of the strengths and limitations of these data
Loughborough University	Collection of patient responses	Suggestions to focus on sequential placement of 'oh-prefaced' responses
University of Oxford	Collection of referral delivery, with a requested focus on how referrals are done	Whether referrals were advice or information may not be useful in an applied setting but their delivery as 'news' may be a helpful way of framing these

I have outlined how I managed and transcribed data from the BWeL trial. I have also shown that I enhanced rigour through attending data sessions at different stages of the analytic process. I now detail my approach to identifying and collecting phenomena. I outline the processes I followed as I moved from initial analysis to results. Following this, in section 2.6.7, I discuss my approaches to quantification.

2.6.6 Identifying and collecting phenomena

2.6.6.1 Mapping consultations

I started analysis by mapping the actions that were done in each brief intervention, and understanding the actions in the BWeL trial within their sequential placement. I learnt this approach to action sequencing from Lerner, who suggested this would be a helpful approach to use in the early stages of analysis. I initially did this using pen-and-paper based methods to categorise the first fifty conversations. However, the corpus was relatively large, and there was variation in the action sequences so I moved to NVivo software to facilitate this sequential mapping. I detail my use of NVivo in section 2.6.3 of this chapter. I used this mapping to identify a typical consultation sequence, which was the sequence most frequently used throughout all BWeL recordings, and also to create a wider more comprehensive map which represented the range of actions within the wider sequence. This map is presented in each conversation analytic results chapter of this thesis. Creating a consultation map gave me perspective on the sequential context of actions in the brief intervention discussions. Identifying what actions were done and in what sequential context, provided a useful grounding for my next stage of analysis where I explored how actions were achieved.

2.6.6.2 Building collections

The next stage of analysis followed an 'unmotivated looking' approach. Here I follow Psaths' definition of this process (84). He states that the term 'unmotivated looking' is somewhat paradoxical as researchers are motivated in

their approach to some degree. However, this term implies that examination is not driven by "prespecified analytic goals" p172 (85), rather "the investigator is 'open' to discovering new phenomena instead of searching for instances of already identified or described phenomena" p24-25 (84). When I noticed particular phenomena which I found interesting, during transcription or sequential mapping, I made initial collections. I explored collections in two key ways, which follow the approach outlined by Schegloff:

> *"The trajectory of such analyses may begin with a noticing of the action being done and be pursued by specifying what about the talk or other conduct – in its context- serves as the practice for accomplishing that action. Or it may begin […] with noticing some feature of the talk and be pursued by asking what – if anything- such a practice of talking has as its outcome."*
> *p.172(34)*

In chapter five, for example, I identified a phenomenon of interest – 'Oh-prefaced responses' – and worked backwards to what features of prior talk may have served to accomplish this particular action. The phenomenon I identified as accomplishing this action – 'good' news delivery - is presented in chapter four. Conversely, in chapter six, it was the GP's action I first noticed and I then explored the consequences of this action – linking weight and health – in terms of the ways patients were likely to respond.

2.6.6.3 Focusing analysis

The BWeL corpus provided a rich dataset and I built a number of collections. Identifying which collections to focus on in detail was informed by three key factors:

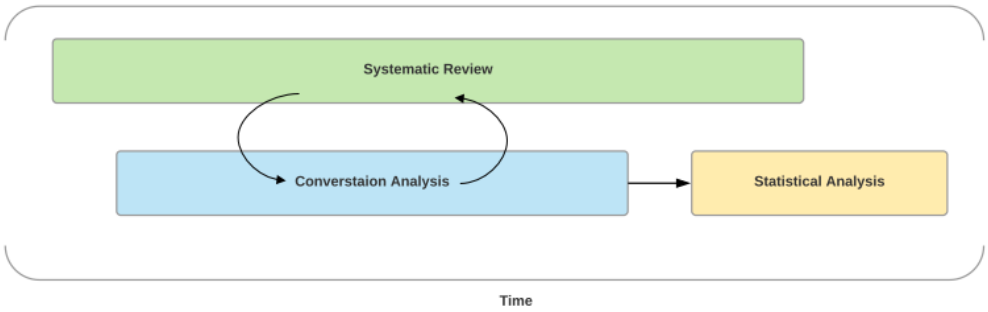
1. Collections which I found analytically interesting.

2. Collections which I thought seemed associated with patient displays of agreement or resistance – and therefore may be useful for GP training.

3. Practices which were relatively prevalent and offered prospect for statistical analyses.

An overarching factor which also guided my choice was the conversational practices and evidence gaps in clinical guidelines identified in my systematic review (chapter three). The conversation analytic processes which I have outlined took place alongside my systematic literature review. In this review, I explored clinical guidelines on behaviour change interventions and conversation and discourse analytic literature. Figure 2.2 illustrates the co-occurrence of these two work packages. This meant that research was an iterative process, and each analysis was informed by the other. For example, my selection of 'linking weight and health' as a phenomenon for detailed analysis (presented in chapter six) was informed by observing this action across a number of consultations, and being interested in the varying results this practice seemed to motivate; by the synthesis of literature about this practice in my systematic review; and by a review of guidelines which recommend this practice. To a lesser extent conversation analysis also informed my systematic review through identification of additional literature which I drew into the discussion section.

Figure 2.2 Iterative analytic process



2.6.6.4 Refining collections

Having decided on which collections I would focus, I next refined these. I did this by placing the actions in which I was interested within their sequential context. 'Oh-prefaced responses' were refined, for example, to focus on 'oh' in second position following the announcement of news. This ensured detailed analysis

explored similar actions in similar sequential contexts. Following this, my analysis took a more motivated approach. When I noticed a specific action, I formed 'parallel collections' of what other actions were done in this sequential placement. For example, chapter four presents three parallel collections each illustrating a different valence asserted towards news delivery by GPs, and with what response from patients. Similarly, for analysis in chapter five I made a series of parallel collections of patient responses to news announcement. Throughout this process I grounded analysis in existing literature.

2.6.6.5 Deviant cases

Deviant case analysis (29) is foundational to conversation analysis, and played a key role throughout this work. Clayman and Maynard identified three uses of deviant case analysis (86). These were summarised by Edwards (87), below. A mixture of two of these (b) and (c) were the case in my analyses:

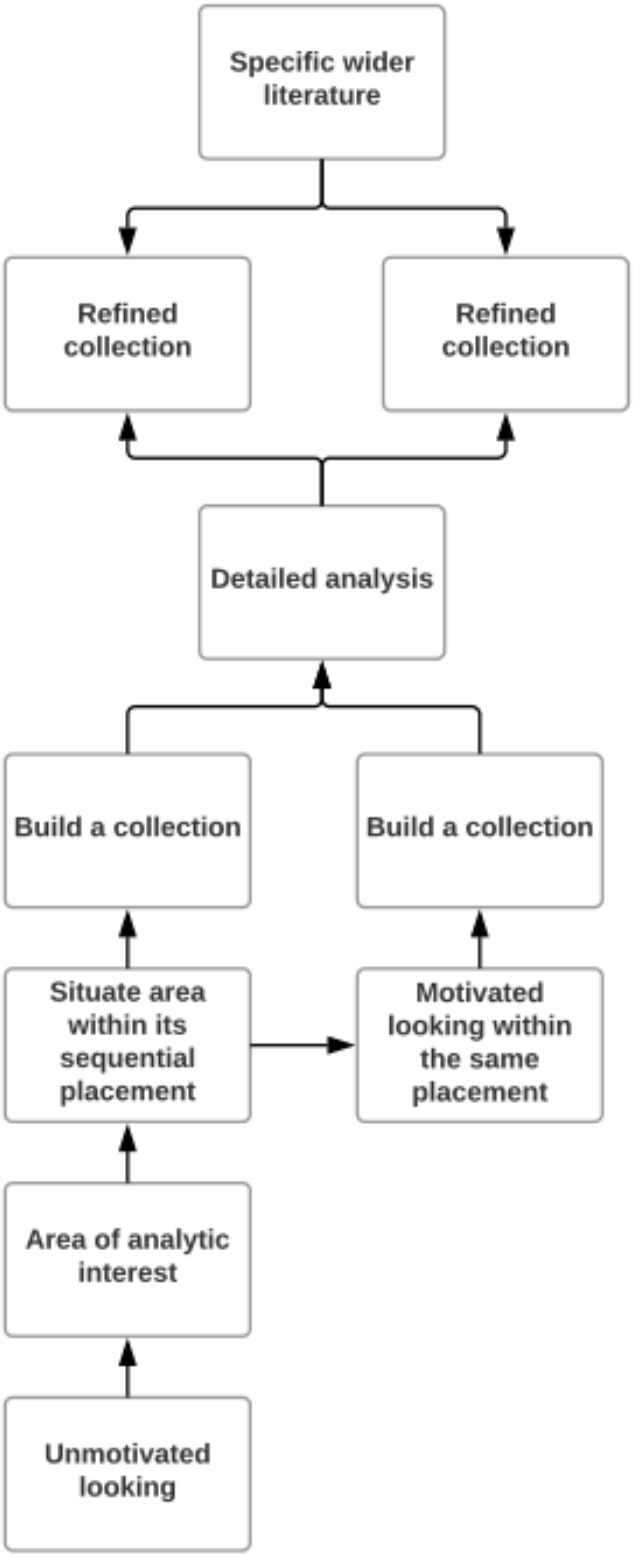
> *"(a) Deviant cases may turn out, upon analysis, to instantiate the same normative orientations as are proposed for the standard cases; (b) a new analysis may be proposed that now takes full account of both the (apparently) deviant cases, and also the main set; and (c) a deviant case may turn out to exhibit a different kind of order in its own right, such that it properly belongs in a different collection." p.2(87)*

For example, I had identified 'linking weight and health' as a phenomenon of interest. However, a few deviant cases emerged in this collection where patient response was markedly different. Closer analysis of the collection led to a new analysis which considered these deviant cases and resulted in a series of smaller sub-collections of how linking weight and health could be achieved. Through deviant case analysis this *phenomenon* became a series of *phenomena*. This was useful for this analysis as the presence of initially 'deviant' cases facilitated identification of a way of linking weight and health that was more successful than others.

2.6.6.6 Presentation of conversation analytic results

I followed the processes above throughout all of the conversation analyses in the forthcoming analytic chapters. These processes are illustrated in Figure 2.3. Combining qualitative and quantitative analyses with an applied aim to generate recommendations for practice required careful decisions about how to present results. In each chapter I chose to present results in enough detail to appropriately evidence the subsequent recommendations for practice. This means that conversation analyses presented may be broader, or more in-depth depending on the phenomenon of focus. To maintain my applied focus, when the work done by interactional practices was more self-evident, I present an overview of this detailed analysis. I foreground in-text where these overviews, rather than detailed presentation of my full analysis, are provided.

Figure 2.3 Process of identifying and collecting phenomena



2.6.7 Approach to quantification

I have outlined the processes I followed whilst undertaking conversation analysis. I have also stated that, during conversation analysis, I was blinded to patient outcome data. This was to minimise risk of unconsciously biasing qualitative analysis. Having completed conversation analysis, I examined relationships between conversational features and a series of patient outcomes. I will now present my approach to these quantitative analyses. The aim of the statistical analyses was to examine which phenomena, identified as signalling or causing displays of positive or negative reception through conversation analysis, were also quantitively associated with agreement-to-attend; post-consultation reported satisfaction; and attendance at the CWMS referral. Identifying a particular phenomenon as 'effective' through both types of analysis suggests a causal relationship with patient attendance. A product of this thesis will be an information resource for GPs. Therefore, the quantification work is important in highlighting conversational patterns likely to encourage patient attendance. I start by describing how complex interactional phenomena were transformed into variables for quantitative analysis. I next present and justify the outcome measures I used throughout this thesis, and then I outline my approach to potentially confounding variables in this section. Finally, in section 2.6.8, I present quantitative methods for the subsequent conversation analytic chapters.

2.6.7.1 Quantifying conversation – the transformation of phenomena into variables

In the forthcoming conversation analytic chapters I identify, describe, and analyse a conversational phenomenon, such as 'linking weight with health', or 'news delivery format'. I then explore associations between this phenomenon and patient CWMS attendance. However, these phenomena are always part of wider sequences of action. Some actions in these sequences I may have identified; others I may have collected, described, and analysed in detail. The vast majority of actions in these sequences, however, are undescribed, and uncategorised 'dark matter' (85). These phenomena work with each other to produce the conversation

which I observe unfolding. CA cannot currently account for sequence of action in quantification (66, 73). Therefore, following Stivers et al (75), when transforming phenomena into variables, I chose a quantification point. I have detailed Stivers et al's approach in section 2.4 of this chapter. When analysing how GPs asserted a valence towards news, for example, I coded the valence asserted in the preannouncement. This was because evidence from conversation analysis, and existing literature, indicated that the valence at this placement had important implications for how the referral was received. Following Stivers' approach I grounded my identification of a phenomenon, and its transformation into a variable, firmly in the participants' reality.

2.6.7.2 Outcome measures

2.6.7.2.1 In-consultation displays of agreement to attend

There were a number of points during the referral sequence where patients could potentially display agreement to attend. Responses were often non-committal or equivocal. I did not want to impose my own ideas of what did or did not constitute agreement on these data. At the end of the referral sequence GPs in the BWeL trial ticked a box on the randomisation card indicating if the patient had accepted or declined referral. I used these this as a measure of 'acceptance' as this showed GPs' local orientation to participant responses.

2.6.7.2.2 Post-consultation attendance

The main trial analysis showed that the effect of the brief intervention on weight loss was facilitated through attendance at the weight loss programme. Therefore, assessing this was a key outcome for these analyses. However, there are many variables outside of the GP's control that mediate continued attendance, which is necessary for weight loss, such as reception, whether one feels comfortable in a group, or convenience, and so on. All the GP can do is initiate the process by achieving attendance at the first session, and I used this variable as the health

variable most strongly connected to the GP's effectiveness in brief intervention delivery.

2.6.7.2.3 Patient satisfaction

I wanted to train GPs to deliver interventions that patients found were helpful and appropriate and I therefore assessed patients' post-consultation ratings of these variables. Patients rated the appropriateness and helpfulness of the conversation on a Likert scale from 1-5. I conducted reliability analysis to test the reliability of a scale that included both of these measures. The Cronbach's alpha was 'minimally acceptable' at 0.65 (88). I therefore decided to average these to create a combined measure which I called 'satisfaction' to simplify the analysis and avoid multiple testing. I examined the association between conversational practices and this satisfaction measure.

2.6.7.3 Confounding variables

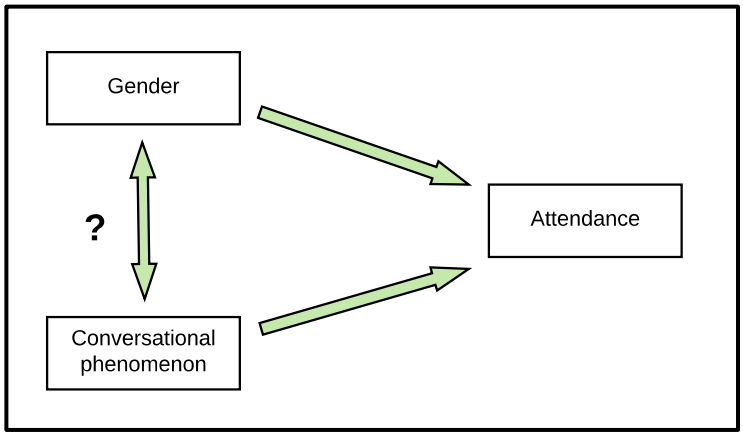
In most quantitative studies, potentially confounding factors such as age; gender; or socio-economic status are accounted for. Some quantitative conversation analytic studies of patient actions do incorporate potentially confounding variables (89) and some do not (90). There is no consistent method to include (or not) potentially confounding variables when analysing factors external to the consultation. Placing my data within the wider context of the BWeL trial was a helpful way to decide on the incorporation of confounders. Some factors independently predict outcomes in the BWeL trial; for example, self-identifying as a woman independently predicted both agreement-to-attend and attendance at the programme. Therefore, it was important this was controlled for in analyses.

It was not the aim of this thesis to explore if GPs *delivered* referrals differently depending on patient demographic features, but this could have been possible (Figure 2.4). If certain demographic categories were made relevant in the talk, I

would have also considered incorporating these into the qualitative analysis, but none were foregrounded locally as relevant.

To ensure the relationships I was observing were between conversational features and outcome measures (e.g. attendance), rather than participant demographics, I conducted adjusted analyses. In the BWeL trial both age and self-reported gender were shown to be independent predictors of patient attendance. Therefore, I controlled for these in my analyses, and present both univariable and multivariable analyses for each phenomenon of interest.

Figure 2.4 An example of a variable predicting attendance



2.6.8 Quantitative methods for forthcoming chapters

In each of the conversation analytic results chapters in this thesis I outline the detailed methods of quantification I used. For each chapter I was interested in relationships between the conversational phenomena I had identified and the following outcomes: consultation time, patient agreement to attend the CWMS; patient attendance (at least once) at the CWMS; and patient reported post-consultation satisfaction. For continuous outcomes (patient satisfaction score and consultation time) I conducted linear regression; and for binary outcomes (agreement-to-attend and attendance) I conducted binary logistic regression

analyses. I conducted both univariable and multivariable analyses, where I controlled for age and gender. Statistical analyses were conducted using Stata.

2.6.9 Stakeholder involvement in training resource development

2.6.9.1 Identification of trainables

Having explored and analysed data so that practices can be described and theories generated as to the 'how and why' of the interaction, following the process above, I then explored how these results could be translated so they could be understood and implemented by clinicians. In this section I detail the methods I used to translate results from conversation analysis into useable recommendations for practice including the support I received from patients, clinicians, and policy makers.

Once I had completed both qualitative and quantitative analysis, I had identified a series of practices which (1) were particularly effective or ineffective in producing in-consultation displays of agreement, and post-consultation attendance at CWMS; and (2) offered opportunity to shorten brief interventions. The next step was to identify how best to translate the evidence base I had identified so findings would be understandable for clinicians. I did this by following the initial stages of Stokoe's Conversation Analytic Role Play Method (CARM) approach (63, 91), which has shown potential in changing clinicians' behaviours (65). This process facilitates analysts to deliver training to practitioners while maintaining the integrity of the underpinning academic endeavour (91). I explored results and simplified the practices that I had identified so that they were still accurate, but also had a clear focussed message. For example, chapter four demonstrates how news is delivered. The key emerging trainable element was 'make the news sound good'; the practicalities of metaphor use, prosody; and footing, whilst of interest analytically were put aside for the wider action they achieve - 'good news delivery'. The complexities of sequential placement were simplified to 'do this near the start of the conversation'. In each conversation analysis results chapter, I present the key trainables that emerged from those results, and describe and

justify how I translated these. These trainable elements were identified through consultations with a multi-disciplinary supervisory team comprised of a GP (Prof. Aveyard); a medical sociologist (Prof Ziebland); and conversation analysts experienced in developing training from their work (Prof. Stokoe and Dr. Webb).

2.6.9.2 Information resource development

Having identified a series of trainables, I next started development of an animated information resource for training clinicians. In chapter one I demonstrated that clinicians have expressed a need for more specific training in discussing weight, but also have limited time to learn. This animation aims to address these two barriers. I aimed for the animation to be under five minutes long, and to provide brief tips to support clinicians to deliver brief interventions for weight loss. It will be freely available through the Public Health England website to complement their guidelines on brief intervention delivery. I will now describe the methods for developing this information resource.

I first formulated the trainables into a draft script (appendix 2). I did this in consultation with Prof. Liz Stokoe (a conversation analyst specialising in CARM) and 'A dozen eggs' a professional design company experienced in translating results from conversation analysis into clear and understandable training for professionals, and who developed the animated video. The script briefly outlined the evidence base for brief interventions, and how they can be delivered in ways which I had identified are likely to be brief, acceptable, and result in patient attendance at their referral. Following development of a draft script I next consulted with patients with obesity, and members of the public (PPI); public health policy professionals; and primary health care professionals.

Stakeholder involvement in this work comprised 42 patients, 7 GPs, 4 nurses (one of whom was a specialist diabetes nurse), one practice manager, the head of Public Health England's Obesity and Healthy Weight team, and a member of Public Health England's Obesity and Healthy Weight team who is responsible for communicating delivery of brief interventions for weight loss to clinicians. I

recruited patients and members of the public through our departmental database of people with obesity (PWO), or who are interested in weight management, and our departmental database of members of the public interested in PPI. Most patients and members of the public who responded stated that they had experience of discussions about weight with their GP. Others did not mention experience of these discussions, but did state an interest in clinical communication.
Health care professionals were opportunistically recruited through professional networks. I sought feedback from healthcare professionals who work in areas with a high prevalence of obesity. This was because they were likely to have experience of discussing weight with their patients, and could offer further insights on how referrals are carried out in practice.

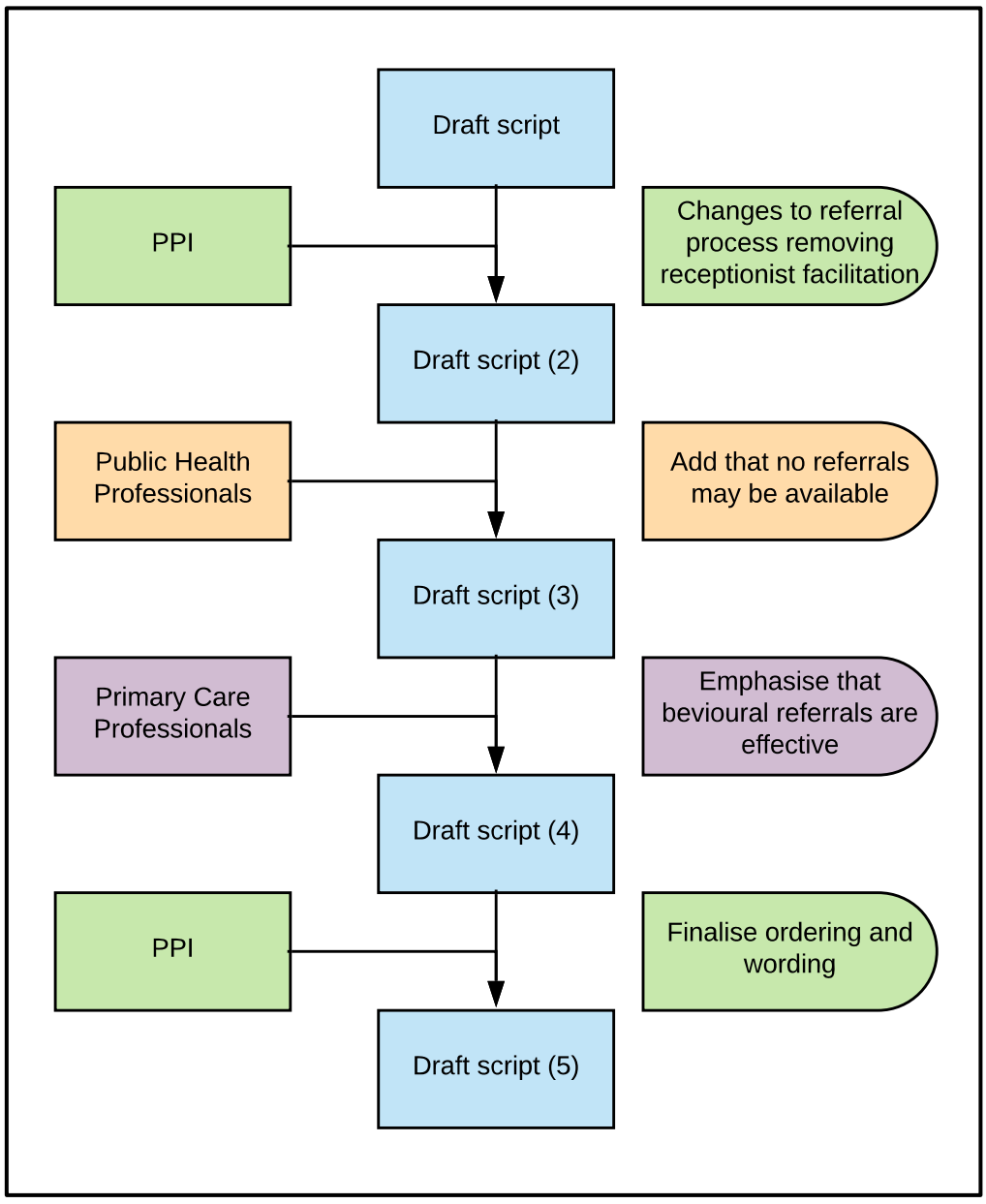
Patient and public involvement is increasingly recognised as 'an essential component'(92) of clinical resource development (93, 94). In line with National Institute for Health Research Patient and Public Involvement (NIHR PPI) standards (95), I now present my methods for involving patients, public, and stakeholders. I detail how this involvement strengthened the final resource for training which was produced. This is considered further in my discussion chapter, (chapter 7).

I sought the views of people with obesity, or an interest in clinical communication, through email discussion at two key stages. These were at the start of this work and to provide comments to produce a final version. As this training is to support clinicians to offer referrals to patients, I felt it was important to include people with obesity, but also these other key stakeholders in the resource development process. As patients have reported the importance of communication in discussions about weight I involved patients at the start and end of this process, to ensure suggestions from other stakeholders were also acceptable to people taking part in these discussions. I iterated the resource following feedback from each group to reflect their suggested changes. This process is illustrated in Figure 2.5. This work was assessed by Oxford University Ethics division, classified as service evaluation, and no ethical approval was required. I also consulted PPI experts, who stated that this work was patient,

public, and stakeholder involvement, rather than research. I visited one practice, with a high prevalence of obesity, to conduct a focus group. This focus group included seven GPs; four nurses (one of whom was a specialist diabetes nurse); and one practice manager (N=12). I then held 3 one-to-one discussions with a GP; GP trainer; and a practice nurse. I asked for their comment on the trainables, including their acceptability, and key take home points.

This process was designed to gain feedback from all stakeholders in the referral process. It was helpful in producing a resource to which clinicians and patients had both contributed. It was important that both these stakeholders in the process were involved to ensure this resource was acceptable to them, and met their needs. The results of this stakeholder engagement are presented at the end of each chapter, where I show the trainable which was identified, and discuss stakeholder comment. I discuss the overall results of stakeholder engagement, and how these related to training development in the final chapter of this thesis.

Figure 2.5 Input on information resource and resulting changes at each stage



2.7 Summary

I have described and justified the methods I used to answer my research questions. I have described the type of data that will be systematically reviewed in the next chapter (chapter three), and provided detail on data from the BWeL trial that will be analysed in my three conversation analytic results chapters (chapters four, five. and six). I have also described in detail the qualitative and quantitative methods I followed when analysing these data from the BWeL trial, and the process of stakeholder engagement in translating findings into useable recommendations for practice. To summarise, in these three chapters, I used conversation analysis blinded to the outcome data to identify conversational features in the consultation. Having identified conversational features, I used statistical analysis to examine associations between these features and four key outcomes – patient agreement-to-attend in the consultation, post consultation reported satisfaction, consultation length, and objectively measured attendance at the weight management session at least once. I have demonstrated that I largely followed established methodological approaches. However, there were no established practices to support my objective to explore relationships between conversational practices and subsequent patient action. In this chapter I have drawn on current conversation analytic approach to quantification, and explained and justified how these had been used or adapted when addressing my objectives. In the subsequent chapters I will examine, for the first time, how brief interventions for weight loss are communicated and received, and also offer an incremental methodological insight by demonstrating how in-consultation communication can be associated with subsequent patient action.

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Chapter 3

Communicative practices in health behaviour change talk: A systematic review and thematic synthesis

3.1 Policy, conferences, and Publications:

Result from this chapter have been used to develop national guidelines for health care professionals:

1. Thompson, L., Blackshaw, B., Coulton, V., Albury, C., Tedstone, A. (2017) Let's Talk About Weight: A step-by-step guide to conversations about weight management with children and families for health and care professionals. *Public Health England*. Available online. Ref: PHE publications gateway number 2017402.

Results from this chapter have been presented at the following conference:

2. Albury, C., Hall, A., Syed, A., Ziebland, S., Stokoe, E., Roberts, N., Webb, H., Aveyard, P. Communication practices for delivering health behaviour change conversations in primary care: A systematic review and thematic synthesis. *14th UKSBM Annual Scientific Meeting.* Birmingham, December 2018.

3.2 Introduction:

I have already identified GPs' concerns about talking about health behaviours with their patients, and an absence of guidelines providing detailed support in doing so. Despite this, no study has been conducted which reviews how health care professionals actually talk about health behaviour change with their patients in practice. What we currently know about this aspect of care is derived from after-the-fact reports from patients or clinicians (1, 2) which can be subject to recall or social desirability biases (3). Therefore, I chose to undertake a systematic review to identify what is currently known about health behaviour change talk used by health care professionals, in health care settings, and how patients respond to this. As literature on weight management in sparse, I examined literature from across all health behaviour change discussions to find out how these are conducted in practice, and map the available evidence. The systematic review methodology aims to summarise the evidence available in a particular field and to limit potential biases in searching and reporting (4, 5). Whilst existing work has explored post-hoc reports of behaviours or conversational practices from either doctors or patients (2, 6, 7), I chose to review studies which analysed the conversations themselves, and did so from recorded data, to provide specific insights into communication practices, and how they may be received.

The unique offering of conversation analysis and discourse analysis is an understanding of practices and patterns of communication. To my knowledge there have only been two other systematic reviews of conversation and discourse analytic work (8, 9) The first, a pilot review, reviewed research using German language data which explored aspects of doctor-patient interaction, and the second examined research using English language data on communication with patients about illness progression at end of life. In their review Parry et al (9) state that the "methods and findings of conversation and discourse analysis differ considerably from both qualitative and quantitative research approaches". The reliance of CA and DA on recorded, naturally occurring interaction; descriptions of typical and atypical features of communication; and analysis situated within previously established work on communication practices, are features that set them apart from other research

methods. For this reason, I carefully considered which approaches to take when conducting this review. Whilst Nowak (8) largely followed established systematic review processes, Parry et al adapted the process to increase its relevance for the unique aspects of conversation and discourse analyses. Their adaptations resulted in a review which clearly described communication practices, and also outlined their implication for clinical pratice. Parry & Land also produced a guide outlining how evidence from conversation analytic and related discursive research can be systematically reviewed and synthesised to inform healthcare communication and policy (10). This review generally follows the methods outlined by Parry & Land, however I took a critical apporach to their methods and adjusted and adapted these where appropriate.

3.3 Aims:

The aim of this chapter is to:

1. Identify and synthesise evidence from conversation and discourse analytic studies regarding how health care professionals communicate with their patients about health behaviour change.
2. Explore how different communication practices used by health care professionals are responded to by patients.
3. Consider the potential clinical implications of this work.
4. Establish gaps in current evidence.

3.4 Methods

3.4.1 Protocol and registration

The protocol was registered with Prospero: International Prospective Register of Systematic Reviews and is available online. Prospero Protocol ID 42016041782.

3.4.2 Eligibility criteria

This review explores health behaviour change talk (HBCT) used by healthcare professionals (clinicians) when communicating with patients in a healthcare setting. CA researchers do not traditionally make a solid distinction between 'institutional' and 'ordinary' talk (11), however it is understood that 'institutional' talk is goal oriented in institutionally relevant ways, and institutional and professional constraints influence conduct. As one aim of this review is to inform healthcare practice, occurring within those constraints, I decided to limit the studies to include only those which occur within the institutional context of a healthcare setting. Studies which met the following criteria were eligible for inclusion:

- Naturally occurring talk in interaction
- Audio or audio-visually recorded interactions
- Healthcare professional/patient interactions
- Interactions occurring within a healthcare context
- Conversation or discourse analytic methodology
- Peer reviewed papers or published book chapters
- Behaviours with potential to be repeated or long-term
- The ability to change behaviours is within the patient's control

I excluded studies which solely used coding frameworks, group interactions not resembling medical consultations, interpreter mediated encounters, encounters that have been translated into English, dissertations, book reviews, conference proceedings, and interactions including proxy decision making. No limits were placed on healthcare professionals' roles, patients' reasons for visit or any patient characteristic, although interactions which include proxy decision making have been excluded.

I defined 'health behaviour change talk' as talk designed to change health behaviours. I classified activities as 'health behaviours' if the behaviour could influence the person's health or risk of future ill-health. Furthermore, the behaviour would need to be repeated or represent a long-term change that was considered to be within the patients' control.

3.4.3 Search Strategy:

A research strategy was designed with advice from an information specialist (NR, see section 3.9). The following databases were searched: MEDLINE; Embase; Web of Science; AMED; CINAHL; psycinfo; Scopus; Sociological Abstracts CSA, and restrictions were applied to specify human subjects and English language. I searched peer-reviewed journals and published book chapters from 1945-2016. I additionally searched the following resources: bibliographies of included full-texts; specialist online discussion lists; and review team knowledge and contacts. All searches were conducted from January to March 2016. Searches were updated in March 2018. The full search strategy is available in appendix 3.

3.4.4 Study selection and appraisal

Titles were screened by a single reviewer (CA). Abstracts and full-texts were independently reviewed by two members of the review team (CA and AH, PA, or AS), and conflicts were resolved through discussion, or involvement of third team member (SZ or PA).

I followed existing practices for appraising studies which use conversation or discourse analysis (10). Two reviewers (CA and AH) identified the type of data analysis; how many examples were collected; and the depth of analysis used in each study. Some studies conducted a detailed sequential analysis of a number of similar interactions and offered comprehensive results on conversational practices and their relationship to patient responses. Others explored conversations in less depth, but nevertheless provided evidence on the presence or absence of particular conversational practices.

3.4.5 Data Extraction and Synthesis

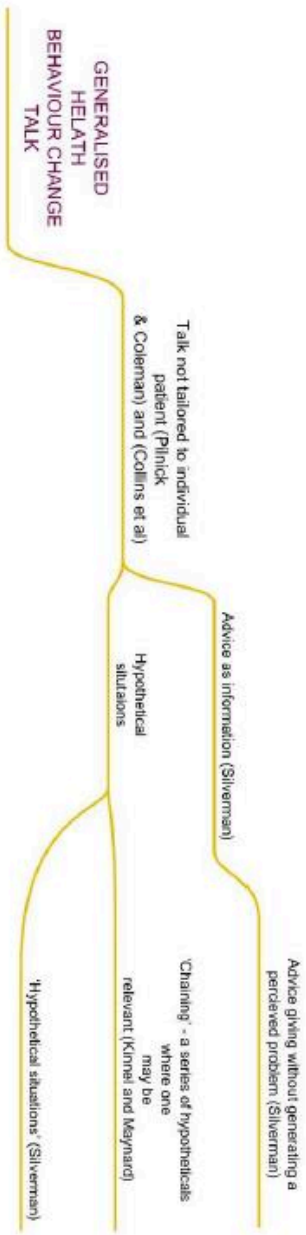
I adapted data extraction materials used by Parry et al 2014 (9) for the purposes of this review. Parry et al's template was designed specifically for studies which use conversation or discourse analysis, and I added data extraction sections to facilitate extraction of the types of health behaviour discussed, healthcare setting, and implications for practice (appendix 4). Data extraction was conducted independently by both CA and AH. Information was extracted regarding the types of talk used by health care professionals when discussing health behaviour changes and, where possible, the responses these received from patients, although these were analysed rarely. Any discrepancies were resolved through discussion, or through involvement of a third reviewer (PA or SZ). Some studies included data from more than one healthcare setting (12), or types of talk not related to health behaviour change. In these cases, only the findings from the parts of the study which met our inclusion criteria were extracted for synthesis.

Synthesis initially followed a thematic synthesis approach (13) where data were coded and grouped descriptively. This involved line-by-line coding of the results and discussion sections of included studies, and the inductive development of descriptive themes which were generated from primary studies. Similar codes across studies were then grouped hierarchically using the 'One Sheet Of Paper' (OSOP) technique (14) resulting in a total of 14 top-level descriptive themes Figure 3.1 shows an example of how sub-themes were grouped to develop top-level themes). In a typical thematic synthesis further interpretation would then occur where new theoretical concepts, or analytical themes are generated from the descriptive groups. However, following Parry et al, synthesis took an aggregative approach, and did not seek to generate new theoretical concepts. This is because generating analytic themes necessitates a high level of inference from reviewers (13) and is typically theory driven. This method, while often appropriate for more traditional qualitative approaches, is not appropriate for conversation and discourse analytic work where examples presented are chosen to exemplify or ilustrate the points the researcher is making, and results are grounded significantly in previously established findings about communication practices, limiting what can be inferred or re-interpreted. The aggregative approach used here ensured results were 'accumulated' and

‘summarised’, rather than ‘transformed’(15) , therefore not differing significantly from the reporting of primary studies.

Synthesis was conducted by one reviewer (CA) with a second (SZ) providing input on final grouping of descriptive themes. Data were coded and managed using Nvivo 11 for Mac, and OSOPs were generated using MindMaple for Mac.

Figure 3.1 Hierarchically grouped themes contributing to top level theme 'Generalised health behaviour change talk'



3.5 Results:

3.5.1 Included studies

Of the 17562 studies identified through systematic searching, ten papers from eight unique observational studies fulfilled the inclusion criteria. Figure 3.2 illustrates the screening and assessment process. Included studies were conducted in four countries (USA; Canada; Australia; and UK) and in two healthcare settings (general practice, and specialised primary care clinics). Studies were published between 1992 and 2014. The characteristics of included studies are described in Table 3.1.

From the eight included studies seven papers, from six unique studies, were from general practice (12, 16-21) and three papers, from two unique studies, were from specialised primary care clinics (22-24). Some papers reported multiple health behaviours, or analysed HBCT from more than one healthcare professional. The behaviours discussed were: weight management (5 studies)(12, 18-21); smoking cessation (3 studies)(16-19); safer sex practices (2 studies)(22-24); and lowering alcohol consumption (1 study)(19). Health care professionals engaging in HBCT were general practitioners (4 studies)(12, 16-19); sexual health counsellors (2 studies) (22-24); dieticians (1 study)(20); nurses (1 study)(19); and family health team members (1 study)(21).

All studies conducted a sequential analysis of recorded talk. Seven of the eight unique studies used a conversation analytic methodology (12, 16-20, 22-24) and one used discourse analysis (21). Seven were also multi case analyses (12, 16-20, 22-24), while one was a single-case study (21).

Most studies focused on clinician communication behaviours. Only one study focused in detail on patient responses to HBCT (16); five studies outlined, to varying degrees, typical patient responses to the HBCT which were presented without these analyses being the main focus (12, 17-19, 22-24), and one explored HBC conversations between one patient and two different health care professionals (21). HBCT which produced patient resistance displays (responses which could be seen to resist advice) were highlighted by all papers, and in all

instances patient response was used to indicate the potential efficacy of HBCT. All studies used audio data and two used audio-visual data (16, 17, 19). One study conducted limited analysis of embodied action, focusing only on gaze (19).

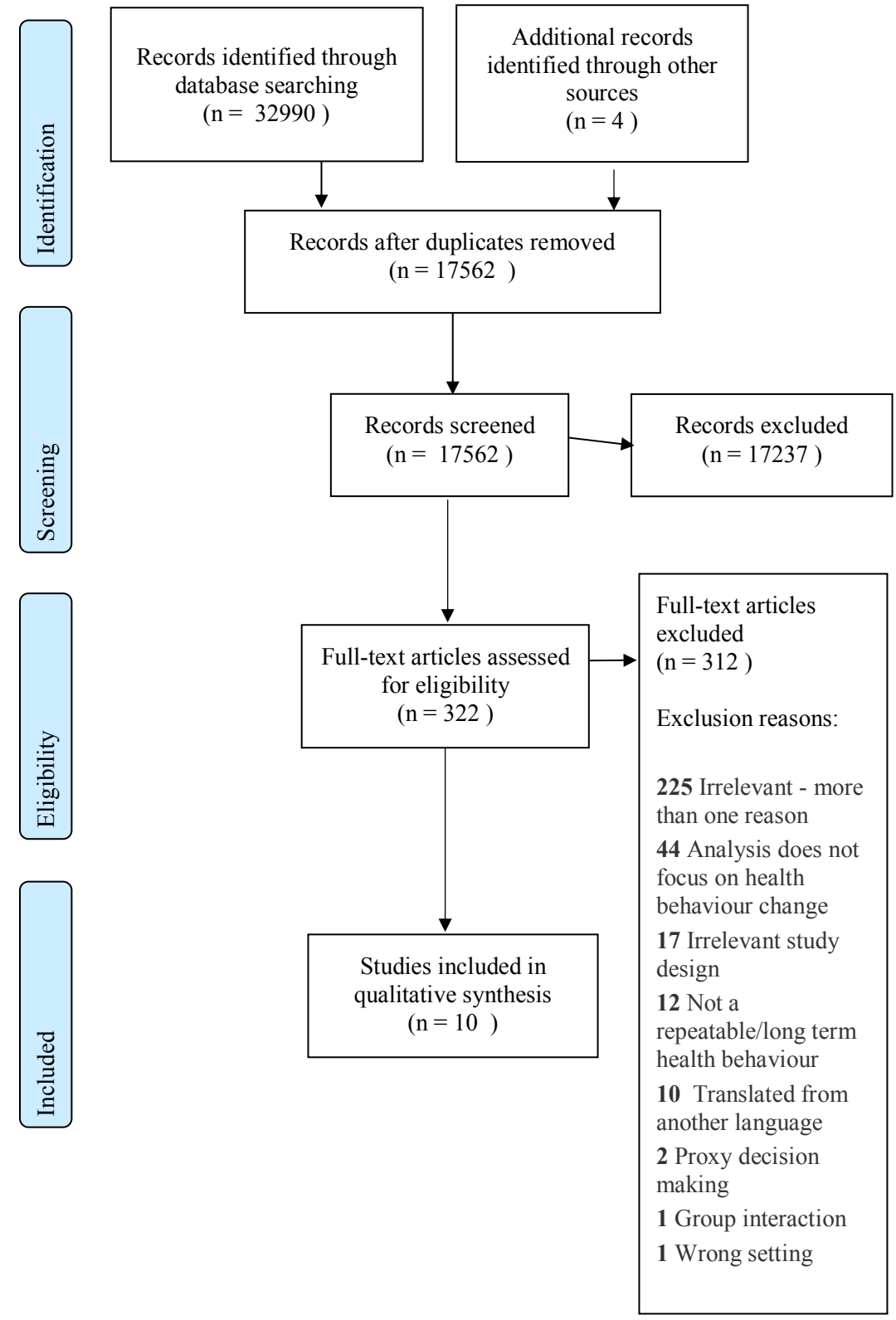


Figure 3.2: Prisma Flow Diagram

Table 3.1 - Description of included studies

Authors	Country	Health Behaviour (s)				Participants	Setting	Method	Audio/ video	Corpus size	Recordings used for analysis
		Weight management	Smoking cessation	Promoting lower alcohol consumption	Safer sex						
Cohen, D.J. et al 2011	USA	✓	✓			General practitioner / patient	General Practice	Conversation analysis	Audio	811	541
Collins, S. et al. 2005	UK	✓				General practitioner / patient	General Practice	Conversation analysis	Audio	168	80
Freeman, S.H. 1987	USA	✓	✓	✓		General practitioner /patient & nurse/patient	General Practice	Conversation analysis and observational methods	Video	200	200
Kinnell, A. & Maynard, D. 1996	USA				✓	Counsellor / patient	Primary Care	Conversation analysis & ethnography	Audio	66	25
Pilnick, A. & Coleman, T. 2003;2010	UK		✓			General practitioner / patient	General Practice	Informed by conversation analytic principles	Video	538	47
Silverman, D. et al 1992	USA UK				✓	Counsellor/ patient	Primary Care	Conversation analysis	Audio	100	100
Tapsell, L. 1997	Australia	✓				Dietitian / patient	General Practice	Conversation analysis	Audio	30	30
Thille, P. et al. 2014	Canada	✓				Family health team member /patient	General Practice	Discourse analysis	Audio	12	12

3.6 Aggregative Thematic synthesis

Included studies were coded and thematically aggregated. Initial coding produced 102 codes across all 10 included papers, which were aggregated into 14 top-level themes. To best reflect the content of included studies, and optimise the clinical relevance of results, the conversational strategies used by clinicians are presented separately for each stage of the behaviour change discussion (10). These stages are: initiating HBCT; carrying out HBCT; and closing the HBCT. Quotations are presented to illustrate conversational practices, and verbatim transcriptions have been adapted from the original Jeffersonian format. A description of the frequency of each conversational practice, across studies, is presented in Table 3.2. Table **3.3** summarises each conversational practice and the response it was reported as likely to receive from patients.

3.6.1 Initiating Health Behaviour Change Talk:

All studies included in this review documented strategies which are used by clinicians to initiate these conversations. These strategies were: direct questions (16, 20, 23, 24); linking HBC to a medically relevant concern (12, 16, 18, 19, 21); non-personalised initiation (16); patient initiated discussions (17, 18, 22, 24); and opportunistic HBCT at the end of a consultation (19). The following sections will discuss each of these in detail. One paper used patient responses as a unit of analysis (16), others used them as proxy measures for the success or failure of clinicians' talk.

1. Direct questions

Health behaviours can be raised as a direct question targeting a specific health behaviour, such as '*Do you smoke*?' (16), or "*When the two of you engage in any type of sexual activity do you use safe sex?*" (24) . Four studies; two from specialised primary care clinics (23, 24), and two from general practice(16, 20) reported this practice. Depending on the healthcare setting, these questions can be

used to initiate HBCT at the start of a consultation, or when a relevant moment arises (see 'linking to a medically relevant concern' below). One general practice study (16) documented direct questions as the most common way of initiating health behaviour change discussions about smoking cessation.

Only one study, from general practice, described patient responses to these direct questions(16). It outlines a pattern where patients acknowledged the undesirability of their behaviour and provide more information, such as recounting attempts to change behaviours, or giving rationales for not doing so. Clinicians then used information provided by patients to inform subsequent discussion. In some studies these direct questions from the clinician formed the basis of a step-wise entry into advice giving, through question and answer sequences (20, 23, 24) the process of which is outlined further in section 0 of this chapter.

2. Linking to a medically relevant concern

There are opportunities to initiate health behaviour change talk when an associated, medically relevant, concern is discussed. Five studies from general practice (12, 16, 18, 19, 21) reported that linking health concerns and health behaviours can be used to initiate HBCT, and three of these explored this phenomena in detail (16, 18, 19). Articulating a link between an existing health concern and a health behaviour may be expected to facilitate HBCT by emphasising its personal relevance for a particular patient. However, this strategy was reported to have varying effectiveness.

Two general practice papers (16, 18) state that this method can be unsuccessful if the link is made to a health concern which does not have salience for a patient. For example, in one study, a clinician explained weight loss would be beneficial, but the patient resisted this advice (18). However, when the same clinician linked dieting, weight loss, and reduced risk of mortality (associated with the patient's status a new parent), the patient engaged with and oriented to this as salient:

Excerpt 3.1 Cohen et al., 2011

Clinician: *We want to – you know keep you around as long as possible*

Pat: *Yes*

Clinician: *Since .you've got a little one. So.*

Pat: *Yeah.*

Clinician: *I would recommend exercising and really watching your sugars.*

Evidence from one paper showed that links to salient concerns could also be rejected (18). In Excerpt 3.2, following the clinician's link between their smoking and respiratory infection, this patient responds in a louder voice overtly rejecting the association, and saying instead it was air conditioners on the bus which caused cold symptoms:

Excerpt 3.2 Cohen et al., 2011

"That's from getting off- ((audible exhale)) actually being on the bus and they had the air conditioners up up and don't turn them down. I caught a cold from there."

These displays of resistance in response to linking are reported by Pilnick and Coleman as 'rarely seen in other medical consultations'(16). Conversely Freeman, states that linking HBC with a well-known illness condition was the most frequent and 'least disruptive' pattern which was observed in her USA general practice study (19). However, the examples presented by Freeman are links between weight-management and diabetes, and chronic bronchitis and smoking cessation. These behaviours and conditions have well-known relationships. There is a possibility that Freeman's results differ due to clinicians in this study creating links between salient health concerns and health behaviour change.

Two papers (16, 18) use the data to infer that there are strong moral implications of associating a patient's illness with their behaviours. Doing so evokes connotations that the patient is responsible and can be blamed for her/his own illness. Patients appeared to be displaying that clinicians were undermining the legitimacy of a patient's illness and their request for medical assistance. These

moral elements may result in the significant displays of resistance seen in response to linking health behaviours and medically relevant concerns.

Pilnick and Coleman argue that to link smoking behaviours and health concerns successfully there needs to be a mutual understanding that a given health behaviour is a legitimate problem to discuss in its own right, before moving to discuss health behaviour change (16). Rather than linking to *initiate* HBCT, this study recommended a general, non-personalised entry into HBCT (e.g. Establishing smoking is a problem), securing agreement on this statement from the patient, and then moving to a more personalised discussion, as this process is less likely to generate resistance displays.

The available evidence here outlines the varying success of linking existing conditions and health behaviours, and the moral dimensions of doing so. Two studies demonstrated that a link between health behaviour and a non-salient concern had potential to generate resistance displays. All three studies which examined this phenomenon in detail showed that linking to a concern for which there is a shared understanding of salience has some potential to be successful in motivating health behaviour change (16, 18, 19). Overall, linking was shown to be a strategy which carries latent potential for resistance, particularly if used to initiate the topic of HBC.

3. Non-personalised initiation

Pilnick and Coleman (16) found a general, non-personalised entry into smoking cessation talk was used by health care professionals to initiate discussions. They found that if health behaviours can be established as a general problem for health (e.g. Smoking is a problem), and agreement secured on this statement from the patient, then a more personalised discussion can be had which is less likely to generate resistance displays. In contrast, personalising a health behaviour (such as *your* smoking or *your* exercise habits) before both clinician and patient have agreed that it is a problem, was reported to be likely to result in displays of resistance.

4. Patient initiated discussions

Health behaviour change discussions are sometimes initiated by a patient, rather than a clinician. Four studies; two from general practice (16, 18) and two from specialised primary care clinics (23, 24) explored HBCT in this context. Patient initiated HBCT was reported to be rarer than clinician initiated HBCT (16, 23). Patients were shown to initiate HBCT either through asking directly for HBC advice, or raising a potentially relevant topic which provides the clinician with an opportunity to move forwards with HBCT (see linking above). Evidence indicated that, through initiating such conversations directly, patients show that they will be receptive to subsequent HBCT (24), and this provides opportunity for clinicians to engage in such discussions.

5. Opportunistic HBCT at the end of a consultation

Freeman (19) found that clinicians initiated HBCT at the end of a general practice encounter, when the topic was raised without a cue or direct relevance to the preceding talk. Sometimes this was accomplished by 'conversational bracketing'; a change in tone and gaze, so that the conversation sounds 'off the record' or like a joke. Freeman argued this acted to slightly remove HBCT from the rest of the consultation. Secondly, HBCT could be mixed into usual closing talk (
Excerpt 3.3):

Excerpt 3.3 Freeman, 1987

Clinician: *Okay? right…so…are you and Bob getting out there doin' some walkin'…a little bit in the evenings?*

Patient: *'Oh…'yea… a little bit let me see…we went last… Thursday I think it was…down*

Clinician: *'Don't forget this now [hands patient prescription]*

Patient: *Oh no… I'll take it over next door [to the drug store]*

Clinician: *Good cause that is really important that you do that… I could phone that in if you'd rather…at Long's*

Patient: *What? Oh…no…I'll take it*

Clinician: *'Okay then good so we'll see you…soon*

Patient: *Okay bye bye*

The evidence from this study indicated that that mixing HBCT through closings somewhat mitigated the delicacy of these discussions. Both these strategies can be used to opportunistically initiate HBCT with patients at the end of a consultation, and act to divert focus from the potential sensitivity of HBCT. Although only one study, of 200 consultations, examined this practice, and there is therefore limited evidence on how this practice was received by patients, the authors showed that this method can be used to initiate HBCT opportunistically. They concluded that patient responses to this practice showed that it may have generated only minimal resistance.

3.6.2 Conversational strategies used during health behaviour change talk

1. Generalised HBCT

HBCT was sometimes delivered in ways which can be seen to be true for 'patients in general' rather than tailored to a specific person. Four studies; two from general practice (12, 16), and two from primary care clinics (23, 24), explored how generalised health behaviour change talk was carried out, and the responses these produced from patients. Two categories of generalised HBCT have been classified in this review: 'Hypothetical situations' and 'Giving information instead of advice'.

i. Hypothetical situations

Two studies, one from primary care clinics (24), and one from general practice (16) explored how generalised HBCT was achieved through presenting a hypothetical situation, and then a recommendation for a health behaviour to use in that hypothetical circumstance. This hypothetical talk is somewhat ambiguous, and clinicians talk about 'some people' or 'you' which could be seen as referring to "speaker, or recipient, or someone, or everyone" p.351 (25), often combined

with a hypothetical 'if' as shown in Excerpt 3.4. All studies showed that this type of talk mitigated the risk of confrontation, as the health behaviours discussed were not overtly presented as those undertaken by that particular patient. This was presented as a way to acknowledge the delicacy of HBC discussions. However, two studies stated that hypothetically discussing HBC could also be problematic as patients may not have heard hypothetical advice as relevant for them (16), or may have rejected HBCT (24).

Excerpt 3.4 Silverman et al., 1992

Now when someone er is tested and they have a negative test result it's obviously deal uh:m that they then look after themselves to prevent any further risk of infection. I mean obviously this is only possible up to a point because if you get into a sort of serious relationship with someone that's long term you can't obviously continue to use condoms forever, and a point has to come where you make a sort of decision if you are settling down about families and things that you you'd- not to continue safer sex. ....Now whe- when someone gets a positive test result er then obviously they're going to ke- think very carefully about things. Being HIV positive doesn't necessarily mean that that person is going to develop Aids later on.

ii. Giving information instead of advice

Silverman's study from primary care clinics (23), and two from general practice (12, 16) identified how clinicians can give HBC advice without having elicited a perceived problem from a patient. In this way HBCT can be presented as 'information, for people in general', rather than 'advice for you' as demonstrated in Excerpt 3.5 :

Excerpt 3.5 Silverman et al., 1992

As far as sex is concerned it means keeping to the safer sex guidelines [hmm [for two reasons (0.5) firstly to try and prevent them passing it on to anyone else hmm umm and secondly because really they can't afford to catch you know some of the

other sexually transmitted diseases that are around well yeah um uh (0.5) and basically it means either sticking to noninsertive sex like mutual masturbation um (0.5) massage that kind of thing or else if they do you know carry on having full sex to use a condom um preferably with a spermicidal backup as well yeah (1.0) is there anything you want to ask (0.5) so far you no uh heh heh right (2.0) one of the biggest drawbacks with having this test is as far as insurance (0.5) is concerned.

This communication format rarely invited a patient's "experience, opinion and understanding" (12) and was led by clinicians, rather than built collaboratively (12, 23). This format often did not elicit a patient response, perhaps because it created less of a requirement to respond verbally to this type of HBC advice and, in particular, to commit to changing behaviour.

In summary, I've shown that HBCT can be generalised through avoiding tailoring to a specific patient by talking hypothetically, or delivering 'information' rather than 'advice'. In general this non-personalised format produced acceptance (12) or minimal acknowledgment from patients. One study concluded that non-personalised HBCT was shorter than personalisation, fitting better with the time constraints of healthcare consultations. Two studies reported that this talk was largely clinician led (12, 23). No evidence of the relationship between this practice and health behaviour change was presented. However, based on the minimal patient responses this practice received, one study hypothesised that untailored, unilaterally delivered information may not be adequate in motivating behaviour change (23).

3.6.3 Personalised HBCT

The practice of tailoring and personalising HBCT for a specific patient, rather than for 'patients in general', was observed in six studies; four from general practice (12, 16, 20, 21) and two from primary care clinics (23, 24). This

personalised HCBT consisted of four distinct communication practices. These practices, and their associated patient responses, are outlined below.

i. Question-answer sequences

The use of question-answer sequences was explored in four studies, two from primary care clinics (23, 24) and two from general practice (16, 20). These studies examined how clinicians encouraged a patient to talk, and tailored HBCT to individual patients, often by a stepwise move through a question–answer sequence which narrowed in focus towards eventual delivery of individually tailored HBC advice. The resulting HBCT was shown to become a collaborative venture between clinician and patient. Through asking a series of questions, and tailoring them in line with a patient's previous responses, patients became implicated in subsequent talk (Excerpt 3.6):

Excerpt 3.6 Tapsell, 1997

Clinician: *Lite White milk. Have you tried another type of milk?*

Patient: *Shape and skim milk*

Clinician: *What do you think of Shape?*

Patient: *Shape's not bad. I don't like the skim milk except the one you buy on the shelf, that's nice.*

Clinician: *Yeah. um um so would you be happy changing to Shape d'ye think?*

Patient: *Yeah, it wouldn't worry me. It's pretty much the same as Lite White only a little bit less*

Clinician: *Yeah, t' it does have less fat um and that would, that would contribute considerably if you used uh Shape all the time. Do you have any problems with that?*

Patient: *No not at all.*

In Excerpt 3.6 the health care professional asked for the patient's opinion, and tailored subsequent HBCT to the opinion expressed by the patient. One study reported that this format took longer than giving general non-personalised advice (23). Nevertheless, this study also showed that this practice allowed HBCT to be

personalised to a particular patient, and resulted in displays of patient agreement. However, Kinnell and Maynard state that personalised question-answer sequences about sexual health in a primary care clinic can seem 'confrontational and intrusive'(24).

Pilnick and Coleman found that, if the patient's opinion was sought and HBCT initiated immediately, without asking further questions, less uptake, or resistance occurred (16). The authors inferred that this was because HBCT had not been sufficiently tailored to patients' preferences. One study from general practice (16) and one from a primary care clinic (24) hypothesised that it is important a problem is established before HBC advice is delivered this way.

In summary, this question and answer approach was shown to be variable. One study reported that this pattern appeared intrusive (24). Although the evidence presented was sparse; another that it took longer than other methods (23). However, it was reported to often result in displays of uptake from patients which likely indicate receptivity to HBCT.

ii. ***Collaborative HBCT***

Three general practice studies examined how HBCT was built collaboratively (12, 20, 21) through inviting a patient's perspective and accommodating this throughout HBCT, or acknowledging HBC, or the degree of HBC, as the patient's choice:

Excerpt 3.7 Thille et al., 2014

Clinician: And is it two days a week, is that what you think you can maintain, or maybe once a week? Or what would be best?

There was evidence that this was used by clinicians to initiate joint decision-making in a consultation. Such sequences usually led to clinicians inviting patients directly to comment on and agree with proposed HB changes that emerged from this joint enterprise, and patients responded accordingly.

iii. ***Goal setting and assessment***

Two studies, one from general practice (21) and one from a primary care clinic (23), documented goal setting and assessment as components of HBCT. Some goals were clinically oriented, and set or assessed with comparison to guidelines or biomedical recommendations; whilst others were related to self-improvement, or comparison with others (21, 23). There was no evidence on patients' responses to these goal-setting strategies and no data on which circumstances they could be best used.

Thille et al (21) found that, during goal *assessment* in a general practice weight loss review appointment, emphasising personal responsibility for clinical outcomes generated resistance displays. In one example (Excerpt 3.8) a patient's HBC attempt was only positioned as successful if she had lost weight since her previous appointment, rather than if she had changed her diet and exercise behaviours:

Excerpt 3.8 Thille et al., 2014

Clinician: *Well, I would like you to lose weight. So have you lost any weight?*

Patient: *Yes, a little bit. I don't know how much.*

Clinician: *You were 109 kg today.*

Patient: *Yeah, that's the same as when I was at the, the dietician a couple weeks, I thought I'd lost weight, but it was -*

Clinician: *You started at 111 [Patient:: okay] kilograms, in November there. [Patient: okay] So um, that's a little slower than I'd like. [PATIENT: yeah]. Are you making substantial changes in your meal plan, compared to what you were doing last fall?*

Patient: *Yes, yes. Yes.*

Clinician: *Absolutely?*

Patient: *Absolutely.*

The evidence is limited as it is generated from one single case analysis. However, the authors conclude that there was potential for disruptive consequences if only

the desired outcome (e.g. Weight loss) was celebrated and emphasised rather than the HBC itself.

iv. ***Positive reinforcement and negative positioning***

Thille et al (21) examined positive reinforcement or negative positioning with respect to a patient's HBC efforts. Positive reinforcement included emphasis on success, even when HBC targets were not met, and reinforcing behaviour change through praise statements. Praise statements are demonstrated in this weight management example, which takes place as the patient is being weighed (Excerpt 3.9):

Excerpt 3.9 Thille et al., 2014

Clinician: *Oh my goodness. It's moving a lot.*

Patient: *Good, good, good.*

Clinician: *My goodness. It's moving quite a lot. These are kilos, these aren't pounds.*

The patient in the excerpt below (Excerpt 3.10) has not lost as much weight as she had expected. However, the clinician in this study focused on her successes, and then added recommendations for further HBC, following this:

Excerpt 3.10 Thille et al, 2014

Clinician: *Okay, let's see. So how are you feeling?*

Patient: *I've been feeling good. That's why I thought this would be lower. I really have, you know, I, but it doesn't show. (Laughs)*

Clinician: *That's okay. I don't know that you need to be that disappointed, because let's face it. It's, it's much improved compared to 160, isn't it,*

Patient: *Yes*

Clinician: *when you, when you came in. It's not that long ago when, that you first came and found you had diabetes and hypertension and the.*

Patient: *Yes. Yeah, and all the other garbage.*

Clinician: *So you, yeah, so you made really wonderful gains, and uh, let's see if there's anything more we can do. Are you finding the meal plans difficult?*

Whilst the effectiveness of positive positioning was not explored in detail, the converse strategy where a patient could be positioned negatively as a 'failure' for not initiating or achieving health behaviour change, was shown as likely to generate resistance displays. Repairing and recovering from this negative positioning required additional consultation time.

I have shown evidence that personalising HBCT though linking a patient's health behaviour and health, before establishing a shared understanding of the relevance of HBCT and the salience of the associated concern, has been shown to be an unstable strategy with the potential to generate resistance. However, a number of studies demonstrated the importance of personalising HBCT in different ways, and explored how can be achieved, which seemed less likely to result in resistance displays. Question-answer sequences were shown to have great potential for patient engagement and participation, but also could be perceived as intrusive, and took a longer time. Evidence indicated that collaborating in decision making, and positively positioning patients HBC efforts are well received by patients, whilst emphasising personal responsibility for clinical outcomes and negatively positioning patients HBC efforts had potential to generate resistance.

3.6.4 Managing resistance displays

Five studies, three from general practice (16, 18, 19), and two from primary care clinics (22, 24) explored how resistance displays are responded to by clinicians. Resistance displays could be minimal responses, no responses, proposition of alternative views, or overt patient rejection of health behaviour change talk. Two broad strategies emerged where doctors dealt with resistance displays by either initiating a change in topic, or continuing to pursue health behaviour change talk. Clinicians were shown to pursue HBCT in four ways which are detailed below.

i. Pursuing health behaviour change talk

Three of the five studies explored how clinicians pursue health behaviour change talk when faced with patient resistance displays (16, 23, 24). This pursuit could be achieved through evoking 'worst case scenarios'; 'changing recommendations'; 'linking to a salient concern'; and using 'long pauses and repeat questions' to encourage patient responses.

a. Worst Case Scenarios

Pilnick and Coleman (16) examined how clinicians continued to pursue health behaviour change as a topic when faced with resistance, by talking about 'worst case scenarios'. This presented behaviour change, like stopping smoking 'as the solution to a specific (and potentially fatal) problem' p.141 (Excerpt 3.11).

Excerpt 3.11 Pilnick & Coleman, 2003

''here you are with a bloody great pain in the chest and here you are worried to death that you've got something nasty in your chest. Knowing in fact that lungs (sic.) give you lung cancer. I mean Christ what more do you want''.

Whilst it could be expected that this method would emphasise the importance of health behaviour change, it generated further displays of resistance in the form of defensive or contradictory responses from patients. Evidence on this topic is sparse but does indicate that pursuing HBCT in this way may not be successful.

b. Changing recommendations

Kinnell and Maynard's study (24) of primary care clinics outlined how clinicians changed their recommendations during HBCT if they met resistance. If advice was initially met with resistance it could be downgraded. For example, when advice was resisted, Kinnell and Maynard showed that clinicians stated that the first recommendation they gave was "ideal", and acknowledged "the reality here"

and then produced a downgraded recommendation. Although only one study of 25 consultations examined this practice, the authors concluded that this method may not generate subsequent resistive responses.

c. Linking to a salient concern

As reported in section 2 'Linking to a medically relevant concern' there was evidence that creating a second link to a salient concern was shown to often address resistance to the initial link, and allow for more productive HBCT (16, 18).

d. Long pauses and repeat questions

Long pauses and repeat questions were identified by Silverman et al's study of primary care clinics (23) as a method used by clinicians to pursue HBCT and to promote a response from resistive patients. Repeat questions were tailored to an individual patient and so, the authors argue, have potential to result in behaviour change. This study showed that silence from a clinician encouraged initially resistive patients to take the floor during a discussion.

These practices demonstrate how HBCT can be pursued when faced with resistance. Whilst evidence indicates worst case scenarios are likely to be unsuccessful, changing recommendations may not generate further resistance responses. Long pauses and repeat questions were shown to encourage patients to discuss HBC. I next show how clinicians responded to resistance displays by changing the topic.

ii. Initiating a change in topic

Two studies from general practice (16, 19) outlined a change of topic in response to resistance displays. Rather than pursuing HBCT, clinicians in these cases avoided addressing displayed resistance, and changed topic to discuss less-delicate matters (Excerpt 3.12):

Excerpt 3.12 Freeman, 1987

Clinician: *Do you smoke?*

Patient: *Yes*

Clinician: *There's some things you can do these days that really help with cutting down… with quitting . . cause that is really something you should think about*

Patient: *[5 sec silence]*

Clinician: *Well. . . so . . . how're you getting along with the Tagamet so far? seem okay?*

Patient: *Seems okay. . . no problem*

Clinician: *No problem. . . good.*

Both studies which examined this topic demonstrated that following this strategy enabled HBCT to be discontinued successfully and the normal business of a consultation resumed with minimal disruption.

3.6.5 Closing health behaviour change discussions

Two studies from general practice discussed methods for closing HBC discussions, and oriented to difficulties in doing so effectively (17, 21). I identified two patterns that were reported for closing HBCT; 'non-specific advice' and 'providing a next step'.

1. Non-specific advice

Two papers showed how, when closing HBCT, clinicians often presented the harms of a health behaviour, with no specific follow-up advice. One paper additionally found that clinicians did not assess a patient's capability to carry out behaviour change (21) and a second demonstrated that they also gave vague non-expert advice (17). I have termed these strategies 'Non-specific advice' as the HBCT was vague, non-personalised and lacked a next action step:

Excerpt 3.13 Pilnick & Coleman, 2010

Clinician: the best way is just to think about it, think about how you'd stop and when you'd stop rather than just having it as something in the future.

This non-specific advice does not acknowledge a patient's health behaviour as a medical problem nor does it give specific instructions to facilitate change. Pilnick and Coleman's study found that this technique expedited closing and does not overtly generate resistance, however its effectiveness in facilitating behaviour change is unclear. Pilnick and Coleman (17) state that patients orient 'to a lack of success' in providing a HBC solution, and hypothesise that this may be associated with a lack of action to change health behaviours.

2. Providing a next step

A second way HBCT was shown to be closed was by offering expert help to patients to let them know that their HBC was indeed legitimate and worthy of attention and support. One study explored this practice and the authors concluded that asserting an affirmative next action step such as a prescription (e.g. Nicotine replacement therapies), or referral to a third party, (e.g. NHS stop smoking services; or commercial weight management) presented a way to end HBCT effectively as it asserted the legitimacy and 'doctorability' of the patient's behaviours and offered specific next steps (17). Pilnick and Coleman showed that when clinicians took these actions with a patient who had expressed willingness to engage in HBC this method was received well (17). Providing a positive next step was concluded to be a practice which offered clinicians a way to end consultations with limited potential for resistance. The studies reviewed do not include data on actions patients took to change their behaviours; however, pragmatic consideration suggests that 'providing a next step' is more likely to result in behaviour change than 'non-specific advice'.

Table 3.2 Frequency of health behaviour change talk across studies	Cohen, D.J. et al	Collins S. Et al	Freeman, S.H.	Kinnell, A. & Maynard,	Pilnick, A. & Coleman,	Silverman, D. Et al	Tapsell, L.	Thille, P. Et al	**Frequency**
Initiating Health Behaviour Change Talk									
Direct question				■	■	■	■		4
Linking to a medically relevant concern	■	■	■		■			■	5
Non-personalised initiation					■				1
Patient initiated discussions	■			■	■	■			4
Opportunistic HBCT at the end of a consultation			■						1
Conversational strategies used during health behaviour change talk									
Generalised HBCT			■	■	■	■			4
Hypothetical Situations				■	■				2
Giving information instead of advice		■			■	■			3
Personalised HBCT		■		■	■	■	■	■	6
Question answer sequences				■	■	■	■		3
Collaborative health behaviour change talk		■					■	■	3
Goal setting and assessment							■	■	2
Positive and negative positioning								■	1
Managing resistance displays									
Pursuing health behaviour change talk				■	■	■			3
Worst Case scenarios					■				1
Changing recommendations				■					1
Linking to a salient concern	■				■				2
Long pauses and repeat questions						■			1
Initiating a change in topic			■		■				2
Closing Heath behaviour Change talk									
Providing non-specific advice					■				1
Provide a next action step					■				1

Table 3.3 Conversational practices used to deliver HBCT, and the responses reported from patients

Type of HBCT	Description of HBCT	Patient response
Conversational strategies used for initiating health behaviour change talk		
1. Direct questions	Health behaviours are raised as a direct question, targeting a specific health behaviour, such as 'do you smoke?'	Undesirability of health behaviour may be acknowledged
2. Linking to a medically relevant concern	Health behaviours are linked with an associated, medically relevant, concern	Varying efficacy. Risk of strong resistance
3. Non-personalised initiation	Health behaviours are established as a general problem for health	Reduces potential for patient resistance
4. Patient initiated discussions	Health behaviour change discussions are initiated by a patient	Receptive to subsequent health behaviour change talk
5. Opportunistic HBCT at the end of a consultation	Health behaviour change talk mixed in to closing talk, or delivered so it sounds 'off the record'.	Mitigate the delicacy of discussions. Minimal potential for resistance
Conversational strategies used during health behaviour change talk		
1. Generalised HBCT	Not tailored to specific patients' concerns or conditions. HBCT is framed as relevant for 'patients in general'.	Avoids potential for resistance but does not implicate patients to engage in future action.
a. Hypothetical Situations	A hypothetical situation is presented and recommendations given for a health behaviour to use in that hypothetical circumstance	Limited risk of confrontation. May be heard as personally irrelevant and rejected.
b. Giving information instead of advice	HBC advice is given without eliciting a perceived problem from a patient. It can be heard as 'information, for people in general'.	Minimal potential for resistance. Acceptance or minimal acknowledgement may be displayed.
2. Personalised HBCT	HBCT was tailored to individual patient, and often involved patients in decision making and elicited their views	Facilitates patient engagement. Can be perceived as intrusive. Potential to implicate patient action.
a. Question/ Answer Sequence	HBCT occurs after seeking a patient's opinion through a series of questions and answers so it can be tailored to a patient. Clinician led-talk.	Displays of uptake. May appear intrusive.

b. Collaborative HBCT	Inviting and accommodating a patient's perspective and presenting decisions as the patient's choice	Displays of uptake
c. Goal setting and assessment	HBC goals are set and reviewed	Potential for resistance if biomedical outcomes, rather than changed behaviours, are prioritised.
d. Positive and negative positioning	A patient is positioned positively or negatively with respect to their HBC efforts.	Negative positioning is likely to result in resistance displays.
Conversational strategies used for managing resistance to behaviour change talk		
1. **Pursuing health behaviour change talk**	Continuing with HBCT despite patient resistance displays.	Patient response depends on strategy used (below)
a. Worst case scenarios	Importance of HBCT is emphasised through evoking a worst-case scenario such as serious illness	Likely to generate further resistance
b. Changing recommendations	Downgrading recommendations from 'ideal' levels of HBC to ones that are more realistic for the patient	May not generate further resistance displays
c. Linking to a salient concern	If 'linking' has generated resistance a second link can be made to a concern that is salient for the patient	Facilitates further HBCT
d. Long pauses and repeat questions	Using long pauses and repeat questions to encourage a patient to engage in HBCT	Patients may be encouraged in engage in discussion on HBC
2. **Initiating a change in topic**	Clinicians avoid addressing displayed resistance, and change the topic	Unlikely to result in further resistance
Conversational strategies used for closing health behaviour change talk		
1. Non-specific Advice	HBCT is vague, non-personalised, and lacks a next action step	No overt resistance, but no evidence for effectiveness in facilitating behaviour change
2. Providing a next step	Offering a clear next action for patients, such as expert support of prescription	Limited potential for resistance, received well when patient has expressed willingness to engage in HBCT

3.7 Discussion

3.7.1 Statement of principal findings

In 10 papers from eight studies, I found that practitioners used a range of strategies to talk about HBCT. I grouped these into 14 categories, and three domains which indicated their positioning within a consultation. These domains are: initiating health behaviour change; carrying out HBCT; and closing HBCT.

HBCT was shown to be initiated through 'direct questions'; 'linking to a medically relevant concern'; 'non-personalised initiation'; 'embedding within closings'; and 'capitalising on patient-initiated discussions'. There was strong evidence that patient-initiated talk was successful in terms of patient receptivity to HBCT, while clinician linking of health behaviours with health conditions was shown to be a variable strategy which could generate resistance displays from patients. Two methods were identified for delivering HBCT, once initiated. These were 'generalised' and 'personalised' HBCT, and there were a number of ways to implement each of these. 'Generalised HBCT' was not overtly presented as personally relevant for patients. Strong evidence indicated that that presenting 'information, for people in general', rather than 'advice for you' avoids potential problems, but does not implicate patients to engage in future action. 'Personalised HBCT' was tailored for specific patients. It was reported to be well received in general. However, there was some limited evidence that there needed to be a shared understanding of the relevance of HBC before it was personalised for particular patient. Personalising too early was shown to generate resistance displays, whilst limited evidence showed that positive positioning was consistently well received. I identified two strategies for managing resistance displays; either 'pursuing HBCT', or 'dropping the topic'. HBCT could be pursued through linking to a salient concern, or varying recommendation, and these strategies were likely to minimise patient resistance displays. Two conversational practices were identified for closing HBCT. These were 'talking about a next step' and 'non-specific' HBCT. Although only one study analysed 'talking about a next step' during the end of HBCT, the evidence was good quality and responses analysed from patients indicated this may be successful in facilitating patient action on health behaviours. 'Non-specific'

advice was reported to expedite closings, but was vague, and unlikely to motivate behaviour change.

3.7.2 Strengths and Limitations:

1.1.1.1.1 Strengths and limitations of the review methods

A key strength of this review is that it makes explicit the conversational practices used during HBCT, and highlights those which address clinicians' concerns about delivering HBCT. This review draws on data from the field of social sciences and foregrounds its applicability for clinical practice and training.

Due to the potential that different languages involve distinctive interactional practices when talking about health behaviours, included data were limited to English language only. However, following Parry et al (9), records were kept of non-English language studies of relevance. These additional studies were written in English and analysed translated data. They analysed many of the features of communication already identified by this review. Personalised and non-personalised advice giving (26); orientations to morality, blame and guilt (26), hypothetical talk (26, 27); shared understanding of a problem (27); collaborative talk (26); positively framing HBCT (28); and direct questions(27) were all observed in this literature. Whilst some results were similar, the information in these studies supported our decision to exclude based on language, as Kettunen et al state that whilst some phenomena may apply across linguistic groups, others may not be cross-linguistically applicable (28), and it was not the aim of this review to explore the cross-linguistic similarities and differences in HBCT.

In this review I have aggregated research from across health care contexts, and across health behaviours, allowing conclusions to be drawn that are widely applicable. It is possible that certain conversational practices may be more or less appropriate for different health behaviours, or healthcare settings, but due to a dearth of current literature these could not be identified in this review.

1.1.1.1.2 Strengths and limitations of the individual studies

Clinicians have reported particular difficulty in initiating health behaviour change talk, and this review identifies a series of strategies which can be used. Most studies in this review focussed on clinicians' talk. This was a strength, as it made available a series of conversational practices with practical implications for practice. However, less focus was given to patient responses. Evidence was therefore limited regarding how patients responded to each conversational practice.

A limitation of this review was a lack of patient outcome data in the included studies. Patient responses were used as a proxy measure for the effectiveness of certain conversational strategies, so their effect in changing health behaviours is not known. Evidence shows that patient responses can indicate receptivity to advice (29), and chapter five of this thesis describes a detailed exploration of the relationship between patient response to HBCT and patient action regarding their health behaviours.

Communication is not only verbal and includes complementary or stand-alone embodied action (30, 31). However, only one of the included studies utilised video data, and analysed embodied action (gaze) in this context. As a result, I was unable to review the role of embodied action in these discussions, or draw out practice recommendations.

A limitation is that the data available do not comprise a comprehensive overview of all interactional practices available to clinicians when delivering HBCT. There are significant knowledge gaps about how to carry out these conversations.

Some older studies which were included in this review explored clinical circumstances which may now have changed. Pilnick and Coleman's study of smoking cessation occurred before nicotine replacement therapies were available on prescription, and before UK smoking cessation clinics were created. Silverman's work explored HIV/AIDS clinics in the early 1990s. However, whilst clinical circumstances may now differ, knowledge about how to carry out effective discussions about safer sex and smoking cessation are still strongly pertinent to

current clinical practice. Additionally, there is good evidence in the existing literature that communication practices are relatively consistent across time. This is also evidenced in this review as communication practices documented in older studies (such as step-wise entry to advice giving) were also identified in those conducted more recently.

3.7.3 How this fits with conversation analytic literature

Existing work has shown that the way clinical conversations are delivered, rather than what is being discussed, affects how they are received (23, 32, 33). This review demonstrates which conversational practices are likely to be well received in the context of health behaviour discussions. The wider conversation analytic literature recognises the complexity of these interactions (34), and orients to their delicacy (29). In line with our findings, stepwise moves towards personalisation (35), establishing a shared understanding of the health behaviours as problematic (29)and positively positioning patients (36), were identified as effective in this literature. The data presented in this review adds to this work by additionally outlining the benefits of a non-personalised approach and the context in which it can be best used.

Two studies of HBCT (37, 38), excluded from this review due to original language of data, and research methods, oriented to the particularly sensitive nature of discussions about alcohol use, when compared to smoking. Data in this review were sparse, particularly on conversations about alcohol consumption. However, from the evidence available, we did not identify any differences in patients' responses according to type of health behaviour discussed.

Current literature observes that advice is rarely explicitly rejected in institutional settings (29, 35, 39). Conversely, this review's identification of resistance displays in relation to smoking cessation advice highlights a practice 'rarely seen in other medical consultations'(16). The potentially face-threatening nature of discussion of health behaviours, the fact that this advice is unsolicited (40) and the unusual placement of clinical talk within the patient's epistemic domain could contribute to the displays of resistance observed in the studies presented here. This review did

identify that resistance displays can be avoided by capitalising on patient initiated HBCT, as advice is expected to be well received.

3.7.4 Implications in the context of relevant guidelines and literature

Existing literature shows clinicians have identified health behaviour change talk (HBCT) as difficult to initiate. This is because they say these discussions are delicate (41), and they are concerned about causing offence (42, 43), one clinician has stated "*It's just not something I enjoy doing because people do get very offended and feel very judged*"(42). In this review I have identified several strategies clinicians used to initiate these conversations, and provided evidence on patient responses. Clinical guidelines in the UK offer support in initiating HBCT, explicitly encouraging doctors to link a patient's health behaviour with an associated condition (44-47). Studies of clinicians' views of HBCT show that this strategy is reported to be used frequently in practice (48). In the context of weight loss, for example, clinicians state they believe this is a 'safe' way to raise the topic. "*We are on safe ground I suppose with medical implications."* (48). However, this review has shown this is potentially a risky strategy to initiate HBC with latent potential for resistance. Therefore, it may be best avoided or used cautiously. Conversely, I have shown here that initiating HBCT opportunistically at the end of a consultation, independent of health concerns, could mitigate the delicacy of discussions, and had minimal potential for resistance. Information on specific responses from patients during these discussions was limited, and there was no evidence regarding patient action on their behaviours. Another strategy likely to be successful is to capitalise on patient initiated HBCT. Clinicians report being more comfortable discussing HBC when the patient initiates the topic (1) and, in line with these reports, I found strong evidence that patients are likely to be more receptive when they have initiated these discussions. Therefore, patient initiation provides good opportunities to engage in HBCT.

Guidelines largely offer advice for HBCT that this review suggests would be would be well-received. Guidelines recommend goal setting (47, 49); facilitating referral to specialist services (44, 45, 47); arranging review appointments within a month (44,

46); tailoring advice to an individual (47, 50) and associating health behaviours with current or potential health conditions (44, 45, 47, 49). However, guidelines provide few details of how to implement these. The studies reviewed here showed that clinicians were using these strategies to varying degrees, but there was great variation in how they were delivered. Having reviewed this variation in delivery I was able to identify ways that recommendations were implemented that seemed more effective, and make recommendations on ways to implement suggested HBC strategies. I have shown that HBC advice could be delivered as personalised for a specific patient, which could generate resistance displays, or uptake depending on how this was operationalised. Alternatively, it could be framed in terms of advice for patients in general, which was unlikely to receive uptake, showing drawbacks of both approaches. A potential solution is to invite and accommodate the patient's perspective, collaborate with patients, and present decisions as the patient's choice. However, this approach could be difficult if patients are unwilling to engage in HBCT, and was shown to take more time than a non-personalised approach. More research is needed on how to deliver HBCT in ways which can motivate patient uptake of HBCT, but avoid generating resistance.

Guidelines advise clinicians to set goals (47, 49), and arrange appointments to review these goals at one month following a HBC discussion (44, 46). This review has shown that during these review appointments it is important to positively reinforce a patient's efforts when reviewing their actions to change behaviours. Learning from 'failure' by discussing it is likely to be a key aspect of effective behaviour change support. However, I found that patients were held accountable for failure to meet clinical outcomes (such as weight loss), rather than whether or not they had succeeded in changing their behaviours. This resulted in patient resistance displays and may have undermined motivation to change. An alternative would be for clinicians to help a person see failure as learning. I saw no examples, but literature indicates this might be effective (51). Fear of causing offence when carrying out HBCT is a key concern reported by clinicians in existing studies (1, 41, 42). Although guidelines mention the delicacy of these discussions they provide little support on how to deal with resistance if it does arise. Most studies in this review also oriented to the delicacy of HBCT and its potential for generating resistance displays from patients, but additionally offered ways to manage

resistance. Evidence in this review showed that evoking a 'worst case scenario' was not a helpful way to encourage further discussion (16), but that there were ways to pursue HBCT, such as using long pauses and repeat questions that could alleviate initial resistance.

There is a paucity of literature on closing HBCT; however, the results presented here align with existing literature, which indicate action planning is a successful way to motivate HBC (52). Clinical guidelines often recommend referring patients to programmes that support behaviour change and give practical advice on how to change (44, 45, 47). Clinicians report that should they give advice they feel unequipped to do so effectively, and faith in referral differs. Whilst GPs report varying confidence in smoking cessation programmes (53, 54), they report consistently less faith in the effectiveness of programmes for weight management, one saying "*there's lots of information on how to help the patient but are they successful? I'd have to say no"(55)*. Results from this review indicate guideline recommendations that provision of an affirmative next action step, rather than general, non-specific advice, is potentially more likely to encourage behaviour change than non-specific advice, indicating clinicians should be more confident in delivering this strategy.

In general, these results complement current guidelines providing further detail on how they can be successfully implemented in practice. A key exception is 'linking' health behaviours and health, which is currently a recommended strategy for clinicians to use, but one for which we have identified sparse evidence of effectiveness, and some evidence that it may be counterproductive.

3.7.5 Unanswered questions and future research

Recent studies have explored associations between clinician communication and patient action in other contexts (56), and there is great potential to explore relationships between communication practice and patient health behaviour change. The ability to demonstrate links between in-consultation communication and patient next-action in this context could have implications for health care policy and

training. The subsequent chapters of this thesis will explore the relationship between clinical communication, and patient action behaviours. They will also explore how results can be translated into training resources.

The communication practices identified as not likely to generate resistance and to receive indication of in-consultation uptake (and therefore potentially be useful for motivating health behaviour change) were reported as taking a longer time to deliver successfully. These may not fit within the time constraints of an ideal consultation. More research is needed to explore communication practices which are unlikely to generate resistance; likely to be well received, and which can fit within a short consultation time. Chapters 4, 5, and 6 of this thesis explore how this can be achieved in the context of obesity referral discussions.

Clinicians report that they do not feel equipped to address resistance displays from patients if they arise during HCBT (41, 42, 57). Existing studies have specifically explored how resistance can be handled in other settings (58), however the studies presented in this review only presented two methods for dealing with resistance and did not pay detailed attention to the apparent success of each one.

Clinicians have expressed concerns that discussing health behaviours may adversely affect their relationship with their patients (1, 42). No studies in this review explored the clinician/patient relationship before or after HBCT, and further research is needed to understand the implications of HBCT for professional/patient relationships.

All studies reviewed were undertaken within a primary care setting, (although it was not a criteria of my review); explored English-language data; and encompassed all types of HBC. Further research could explore similarities and differences in HBCT according to setting, linguistic group, and type of health behaviour discussed.

3.8 Conclusions

Clinical guidelines encourage health care professionals to engage in health behaviour change talk with their patients (44, 46, 49, 59). However, the difficulties in engaging in these often-sensitive discussions are well documented (41, 60, 61). This review has shown that there are different ways that these conversations can be initiated and carried out, which can mitigate their sensitivity, such as delivering HBCT opportunistically at the end of a consultation, or in a general, non-personal way. We found evidence that is mostly consistent with current guidelines, providing further detail on how they can be successfully implemented in practice. However, one practice recommended by clinical guidelines; associating a patient's health concerns and their health behaviours, generally prompts patients to resist HBC. On the other hand, building conversations collaboratively through question-answer sequences may facilitate patient receptivity to changing their health behaviours. Launching unsolicited HBCT could be well received, and clinicians used various conversational practices to do so, including a step-wise move into advice giving. Clinicians can adapt themselves to the delicacy of giving advice that may have not been asked for by depersonalising it and talking 'in theory' or about people in general. This practice seems unlikely to be effective because patients often do not respond to such talk and the clinician then loses the chance to continue and promote action planning, which is an effective technique (52). Future work might build on the categorisation of HBCT I have developed and examine associations between behaviour change talk, and patient action on their health behaviours. Meanwhile the evidence presented here should reassure clinicians that there are several ways of starting and pursuing HBCT that patients respond to well.

3.9 Statement of contributors

I led this review, designed the search strategy; screened all studies; extracted data from all included studies; conducted quality assessment; led aggregative thematic synthesis and ordering of top-level themes; and was the author of this chapter. To ensure

robustness and reliability of results, other reviewers were involved through the process. Below I provide a statement of contribution of each reviewer:

Paul Aveyard (PA) is a professor of health behaviours. He screened studies, and was consulted as a third party when there were disagreements on inclusion or exclusion of potentially relevant studies.

Amanda Hall (AH) is an assistant professor of primary care, an experienced systematic reviewer. She screened studies, extracted data from all included studies, and conducted quality assessment.

Nia Roberts (NR) is an information specialist who advised on the search strategy and identified areas of relevant literature.

Ayeshah Syed (AS) is a researcher in conversation and discourse analysis. She screened studies.

Sue Ziebland (SZ) is a professor of medical sociology. She provided input on final grouping of descriptive themes. SZ also was consulted as a third party when there were disagreements on inclusion or exclusion of potentially relevant studies

3.10 Personal reflections on chapter 3

Systematically reviewing studies like these is uncommon, and each stage necessitated careful critical review of the existing guide and making decisions about when to follow and when to divert from the methods outlined by Parry and Land (10). I have reflected on the key stages of the review process, and considered ways which could facilitate this process:

3.10.1 Searching

Data using CA and DA are most commonly published in social science, rather than medical science journals. Common MESH terms and keywords which may enable identification of medical science papers were not used to categorise those from

social science. Although social science databases were searched, many titles included descriptions of conversational practices, rather than explicitly stating that health behaviours (or similar) were explored within the paper. Identification of relevant papers required much consultation with an information specialist, scoping searches to test the inclusion criteria, and a decision to use broader search terms to identify relevant studies. Although experts in the field were consulted for suggestion of potentially eligible studies, only three were mentioned (16, 23, 24), and these were also identified through systematic searching. For further reviews, systematic searching of databases may not be practical. Asking experts in the field, exploring the publications of key authors, and bibliography tracking, may be ways to identify papers, without screening great numbers of irrelevant titles.

3.10.2 Data Extraction

Data extraction could be improved by only extracting key study characteristics (size of corpus, country of origin) and by coding findings in situ. This would mean that findings can be coded, line-by-line, whilst situated within their original context. Although initially I extracted all study characteristics and results, I later chose to code original papers using qualitative data management software, rather than coding extracted data. This preserved closeness to the original data and I would recommend this method for future reviews. I chose to diverge from Parry's protocol when extracting data. This suggests to only extract and present a conversational practice when it is present in more than one study. However, as the presence of a conversational practice (even if analysed by only one study) indicates its existence within a given setting, I decided not to exclude those only presented once. This added richness to my review and I would recommend this for further reviews.

3.10.3 Data synthesis

I carefully considered which synthesis approach to use but strongly agreed with Parry & Land's recommendation to aggregate data, rather than to interpret it further. The initial steps of thematic analysis, an approach that could code practices whilst keeping them grounded within original data, worked well to code these data.

Aggregating findings was the most difficult step in this review, as the process of systematically reviewing necessitated reducing richly described intricate practices of communication to a 'gloss' of the original studies. I attempted to preserve key elements of each study, however I felt that the finer details and context of these studies were lost in the aggregation process. Nevertheless, the completed data synthesis addressed the aims of this review successfully as the systematic review methods drew out clinical implications at each stage of the process, which would not have been identified with a traditional narrative review.

3.10.4 Conclusions

Whilst more work could be done to identify different ways of systematic searching, and this review necessitated trying and testing new approaches, I feel that despite the drawbacks presented here systematically reviewing CA and DA work can contribute significantly to healthcare practice. This work is largely published in social science journals and this, combined with the focus of this work on interactional practices, may not make studies using CA and DA accessible for clinicians and policy makers. However, we have seen this work has great potential to uncover common conversational practices happening within the 'black box' of the consultation room. Systematically reviewing this work brings it into the healthcare domain and, although some detail is lost, the clinically relevant details are emphasised, and clear implications for practice can be highlighted.

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Chapter 4

The referral sequence in the BWeL trial: facilitating smooth sequences and patient action

4.1 Conferences

Results from this chapter have been presented at the following conference:

Albury C., Webb, H., Stokoe, E., Ziebland, S., and Aveyard, P. *Telling the News in the BWeL trial: Presenting referral to commercial weight management services as good news or bad news and implications for patient action*. UK Society for Behavioural Medicine 14th Annual Scientific Meeting, Birmingham, December 2018 (*Symposium - Conversation analysis: a valuable method for behaviour change research*).

4.2 Introduction

Primary care clinicians have expressed concern about discussing weight management with patients. In chapter one I outlined that clinicians often report feelings that discussing weight is ineffective (1), and can lead to long and difficult conversations (2-4). Conversely, patients state that they welcome appropriately delivered conversations (5, 6), and primary care is their preferred location (5, 7). Patients have stated consistently that 'words matter' (8) when clinicians talk about their weight. They report that clinicians' word choice and tone of voice have potential to motivate or demotivate action (8). In chapter one I outlined that, although patients emphasise the importance of the words clinicians use during these discussions, guidelines are vague and unspecific. This is because there is a dearth of evidence regarding how these conversations are best carried out. Only a few studies have explored recorded conversations about weight management in primary care. These studies foreground the delicacy of these discussions (9-11), and show the potential to generate resistance displays from patients (10, 12). Although they show that it is possible for health behaviour change conversations to occur in primary care

(13, 14), they rarely explicate specific practices that clinicians could employ. Therefore, clinicians have little support in how to discuss weight management.

In chapter three I systematically reviewed the literature on health behaviour change talk. I demonstrated that the evidence on weight management discussions is sparse, but there was evidence that opportunistic health behaviour change talk at the end of a consultation could be well received. In this chapter I focus on such opportunistic discussions at the end of typical primary care consultations which were audio recorded as part of the Brief interventions for Weight Loss (BWeL) trial. I take a strongly applied focus to identify how conversations can be brief, smooth, positively received, and likely to result in patient action.

This chapter is in three parts. In the first part, sections 4.4 and 4.4.1, I explicate the referral sequences in the BWeL trial. I first explore how referrals are delivered and then, in section 4.4.2, I examine how referral sequences are best framed. I argue that rather than 'advice' or 'information' giving, these sequences are news delivery sequences. I situate section 1.5 within the context of existing literature on news delivery sequences. I then map the actions performed during BWeL referral sequences, and place these actions within their sequential context. Following this I identify and describe the actions GPs and patients perform as the sequence unfolds. This work shows for the first time how brief opportunistic interventions for weight loss are delivered in practice, and provides an overview of the referral sequences, specific aspects of which I analyse in detail in subsequent chapters.

In the second part, I focus attention on two specific parts of the referral sequence which provided opportunity to smooth the referral sequence: the news announcement (section 4.5.1), and the referral question (section 4.5.2). In these sections I first show that delivering particular information, for example, about the location and cost of the referral, offered opportunity to avoid apparent misunderstandings, or unnecessary discussion. I next show that the way the referral question is designed has clear implications for the type of responses patients produce in their next turn. I demonstrate that the presence or absences of certain words, in a specific sequential position, have important implications for the length and clarity of referrals to commercial weight management services (CWMS).

In the third part, I focus on how GPs assert a valence towards the news they are delivering. I demonstrate in section 4.6 that GPs used the pre-announcement to display a valence towards the forthcoming news. I explore GPs' use of word choice and prosody to assert a valence. I show that, whilst the same actions were broadly done across delivery types, the ways these actions were designed had clear implications for patient in-consultation uptake (or not) of their referral. Previous work has used patient response as a measure for how well received talk was displayed to be, and hypothesised which types of talk were likely to motivate patient action (15, 16). In this chapter I address knowledge gaps concerning in-consultation talk and post-consultation action in the context of brief opportunistic inventions for weight loss. I combine results from conversation analysis with outcome data regarding patient reported satisfaction, and subsequent CWMS attendance. This highlights the longer-term implications of the way GPs valence news delivery. I show for the first-time relationships between news delivery format during the preannouncement phase of the sequence, and patient action after the consultation.

I conclude this chapter in section 4.7.2 by discussing the clinical implications for clinicians delivering brief interventions for weight loss. I discuss the translation of the results from these mixed-methods analyses into trainable elements which will contribute to the development of an information resource for clinicians to support delivery of brief opportunistic interventions for weight loss.

4.3 Areas of interest

To summarise, I address the following areas in this chapter

- How did GPs deliver the referral sequence?
- What components of the referral sequence contributed to a smooth discussion?
- How did GPs deliver a referral sequence in ways which were displayed as well received by patients in the consultation, and were associated with patient reported satisfaction scores post-consultation, and attendance at their commercial weight management referral?

4.4 The referral sequence in the BWeL trial

In this section I explore the referral sequence used by GPs in the BWeL trial. I will first illustrate how GPs were trained to deliver these discussions, then explore how they were actually delivered in practice. I conclude this section of this chapter by presenting a candidate referral sequence which illustrates the actions done by GPs in the BWeL trial, within their sequential context.

GPs received training in how to opportunistically offer a free referral to a CWMS at the end of a typical consultation (Chapter 2). Figure 4.1 illustrates more broadly the key components of this training.

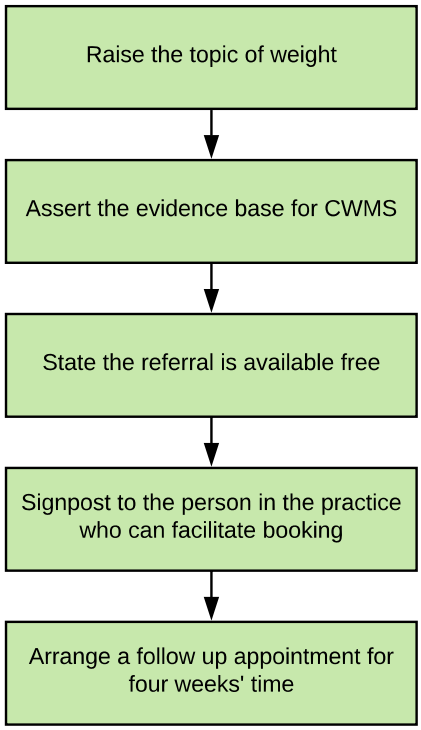


Figure 4.1 BWeL Training Components

This training was delivered through watching videos of a consultation, and commentary to emphasise the key features. GPs did not receive a script, nor top-up training throughout the course of the trial. Although the referral sequence GPs were trained to follow was broadly implemented during brief intervention discussions,

there was some variation in the way these sequences were delivered. In the next two excerpts I explore the typical referral sequence actually used in the BWeL trial. These excerpts have been chosen as they clearly illustrate the overall sequence, and exemplify the wider patterns in this corpus.

Excerpt 4.1 Typical BWeL Referral Sequence - 31-01-39

```
1  Doc:    There is some evidence which shows that using
2          one of these >sort of< commercial weight loss
3          programmes, Something like Weight Watchers,=
4          =Slimming World,= That kind [of thing.
5  Pat:                                [Mmm.
6          (.)
7  Doc:    Will actually help people t- t- to lo:se weight,
8          (.)
9  Doc:    Um and this project through the health service
10         is allowing people to sign up for one of those
11         >sort of< uh- (.) u:m tch. programmes. .hh= Free
12         of charge for an introductory per[iod.
13 Pat:                                     [↑Oh ri:ght,
14 Doc:    >And we would definitely< encourage you to do
15         that.
16         (.)
17 Doc:    I- if you'd like to do that,=
18 Pat:    =Mm. Y[eah I wouldn't mind.
19 Doc:          [Yeah?= Ke-          Keen to do that.
20         (0.3)
21 Doc:    Um (.) so what we- we'll get you to do then
22         is (.) if you pop back and see: (.)the lady that
23         y- you saw ju- just n[ow,
24 Pat:                         [Yeah.
25 Doc:    She will give you all the information of the
26         local groups that you can join.= The vouchers and
27         stuff t- to go with that.
28         (.)
29         U:h (.)and then the other thing I'd encourage
30         >you to do< is to come and see me again, In a
31         month, So we can see if you have ↓actually
32         started to-[to lose weight.
33 Pat:               [Ah-ha.         Yeah. Okay.
```

The recording starts at line 1 where the GP asserts the evidence base for commercial weight management services, explicitly mentioning Weight Watchers and Slimming World as examples. In their turns from lines 1-7 the GP simultaneously acts to topicalise weight management by providing information on how people can best lose weight, foreground their relevance of CWMS for future talk by indicating their

relevance for some 'business to come' (17), and provide information necessary for the understanding of that future business. In performing these multiple actions the GPs turns from line 1-7 are hearable as a preannouncement, foregrounding, and preparing the patient for, business to come (17).

Throughout these turns the patient only responds once, at line 5, with an "Mmm." acknowledgment token. The GP then informs the patient that referral "for one of those" is available for free of charge, which receives an 'oh'-prefaced information receipt (18) from the patient. The GP then elaborates further on the information she has delivered, before delivering a turn that makes a response to the referral from the patient explicitly relevant "if you'd like to do that,". The patient responds with a minimal agreement "mm" followed by "Yeah I wouldn't mind". This is followed by a confirmation receipt from the GP (line 19) which upgrades the patient's "Yeah I wouldn't mind" to "Keen to do that." The GP then signposts the patient back to the "the lady that y- you saw just ju- now", and asks the patient to book another appointment in four weeks to review her weight loss. The patient acknowledges the GP's response and does a minimal agreement at line 33, "Yeah. Okay." concluding the referral sequence. I further illustrate the overall sequence below:

Excerpt 4.2 03-02-20

```
1  Doc:    Okay so (.) you've been given this ↓form. Today.
2          Okay?  .hh u:m  now (0.3) >one of the things
3          we< were looking at um is (0.9) w:eight
4          >problems<.= Mkay.
5          (0.6)
6  Doc:    And I think you'd (.) becoming under the: the
7          class of °being slightly overweight >at the
8          moment.= Okay?<°. I mean >we can try<
9          and help you.
10         (.)
11 Doc:    hhh u::m research is sho:wn (.) that th- the best
12         way to lose weight (1.0) u:h 0.5).hh is by
13         joining (.) a sort of (1.0) a weight management
14         course, Like Weight Watche:rs, °#O- or um (1.1)
15         tch .hhhh (.) e::r (0.7)Diet# World°, >And
16         those sort of things u::h-<.
17         (.)
18 Doc:    So (0.6) >Slimmer's World<. So (0.9) and toda:y
19         what we can do (.) if you're interested
20         .hhhh I could enrol you <for free> to one
21         of those sort of cou:r- those- those- (.) °those
```

```
22          (.) education programmes°.
23          (.)
24 Doc:     .hhh .tch an::d um see how you're getting
25          on in about a month's time.
26          (.)
27 Doc:     U::h (.) how do you feel about that?
28 Pat:     That <sou:nds>,
29          (.)
30 Doc:     You'd like to try it >perhaps<. Joining u:h
31          Weight Watche:rs or   u:h those sort of
32          people yeah?
33          (.)
34 Pat:     Yeah.
35 Doc:     Oka:y so when you hand this back into- to the
36          lady she'll be able to actually u:m help
37          enrol you, And u:h I'll see in a month's
38          time. Oka:y?
```

In this excerpt (Excerpt 4.2) the GP starts by foregrounding that oncoming talk is related to the trial by saying "Okay so (.) you've been given this ↓form". This refers to the form in a sealed brown envelope that the patient was given by the trial team, and that the GP will have opened as an indication to start recording. Following this 'trial talk' the GP topicalises weight "problems" explicitly. He then asserts the evidence base for commercial weight management services and provides specific examples from lines 11-18. As in the previous excerpt, this is hearable as a preannouncement as the GP has topicalised weight, and foregrounded commercial weight management services as a subject for future talk (17). In his subsequent turn at the end of line 18, the GP states that he is able to refer the patient to these services, and from lines 24-25 he mentions the one-month review appointment. Following this turn, the GP explicitly asks the patient about the referral "how do you feel about that?" making a response explicitly relevant (19). That patient starts a response "That <sou:nds>," then pauses; it is unclear if this is a gap in their ongoing turn, or if their turn has been abandoned. The GP takes a further turn at line 30 and upgrades their question from the previous "How do you feel" which is designed neither for an agreeing or disagreeing response from the patient, to a questioning turn strongly designed to elicit agreement. The preferred response to this turn is offered by the GP as a tag question "yeah?" and, after a gap, the patient produces this same response "Yeah." Following this, from lines 35-38, the GP signposts the patient to the researcher and mentions the one-month review appointment. He does a confirmation request "Oka:y" and then the recording ceases.

These two excerpts exemplify the referral sequence in the BWeL trial. There was usually a *preannouncement* which often received *minimal acknowledgment* from patients, followed by an *information delivery* turn where the referral was explained. Following information delivery there was then a second *patient response point*, and the option for an *elaboration turn* from the GP where they delivered further information about the referral. The GP would then do an *explicit referral question* which made a response from the patient relevant and, following this, the GP would close by signposting the patient to the researcher and mentioning the one-month review appointment. The actions of this referral sequence, summarised here, are illustrated in Figure 4.2.

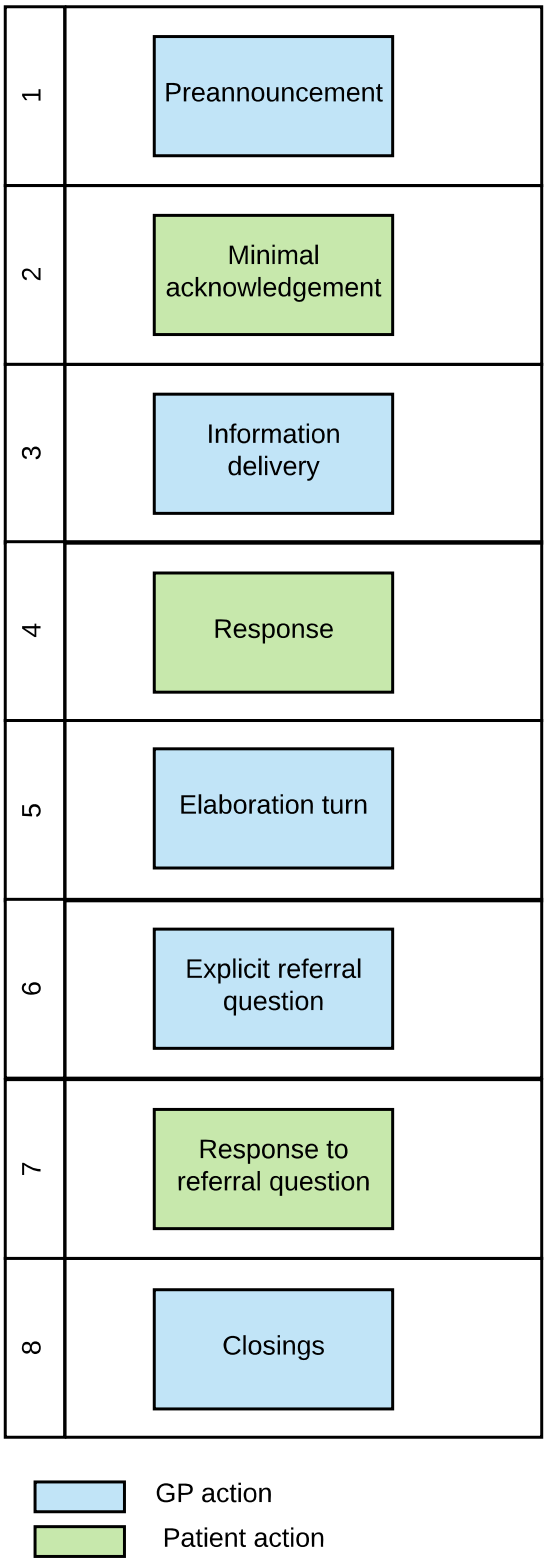


Figure 4.2 Candidate Referral Sequence

As I have shown in my description of the excerpts above, the actions comprising the sequence were the same across consultations, but the components used to achieve each of these actions differed. In Excerpt 4.1, for example, I showed that the GP's preannouncement consisted only of asserting the evidence base for CWMS, whilst in Excerpt 4.2 the preannouncement firstly consisted of establishing the patient is overweight, and then asserting the evidence base for CWMS. In some circumstances the preannouncement included a link between the patient's weight and their health (lines 1-7, Excerpt 4.3); explicit statement of the patient's BMI, or "height weight ratio" (line 10, Excerpt 4.4); or both (lines 3-6, Excerpt 4.5). I next present and explore a detailed action sequence of these brief interventions, to better capture and illustrate this within-sequence variation.

Excerpt 4.3 06-07-35

```
1  Doc:    .hhhh and I know you've had a you've had a-
2           you've had a few knee problems.
3          (0.4)
4  Doc:    Um (1.0) .tch   and we know that also your
5          immunity's not quite as good, (.) If  you're
6          (0.4)um >a bigger weight< than you should
7          be. The u:m (0.4) we also know that the best
8          way to lose weight is through an intervention,
```

Excerpt 4.4 09-02-15

```
1  Doc:    So >basically< you've just had your height and
2          weight measured?
3          (0.4)
4  Pat:    (h)Ye(h)s,
5          (0.5)
6  Doc:    And the-=
7  Pat:    = I'm shrinking.=
8  Doc:    = NO you're no:t.=
9  Pat:    =And expanding the (h)other wa(h)y hh hhh hhh
10 Doc:    Your height weight ratio is over thirty so
11         that's why you've been put into the study.
12 Pat:    Mm
13 Doc:    hh it's really to draw to your intention that
14         (0.7) once the height weight ratio goes over
15         thirty (.).hh it means that you clinically
16         obese.
```

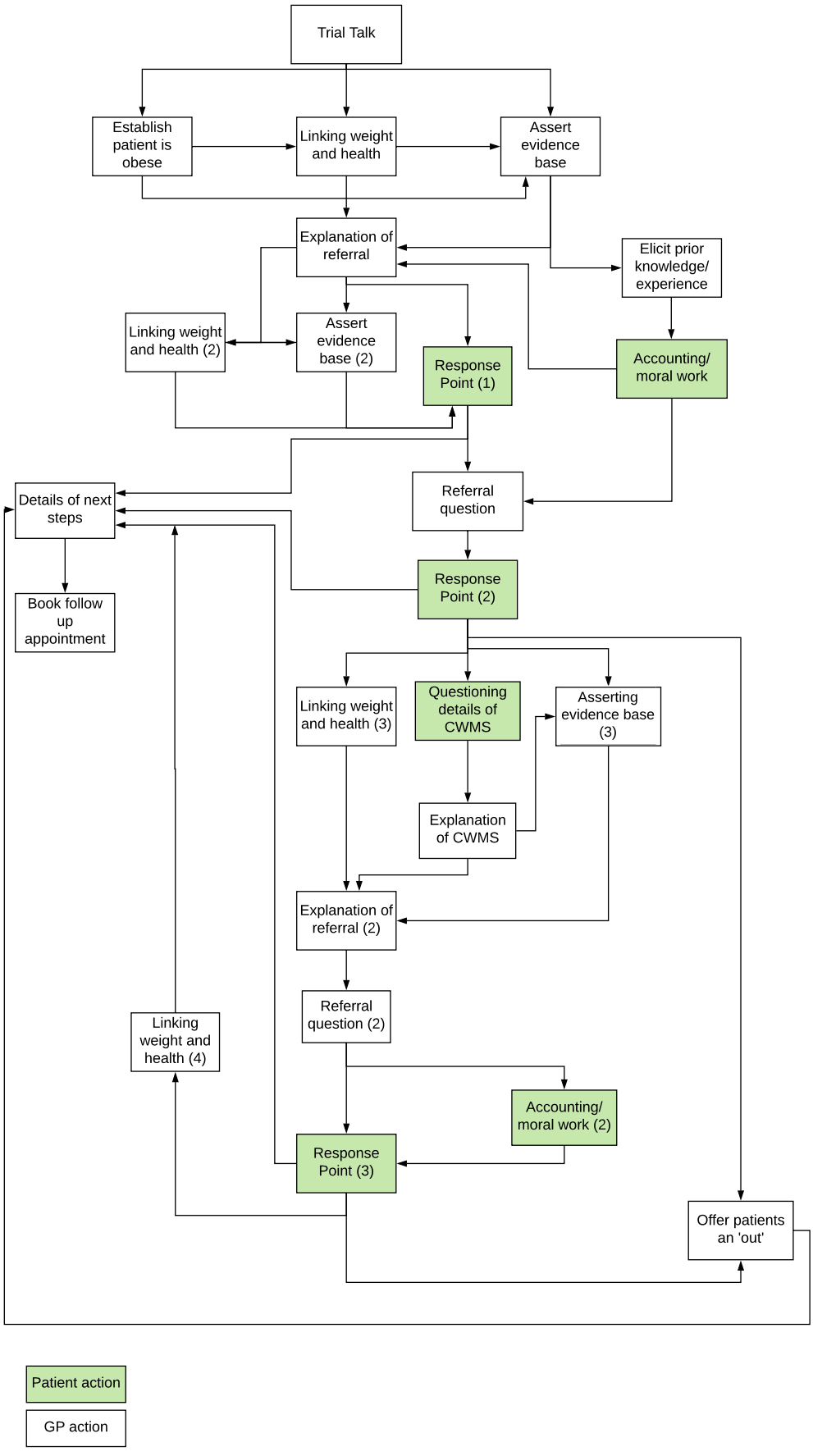
Excerpt 4.5 06-07-03

```
1  Doc:    You've (.) also had your weight done haven't you,=
2  Pat:    =Yes.
3  Doc:    And you know that your bee em ↓eye is-=
4  Pat:    =Quite [high.
5  Doc:           [>Is high yeah<,= And that affects (0.4) you
6          know your health generally.=
7  Pat:    =Yeah.
```

4.4.1 Detailed action sequence

Following identification of a candidate referral sequence, I conducted a detailed action sequence of the actions within the BWeL referral sequence through categorising actions and building a comprehensive map of the BWeL consultations processes (Figure 4.3). This map captures the variation across conversations in this corpus. I identified 13 discreet actions that were part of the wider referral sequence. I subsequently describe and exemplify each of these, to provide a comprehensive and concise overview:

Figure 4.3 Detailed BWeL Referral Sequence



1. Trial talk

Talk which explicitly mentions the BWeL trial, or the trial processes patients have moved through before their brief discussion with the GP. This could include specifically mentioning the trial (Excerpt 4.6), referring to materials given to the patient by the researchers (Excerpt 4.7) or reading a randomisation number which identified the patient recordings (Excerpt 4.8).

Excerpt 4.6 12-01-02

```
1  Doc:    So (.) yes (.) thanks for taking pa:rt in the-
2          (.) in the Oxford tria:l?
```

Excerpt 4.7 05-01-01

```
1  Doc:    Right (.)  missus Jolly u:m we've opened the
2          envelope and it's come up with the letters
3          ess you,
```

Excerpt 4.8 51-01-01

```
1  Doc:    Okay .hh so what the u:m (.) so I just read
2          this number? Five one dash (.) one nine nine
3          zero one. That's the randomisation number.
```

2. Assert evidence base

GPs stated the evidence that CWMS are effective ways to lose weight. They may explicitly refer to "evidence" or "science" (Excerpt 4.9), or state that CWMS are the best way to lose weight (Excerpt 4.10).

Excerpt 4.9 09-02-24

```
1  Doc:    The surprising information comes out that (.)
2          the most successful way for people to lose weight
3          is >actually through< °slimming clubs°.
4          (1.0)
5       →  It's now been scientifically proven.
6          (1.0)
7          That (.) for those people (.) that #go:: to
8          things like Slimming World (.) Weight Watchers
9          (.) they have a far greater percent of success
10         (1.0) in losing weight#.
```

Excerpt 4.10 05-02-12

```
1  Doc:→  The: (0.6) the best way (0.4) to lose weight
2         (0.4) and keep weight o:ff (0.6) is using 0.4) what
3         they call a commercial weight loss programme,
```

3. Establish the patient is obese

Talk which establishes the patient's weight is higher than recommended. This could be done through mentioning the patient's BMI (Excerpt 4.11); using more colloquial terms like, "height weight ratio"(Excerpt 4.12) or "high weight"; or saying the words "obese" (Excerpt 4.12) or "overweight".

Excerpt 4.11 06-07-35

```
1  Doc:   So (.) u:m (.) Petunia (.) you saw the research
2         (.) um (0.4) nurse today, And (.) she found that
3         your (0.6) be em eye which is a (0.6) function of
4         you:r (0.4) °height and your weight° (0.6) um is
5         forty eight point five,
```

Excerpt 4.12 09-02-15

```
1  Doc:   Your height weight ratio is over thirty:. °So::°
2         that's why you've been put into the study.
3  Pat:   Mm[hm.
4  Doc:      [.hh it's really to draw to your intention
5         that (0.7) once the height weight ratio goes over
6         thi:rty (.).hh it means that you clinically obe:se.
```

4. Explanation of referral

Following a preannouncement GPs would explain that a CWMS referral was available for patients. These turns could be short, only stating their availability, or longer turns which provided specific details about the number or location of sessions (Excerpt 4.13). Later in this chapter I explore the component parts of these explanations of referral in detail.

Excerpt 4.13 30-02-08

```
1  Doc:    And um .tch you've been randomly allocated to
2          the group where we can offer you (.) a referral
3          (.) to one of the commercial weight loss programmes
4          that run in this area.=
5  Pat:    =Okay.
6  Doc:    For free?
```

5. Link weight and health

At a number of points throughout the referral sequence some GPs would articulate associations between a patient's weight and their health (Excerpt 1.14 and Excerpt 1.15). These most commonly occurred during the preannouncement, or immediately following the referral question. In Chapter six I present an in-depth analysis of how weight and health were linked, and how patients responded to this GP-initiated action.

Excerpt 4.14 46-01-62

```
1  Doc:    So (0.8) as you- (.) >we were saying  < (0.4)
2          the problem with the- the weight being hi:gh
3          is the fact that (.) u:m the diabetes is not so
4          well controlled.= As you were saying.=.hh and-
5          and then you have more insulin, More tablets,
6          And more problems.
```

Excerpt 4.15 04-01-19

```
1  Doc:    We know a lot of um (0.4) health problems a:re
2          (.) connected with weight? And if you get
3          weight do:wn (.)- y- you know the (0.4) outlook
4          is often better (.) for [things like blood pressure.
5  Pat:                            [Oka:y.
6          (.)
7  Doc:    Blood pressure would get ea:sier to control if
8          you get your weight do:wn.
```

6. Response Point

I have shown in the excerpts presented so far that these conversations were GP led, with limited responses from patients. Analysis showed there were several consistent response points during the referral sequence. Patients could receipt information, ask questions, or decline or agree to referral (Excerpt 4.16 and Excerpt 4.17). In Chapter five I present a detailed analysis of patient responses in two of these response points.

Excerpt 4.16 23-02-05

```
1  Doc:    If you would be interested.
2  Pat:→   ↑Yeah. I would be foolish not to (do it)
3          really, Wouldn't it?
```

Excerpt 4.17 25-06-05

```
1  Doc:    Would you be <interested i:n> (0.6)
2          using one of the ↑slimming ↓clubs?
3  Pat:→   No.
```

7. Elicit prior knowledge or experience

After asserting the evidence base for CWMS some GPs specifically asked if a patient had "heard of" (Excerpt 4.18) or "attended" a CWMS before.

Excerpt 4.18 46-01-62

```
1  Doc:    .hh like e:r - we call it like Slimming
2      →   Slimming World?= Have you heard of these
3          [(0.2) commercial programmes?
4  Pat:    [Yeah,                          Yeah.
5  Doc:    Y- where you- you go once a week?
```

8. Accounting/moral work

During discussions about their weight, patients would sometimes enter into turns which accounted for why they were overweight, or had not lost weight (Excerpt 4.19). These turns often asserted a moral positioning as patients asserted their status as a 'good patient'. Morality in the BWeL trial is explored further in chapter six.

Excerpt 4.19 51-04-16

```
1  Pat:    hhh I could lose weight >because I've< done it
2          before.
3          (0.4)
4  Pat:    Where I lost two stone in a month.
5  Doc:    Mm=
6  Pat:    =And a:ll I did was count the calories.
7  Doc:    Yeah.
8          (.)
9  Pat:    Can't do that no:w, (0.4) because that would
10         give me hypo after hypo and I'd probably
11         do myself i:n.
```

9. Referral question

I demonstrated in my analysis of Excerpt 4.1 and Excerpt 4.2 that GPs ask a question which makes a response to referral relevant. This is illustrated in Excerpt 4.20. This may be formulated in a number of ways, for example, as a suggestion or an offer. Later in this chapter I explore how these referral questions are formulated, and their implications for patient response.

Excerpt 4.20 01-03-07

```
1  Doc:    Um (0.5) but at the expense of er- a commercial
2          group, But one that we can (.) fund (.)through
3          the en aich ess.
4  Doc: →  So (.) is that something that you'd >might
5          consider< doing,
```

10. Questioning details of CWMS

Following the GPs explanation of referral, or referral question, patients often questioned the details of the referral (Line 8, Excerpt 4.21), or requested further information (Line 7, Excerpt 4.22). Later in this chapter I explore how common patient questions highlight the absence of key information.

Excerpt 4.21 05-01-14

```
1  Doc:    Right, (.) mister Holmes (.) yo::u e::rm th-
2          we kno- >we now know< that the best way for you
3          to lose weight is to go to a commercial weight
4          management se:rvice. And I can refer you for
```

```
5           free (.) if you'd like.
6           (0.3)
7   Doc:    U:m would you (.) hh like me to do that?
8   Pat:→   Can you tell me a little bit about what
9           it <actually is>?
```

Excerpt 4.22 06-07-03

```
1   Doc:    .hh and the  ↑best way for you to lose weight
2           is actually through a: (.) a commercial (0.6)
3           weight loss service,
4           (0.4)
5   Doc:    Would you u:m >and I'd< like to refer you
6           for that today, Would that interest you?
7   Pat:→   .hhh (0.6) the: first thing is how much
8           does it cost.
```

11. Offer patients an 'out' or alternative

In consultations where the patient had not agreed to referral, or following resistance displays in response points, some GPs offered patients an alternative. This could be trying weight loss themselves, and reviewing with their GP in one month; offer to defer decision to another time (Excerpt 4.23); provision of a booklet; or no current action, followed by an offer to revisit the discussion in one month.

Excerpt 4.23 10-02-02

```
1   Doc:    Is that something you'd like to take up the offer
2           now (.) or think about it?
3   Pat:    I think I'll thi:nk about it.
```

12. Details of next steps

Whether or not patients agreed to take up their referral, GPs provided further details about what the patient should do after they leave the GP's office, by signposting to the researcher or research nurse who could book them onto the CWMS, and/or book their follow up appointment (Excerpt 4.24).

Excerpt 4.24 10-03-05

```
1   Doc:    A::nd (.) so if you want to go and talk to
```

```
2          the:m u:m  go back and talk to >the the<
3          lady you've just see:n.
4  Pat:    °All right.°
5  Doc:    She can organise with you to get- (.)to
6          actually go on one of these things.
```

13. Book follow up appointment

Most GPs explicitly mentioned the one-month review appointment (Excerpt 4.25), frequently as their closing turn (Excerpt 4.26).

Excerpt 4.25 05-02-07

```
1  Doc:    We'll (.) we can see each other again
2          can [we?
3  Pat:        [Yes.
4  Doc:    Ab[out this.
5  Pat:      [I don't mind, Yeah.
6  Doc:    <In a month?>
7  Pat:    Ri:ght. Yes
```

Excerpt 4.26 05-02-15

```
1  Doc:    So I'll see you again in another m- month,
2          And we'll check your weight then.
3  Pat:    Hm mm
```

So far in this chapter, I have described and explicated the referral sequence used by GPs. I have described the referral sequence (Figure 4.2), and conducted detailed action sequencing to understand the variation in these discussions, and build a map of the referral processes (Figure 4.3). This work demonstrates that throughout the 246 brief intervention discussions there were 13 broad actions done by GPs. As illustrated in Figure 4.2 there was variation in the order in which GPs delivered these actions. However, all occurred at specific placements within the candidate referral sequence. Table 4.1 shows the actions undertaken by GPs and patients throughout this candidate sequence within their sequential placement. Trial talk, for example, occurred only during pre-announcements and closings; whilst linking weight and health could occur in any of the GPs turns, apart from when asking the explicit referral question.

Developing this understanding of how referral sequences were constructed and the actions that occurred is important. This work allows me to now examine which actions or sequential placements facilitated smooth brief discussions and produced displays of agreement, in line with objectives 1 and 2 of this thesis.

Table 4.1 Sequential positioning of actions in the BWeL trial

Sequential position	Actions done in this position	Speaker
Preannouncement	Trial talk Assert evidence base Establish patient is obese Link weight and health Elicit prior knowledge or experience	GP
Response	Minimal response	Patient
Information delivery	Assert evidence base Explanation of referral Link weight and health Elicit prior knowledge or experience	GP
Response	Accounting/moral work Questioning details of CWMS Minimal response	Patient
Elaboration Turn	Assert evidence base Establish patient is obese Link weight and health Elicit prior knowledge or experience	GP
Explicit Referral Question	Referral question Explanation of referral Offer patients an 'out'	GP
Response to referral question	Accounting/moral work Questioning details of CWMS Minimal response	Patient
Closings	Trial talk Link weight and health Offer patients an 'out' Referral question Details of next steps Book follow up appointment	GP

4.4.2 Framing the referral sequence

The intervention discussions which comprise the BWeL corpus take place at the end of the consultation. My analyses so far have shown that these sequences stand alone. They have their own openings, referral business, and closings. The topics discussed stand apart from the main business of the consultation. The sequences in the BWeL trial differ significantly from the primary care consultation model detailed by Byrne and Long (20). Key differential features are the lack of a problem presentation; examination; or diagnosis. Similarly, no other consultation structures of which I am aware accommodate the brief intervention outlined here (20-23). These discussions differ because:

1. Patients have already been weighed by researchers before seeing their GP and may have been told their BMI during this process.
2. Patients are not seeking clinical advice for weight management.
3. Patients do not expect to receive a weight management referral.

If these sequences are not similar to primary care models, how can they best be characterised? First appearances indicate they have much in common with information giving. The question of a free referral was strongly advice implicative, but not packaged wholly as advice. This led to initial conceptualisation of clinicians packaging 'advice as information'(15, 16) and further conclusions that advice and information are not consistently neatly packaged or differentiated in this corpus, nor in other clinical talk (24). However, careful and close analysis of how these sequences were constructed revealed some further features, offering a different way to frame these referrals. First, the details of the possible referral are delivered following a preannouncement, rather than an information request, so it is *unsolicited*. Second the GP announces the possibility to attend a CWMS - the information given is *unusual*. Third, whilst the patient was told they would talk about their weight with GP they were not informed they may receive an offer of referral, so this information was *unexpected*. Finally, the GP provides information the patient almost certainly did not know – CWMS are available for free; this information is *unknown*. The characteristics of this apparent 'informing' are that it is unsolicited, unusual, unexpected, and previously unknown. We can therefore potentially conceive of this

information as ‘news’ (25). Indeed, the pattern of referral sequence that I have observed closely follows Maynard’s news delivery sequence (NDS) (25) which leads into a final sequential action – the referral question.

Maynard suggests that the properties I describe above are strongly news implicative, but tellings also become news through the occasioning practices which foreshadow them - that is preannouncements or news inquiries (26). I have shown in my initial candidate referral sequence that these deliveries are indeed occasioned by a preannouncement, further evidencing these sequences as news deliveries. However, Maynard also outlines how the news delivery sequence is locally co-constructed and how a second speaker can avoid or defer acknowledging a telling as the delivery of ‘news’ (26). As I will outline later in this chapter, some patients explicitly oriented to the telling as news delivery, whilst others resisted or deferred doing so. From one perspective this delivery can be seen as ‘news’ whether or not the patient acknowledges it as such, as the sequential, lexical, and non-lexical features of news are present, in addition to the characteristics of the telling itself as unsolicited; unusual; unexpected; and previously unknown. However, can ‘news’ be news if the patient does not acknowledge it as such in their subsequent turns, and resists its status as news*worthy*?

Maynard addresses this quandary in defining news in his work in clinical settings, where he highlights the ‘disjunctiveness’ that can be present in news deliveries (26). He shows, for example, one case where news is delivered by a clinician and repeatedly valenced as *good news* despite silence from a patient (interpreted by Maynard as resistance). The GP proceeds with elaboration of news, which is minimally acknowledged by the patient. Maynard states that, in his clinical data in particular, episodes commonly occur “in which participants are contentious about the newsworthiness of some report and/or whether it is good or bad news” p.119 (26). These sequences are nevertheless classed by Maynard as ‘news delivery sequences’, as news is *set out* to be delivered, although its newsworthiness may be resisted. Latent within these news delivery sequences then, is potential for disjunctivity as interlocutors work collaboratively to achieve “a mutual sense of some event-in-the-world” p.119 (26) as newsworthy. Similarly, GPs in the BWeL trial retrieve information as worthy for announcement and embark on a news delivery, even if this

is resisted by patients. Whist I am aware of the co-constructed nature of 'news' I will follow Maynard here, in my subsequent exploration of 'news' (even though its newsworthiness may be resisted). The sequential, lexical, and non-lexical features of these conversations display that, although they are not always receipted as news by patients, GPs embark upon what is hearable as a 'news delivery sequence'.

In six instances across the corpus GPs did not occasion forthcoming news with a pre-announcement. Rather they engage in what Maynard has called a perspective display series (PDS) (27, 28). In this three part sequence clinicians: (1)"elicit a view of the matter at hand from potential recipient(s)"(Excerpt 4.27, lines 1-6) (2) "the recipient reports their perspective or view" (Excerpt 4.27, line 7) and (3) "the physician delivers the news" (Excerpt 4.27, lines 10-18), p.7 (27).

Excerpt 4.27 51-04-22 Forecasting news with a perspective display series

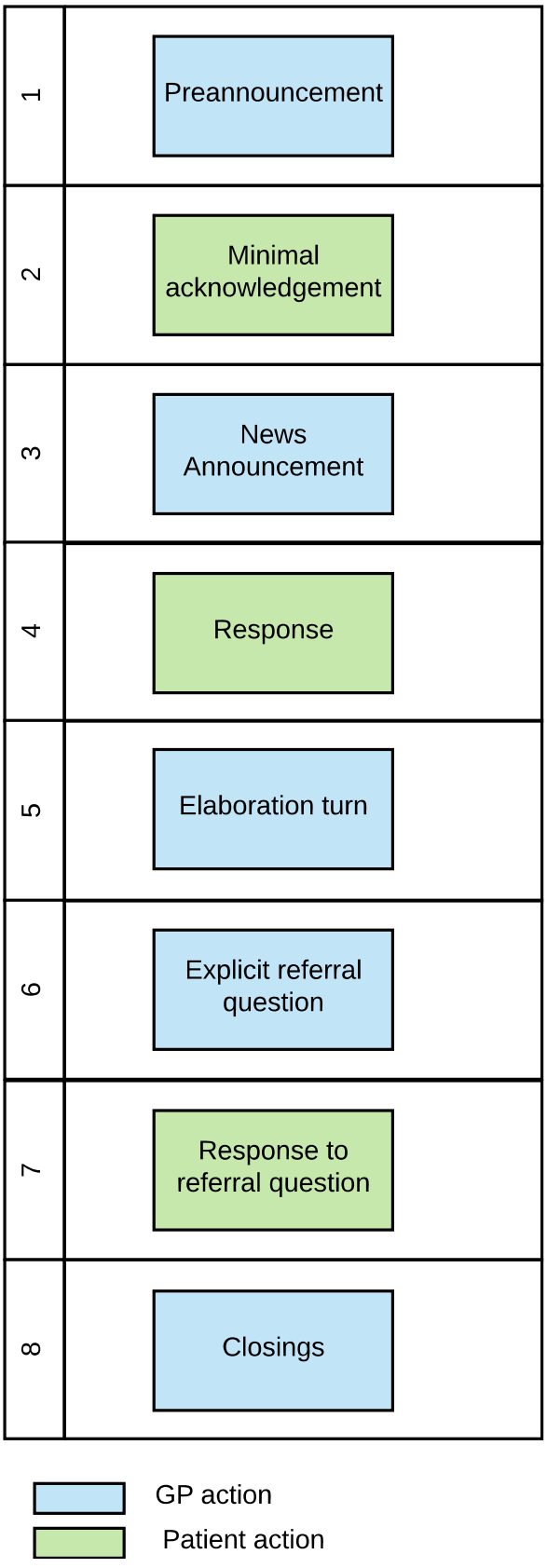
```
1  Doc:    Okay, (0.6) so (0.4) um (.) as regards your
2          weight.
3          (0.6)
4  Doc:    How would you feel about (.) trying to lose a
5          little weight (.) via going to (0.6)
6          <slimming wo:rld>?
7  Pat:    Hh h hh (0.4) not rea(h)ll(h)y n(h)o.
8  Doc:    Not really, [.hhh
9  Pat:                [No.
10 Doc:    It's only that (.) toda:y?
11 Pat:    Yeah.
12 Doc:    There's a really good offer because of the
13         study.
14         (0.4)
15 Doc:    It's free?
16         (0.6)
17 Doc:    And so it would be free for a twelve week
18         course.
19         (1.8)
20 Pat:    Not really no.= I- I could- I could do a sorta-
21         (.) I do a lot of wa:lking myself.
22         (0.6)
23 Pat:    You know (.) round the- (0.6) °(all round [here.)°
```

Although in a few rare cases the GP initiated news delivery sequences with a perspective display series, the BWeL news delivery sequences typically consisted of eight stages: a preannouncement; minimal acknowledgment; news announcement;

announcement response; and elaboration turn. This was followed by an explicit referral question; response to referral question; and closings, completing the referral sequence. Figure 4.4 illustrates this revised referral sequence, reflecting the framing of these tellings as news deliveries.

I have established the components of the BWeL referral sequences, and the actions which constitute these. In the next section I examine these actions in more detail, exploring particular actions done by GPs at specific points of this sequence which contribute to a smooth referral sequence.

Figure 4.4 Revised referral sequence



4.5 Specific features likely to produce 'smooth' referral sequences

In chapter 1 I presented GPs concerns about delivering weight management advice that are reported in the existing literature. A leading concern was that they felt these discussions would "open a can of worms" p.4 (2) that would take a significant amount of consultation time. GPs reported wanting advice on specific words and phrases to use when delivering these interventions. I address these needs in the forthcoming sections and so am taking a strongly applied conversation analytic approach.

Although GPs received training in the components of the referral sequence, they were not explicitly trained in the order in which these components should be delivered. This was advantageous for this analysis as within sequence complexity and variation (demonstrated in Figure 4.3, which illustrates the detailed BWeL referral sequence) provided the opportunity to identify particular components that facilitated or hindered delivery of a 'smooth' referral sequence. Here I define 'smooth' sequences as those where the patient did not display trouble with knowledge or understanding, and the GP could move through the sequence *swiftly and efficiently*. I now explore those key aspects of the sequence which - through their presence or absence - were followed by trouble in the patient's subsequent turn, or generated lengthy responses. The next sections of this chapter focus on components of the *news announcement*; and *explicit referral question* which were foregrounded in patient's next turn as particularly problematic or useful. These analyses lead to recommendations for practice, presented in the final section of this chapter.

4.5.1 News Announcement

4.5.1.1 Describing commercial weight management services

In this section I explore how GPs talked about 'commercial weight management services' (CWMS). A consistent component of the 'announcement of news' was stating *where* patients could be referred, which necessitated mentioning CWMS.

There was variation in how GPs did this. This provided the opportunity to observe components that facilitated a smooth delivery sequence, and those which could cause patients to display problems in understanding. The excerpts presented below illustrate this variation.

Excerpt 4.28 05-01-14

```
1  Doc:    Right, (.) mister Holmes (.) yo::u u::m th-
2          we kno- >we now know< that the best way for you
3          to lose weight is to go to a commercial weight
4          management se:rvice. And I can refer you for
5          free (.) if you'd like.
6          (0.3)
7  Doc:    U:m would you (.) hh like me to do that?
8  Pat:→   Can you tell me a little bit about what
9          it <actually is>?
```

From lines 1-4 the GP asserts that the best way to lose weight is through a "commercial weight management se:rvice.". However, he does not provide clarification on this terminology. The GP then goes on to explicitly ask the referral question, at line 5. The referral question is initially designed as a conditional one "if you'd like", and this receives no response from the patient. This could indicate either a resistance display to the referral, or a problem in hearing or understanding the GPs news (29). The GP then upgrades the referral question, reformulating with a "would" preface making a response from the patient explicitly relevant (19). In his response at line 9 the patient requests clarification on what a commercial weight management service "<actually is>" displaying a problem in understanding the way the GP had described this service.

This excerpt illustrates a common pattern in this corpus. When the news of referral was delivered, but no clarification provided on what a CWMS "actually is", patients often displayed a lack of knowledge or understanding. Some GPs oriented to this by offering clarification through provision of examples, as illustrated in Excerpt 4.29 and Excerpt 4.30:

Excerpt 4.29 22-03-32

```
1  Doc:    >Did you know< that the best way to lose weight
2          could be through a commercial (.) ↑weight
3          ↑management ↑system?
4  Pat:→   A whatta?
5  Doc:    <Commercial weight manageme:nt ↓system>.
6  Pat:    Okay.=
7  Doc:    =Yea::h like (.) u:m (.) >things like
8          Slimming Wor[ld<.
9  Pat:                [Oh yeah,(.) >Yeah yeah yeah.<
```

Excerpt 4.30 05-02-12

```
1  Doc:    The (0.6) the best way (0.4) to lose weight (0.4)
2          and °keep weight off° (0.6) is using (0.4) what
3          they call a commercial weight loss programme?
4          (0.6)
5  Doc:    >Do you know what they are<?
6  Pat:    No.
7  Doc:    .hhh things like (0.4) <Slimming Wo:rld>?
8  Pat:→   Oh, Yeah yeah yeah,=
9  Doc:    =Rosemary Conley, Weight Wat[chers,
10 Pat:                                [Oh right, Yeah,
11 Doc:    Those kinds of th[ings,
12 Pat:                     [Yeah,
```

In both Excerpt 4.30 and Excerpt 4.29 patients display a lack of knowledge about a "commercial weight loss programme" and a "commercial weight management system" respectively. In Excerpt 4.29 the patient displays trouble with the GP's description and requests clarification at line 4, with her repair initiator "A whatta?". The patient's interrogative "whatta" occurs following a partial repeat of the prior turn "a". Here, the interrogative word targets the trouble source (30, 31), whilst the partial repeat "helps to locate it, serving as a 'frame'" p.170 (32). The GP orients to this and repeats her description of the targeted trouble source "<Commercial weight manageme:nt ↓system>." again more slowly, and the patient responds with an unmarked "Okay." that does not display she has understood the GP's slow repetition of information. In Excerpt 4.30 the patient displays potential trouble at line 4 by not responding to the GP's complete turn. The GP orients to this asking, ">Do you know

what they are<?". The patient replies "No." clearly displaying either a lack of knowledge, or trouble understanding, the GP's description.

Following these displays of trouble in understanding, GPs in both excerpts provide the same specific example, saying "things like Slimming World" (lines 7-8, Excerpt 4.29; line 7, Excerpt 4.30). "Things like" evokes a group of similar organisations, and Slimming World exemplifies the type of offering from this group. The patients both respond with 'oh'-prefaced turns displaying change in knowledge or understanding (18) (line 9, Excerpt 4.29; line 10, Excerpt 4.30). Additionally, both patients follow this with a series of "yeah"s displaying a 'no problem' understanding display (33). These turns act to display changes in understanding following provision of specific 'like'-prefaced examples, and this pattern was common across these data.

I have demonstrated that patients displayed problems understanding 'commercial weight management service' or equivalent. However, following 'commercial weight management service' with a named 'like'-prefaced example remedied these troubles in understanding, facilitating a smooth move to next actions. However, not all named examples resulted in displays of understanding, as I exemplify in the excerpt below.

Excerpt 4.31 11-02-01

```
1  Doc:    So (0.5) hh (.) essentially (.) um it's been
2          proven that you join a comme:rcial weight
3          management progra:mme (.) it can: help you lose
4          weight,= And is more effective than you trying
5          to do that on your own?
6          (.)
7  Doc:    Would you be keen on doing that, Something
8          like ↑Rosemary ↑Conne:lly?
9  Pat:    °I don't-° I don't know nothing about her.
10 Doc:    h hhh h [h
11 Pat:             [She's an actress or summi:t.
```

The GP in Excerpt 4.31 provides clarification on commercial weight management programme by giving only one example - Rosemary Conley. In his subsequent turns at line 9 and line 11, the patient displays a lack of knowledge of this particular CWMS, saying "°I don't-° I don't know nothing about her.". Rosemary Conley, when used as a single exemplification, rarely received the displays of understanding.

Not only did patients display trouble when Rosemary Conley was used as an example, but GPs also displayed difficulty when referring to this provider. GPs either mispronounced its name, such as “Rosemary O’Connoley” or “Marjorie Conley”, or displayed some trouble in delivery, one saying “Rosemary Con-Connoley (.) #I can’t ↑spea:k#! (0.3) <Ro:semary Conely>”.

Both GPs and patients could display trouble when Rosemary Conley was used as the sole example of a commercial weight management services. This is probably because Weight Watchers and Slimming World are market leaders in commercial weight management and so are more easily recognisable and memorable that Rosemary Conley. This is evidenced in the data, as GPs displayed no trouble when exemplifying weight management services with market leaders ‘Weight Watchers’ or ‘Slimming World’. Furthermore, no patient displayed a lack of knowledge or understanding following mention of these particular providers. Interestingly, Weight Watchers was not offered to patients through the trial. The two services available were Slimming World or Rosemary Conley. GPs, however, frequently used Weight Watchers as an example when describing CWMS (137 consultations) and Rosemary Conley, which was offered by the trial, was only named in 84 consultations. Although Rosemary Conley is no longer operating, in many areas referrals are to weight loss groups run by local authorities or small providers with names that neither clinicians nor patients will recognise. The evidence here shows that exemplifying services with well-known brand names smoothed the referral sequence though avoiding display of troubles in understanding what the referral comprised.

I have shown so far that GPs can topicalise referral to a ‘commercial weight management service’ and then provide examples citing market leaders. These examples are usually prefaced with ‘like’ to show that there is a choice or the examples provided are not the only ones on offer; something ‘like’ Slimming World, may be Slimming World or could be something else. Conversely, some GPs did not exemplify with a ‘like’ preface, and would instead use an ‘it’s’ preface to their example. I next illustrate how this was done, and how patients responded.

Excerpt 4.32 51-04-20

```
1  Doc:    We could offer you (0.6) um (.) .tch a weight
2          support (.) group.
3          (0.4)
4  Doc:    Um (0.4) for free.
5          (0.6)
6          Um (.) and it's (0.4) Slimming Wo:rld?
7          (0.4)
8  Doc:    Twelve weeks free,
9          (0.6)
10 Doc:    If you'd like.
11         (0.4)
12 Doc:    .hhh and the benefits to that would be
13         obviously decreasing your risk of diabetes,=
14         ↓Heart attack.= ↑Stro:kes?
15 Pat:    Huh huh.=
16 Doc:    =Etcetera.
17         (0.4)
18 Doc:    How do you feel about that?
19 Pat:    I don't like Slimming World.
20 Doc:    Have you been there already.
21 Pat:    My friend has been there already. And I went with
22         her to of the meetings and I just thought they
23         talked (0.6) poppycock. Hh hhh hhh h hh.
24 Doc:    Right so not really, (0.4) a [big fan.
25 Pat:                                 [Not (really).
```

In this excerpt (Excerpt 4.32) the GP states that the free referral is for Slimming World (line 6). In the patient's turn following the referral question she orients to this as problematic "I don't like Slimming World." (line 19). She then accounts for this statement from lines 21-23. This excerpt illustrates that naming something specific as the only option for patients provides opportunity for them to express previous, often negative, experiences with a specific provider.

In this section so far I have demonstrated that the way commercial weight management services were described could facilitate or hinder the smooth running of the referral sequence. If commercial weight management services were mentioned, but no example provided, then patients frequently displayed a trouble in understanding what they were being referred to. This could be avoided by exemplifying CWMS through stating the market leaders prefaced with 'like'. In the final part of this section I showed that saying the names of CWMS without explaining that this was an example of where a patient *could* be referred could lead

to conversational troubles, as patients may have had a negative experience with a particular company, provide an account of the previous experience, and decline referral on that basis. GPs, therefore, may need to undertake additional interactional work, and take additional consultation time, to rectify a misunderstanding that could have been avoided.

So far, I have used the term 'commercial weight management *service*' (CWMS). However, the excerpts I have presented in this section evidence that GPs did not use this term consistently, and there was significant variation in the terms that were used. Whilst the GP in Excerpt 4.28 used the term 'service'; GPs also used the term 'programme' (Excerpt 4.30 and Excerpt 4.31); 'group' (Excerpt 4.32); and 'system' (Excerpt 4.29). Just as I noticed that patients displayed trouble in understanding 'commercial weight management', I also noticed that particular additional components hindered the smooth running of these discussions. I now examine these in the next three excerpts.

Excerpt 4.33 02-01-02

```
1  Doc:    Now (.) today as p- as part of this tria:l
2          (.) they're offering a free membership to
3       →  (0.3) u:m one of those groups, If that's something
4          that you'd like to (.) to take up.
5  Pat:→   .hhh well (.)  I have  got my own little group
6          (.) the Craft Club (.) which I told you about,=
7  Doc:    =↑Yeah?=
8  Pat:    =Which are these kind of geriatric middle-aged
9          mature >gentlemen<.
10         (.)
11 Pat:    There's only five of us in it. Craft standing for
12         (.).hh Can't Remember an Effing Thing. Um and
13         they're all going to give me a tenner each if I
14         go the whole month without drinking any
15         alco[hol.
16 Doc:        [Okay (and then).
17 Pat:    So that is: (.) and they're going to be
18         watching me like a hawk, I can ass(h)ur(h)e yo(h)u.
```

Excerpt 4.34 01-03-07

```
1  Doc:    So what I'm able to offer you in this is
2       →  going to:: a >sort of< weight reduction: °↓group°,
3          Um (0.5) but at the expense of er- a commercial
4       →  group but one that we can (.) fund (.)through the
5          en aich ess. So (.) is that something that you'd
6          might consider doing,=
7  Pat:    =N:o (0.6) I'm not a very (0.6) sociable person
8          to be honest. So I wouldn't mix very well at
9          a:ll hh h hh
10 Doc:    £Right£. It's not so much the mixing (.) as
11         just the learning how to cope with u:m the sorts
12         of things that you ought to do and shouldn't do,
13        But u::h it's an offer rather than an uh
14         insistence.
15 Pat:    Yeah.
```

In Excerpt 4.33 and Excerpt 4.34 the GPs use the term "group" to describe commercial weight management. In Excerpt 4.33 the GP has offered CWMS, stated commercial *groups* "like" weight watchers or Slimming World are the best way to lose weight, and then delivers the news of referral from lines 1-3, once again using the term *group*. The patient states he has his own "little" group – the CRAFT club. Here the patient orients to the term "group" as an informal gathering rather than structured support.

The patient in Excerpt 4.34 also orients to the term "group" stating that he wouldn't mix well as he is not a "sociable person" (line 7). The GP then undertakes additional interactional work to emphasise that it is not about "mixing" but receiving information. These excerpts illustrate that following the term "group" patients could orient to these as informal and sociable, which could hinder the smooth running of a referral sequence, as these orientations were addressed.

Another way of describing CWMS that could hinder the smooth running of a referral sequence was to use the term "class", as exemplified in Excerpt 4.35. Here the GP has established an evidence base, exemplified the referral details, and three times refers to the referral as a "class" (lines 5, 7, and 8). The patient initially responds minimally. However, when the GP uses an interrogative to make a response relevant (line 10) the patient states "I don't like them". Describing these providers as "classes" rarely received uptake in the patient's turn.

Excerpt 4.35 06-06-22

```
1  Doc:    If you're interested in getting your weight
2          down what (0.4) what (0.6) you (0.4)
3          could do: (.) um >and the lady will talk to
4          you a bit more about how the logistics of
5       →  it< (.)but essentially you join a cla:ss.
6          (0.4)
7  Doc:→   Um a class in the area.= And you (.) meet with
8          the class on a kinda weekly basis essentially,
9  Pat:    Yeah.
10 Doc:    .hhhh >does that sound good?<
11 Pat:    I don't like them.
12 Doc:    You don't like classes?
13 Pat:    I've done them before.
```

To summarise, in this section I have shown that using the descriptions 'group'; a 'named provider' only; and 'class' can hinder the smooth running of a referral sequence. Where CWMS were presented as if they were akin to formal education, a 'class', or very informal like 'group' or 'club', patients could orient to these services as undesirable. Conversely, those descriptions which sounded 'professional' such as 'organisation', 'programme' or 'service' were not oriented to as problematic and did not hinder the smooth running of a referral sequence. The frequency of these descriptions across the corpus is presented in Table 4.2. These results hold direct relevance for GPs. In the final section of this chapter I revisit this result, and discuss the implications for development of a training resource for GPs.

	Description	**Frequency**
1.	Programme	73
2.	Group	34
3.	Service	25
4.	Named provider only	16
5.	Class	10
6.	Organisation	10
7.	Club	7
8.	Other	71
	Total	**246**

Table 4.2 Descriptions of commercial weight management across the BWeL corpus

4.5.1.2 Explanation of referral

I have shown that, when announcing the news of the referral, how commercial weight management services are described and exemplified is important to facilitate a smooth referral sequence. After describing and exemplifying the referral, GPs explained the details. I previously stated that the explanation of referral could be short, only stating their availability, or longer turns which provided specific details about the number and location of sessions. Following this GP action of explaining the referral, patients responded. Chapter five focusses on patient responses in detail, with relation to displaying positive or negative reception. However, some responses foregrounded certain (present or absent) components of the explanation of referral as problematic. Next, maintaining my focus on the *news announcement*, I examine aspects of the way the details of the referral are explained which contributed to, or hindered, the smoothness of these sequences. I start this section with analysis of how the cost of referral is presented, and I then focus on the location of the referral.

4.5.1.2.1 Cost of referral

Excerpt 4.36 06-07-03

```
1  Doc:    .hh and the  ↑best way for you to lose weight
2          is actually through a: (.) a commercial (0.6)
3          weight loss service,
4          (0.4)
5  Doc:    Would you u:m >and I'd< like to refer you
6          for that today, Would that interest you?
7  Pat:→   .hhh (0.6) the: first thing is how much
8          does it cost.
9  Doc:    It's free (.) with this referral.
10 Pat:    Oh ri:ght, £Yeah£,(.) I'll try anythink.
11         (.) I would try anything.
```

In Excerpt 4.36 the GP asserts the evidence base for CWMS and then moves to ask the referral question. The delivery of the news of a free referral is absent. The patient orients to this in their turn on lines 7-8, by explicitly asking "how much does it cost.". In responding to the GP's question with a second question, the patient indicates she requires further information before she can answer (19); in this case she displays that cost is a potential barrier to agreement. Following the GP's statement

that the referral is free, the patient produces an 'oh'-prefaced change of state token that orients to this information as 'news for her' (17, 26). She then produces a minimal agreement "£Yeah£" with smiley voice indicating this news is positively received. The patient then uptakes the referral in her next turn "I'll try anythink".

Excerpt 4.37 09-03-27

```
1  Pat:→  Is there a cost to this, That's the other thing.
2  Doc:   No no, [It's free, = No no, It's three months free,
3  Pat:          [With these commercial things.
4         Cos the commercial stuff is so expensive.
5  Doc:   That's the- well that's the nice thing
6         about[this so:,
7  Pat:         [£Yea:h£. h [hhh hh hh hh
8  Doc:                     [hh hhh h
```

Similarly, in Excerpt 4.37 the GP has not stated that the referral is available free of charge. The patient enquires about the cost at line 1 and, following the GPs statement that it is free, the patient explicitly states that the "commercial stuff is so expensive", emphasising cost as a potential barrier to attendance. The patient produces a smiley, affiliative "£Yea:h£." in response to the GPs positive assessment of the cost, hearable as asserting a positive stance towards the referral.

The previous two excerpts illustrate that patients orientated to cost as a barrier. The absence of a clear statement that the referral was free of charge could generate avoidable patient information requests. Some GPs used words other than "free" such as "no cost to yourself" or "on the NHS expense". No patients indicated trouble in understanding these terms, but no patient also displayed clear uptake following their use. Conversely, Excerpt 4.38 illustrates that the term "free" was foregrounded when patients responded to the GPs news delivery.

Excerpt 4.38 05-02-07

```
1  Doc:   And as part of this study:,
2  Pat:   Yes.
3  Doc:   You get a free  (0.4) membership, (0.6)
4         [for twelve weeks?
5  Pat:→  [Oh right. Yes.
```

The previous excerpt exemplifies that stating the referral was "free" before explicitly asking the referral question was important in facilitating a smooth referral sequence and avoiding troubles in understanding. However, some patients also requested further information following the news delivery turn, even if the term "free" was used, as illustrated in the excerpt below.

Excerpt 4.39 17-02-02

```
1  Doc:    U:m (.) normally costs money, But I can
2          refer you for free today if you like.
3  Pat:→   Is this just for one day free and then you
4          have to pay for it.
5  Doc:    No, (.) <Its free the whole time>.
6  Pat:    Yeah,
7  Doc:    Yeah.
8  Pat:    Okay then,
```

The GP in Excerpt 4.39 states he can refer the patient "for free today". In their turn following the compounded news delivery and referral question the patient asks a second question rather than producing the 'yes' or 'no' response for which this turn is designed (34). As in Excerpt 4.36 this indicates the patient requires further information before producing their response (19). Following the GPs clarification that the referral is "free the whole time" the patient does a minimal agreement "Yeah" to the referral question.

Excerpt 4.40 30-02-08

```
1  Doc:    And um .tch you've been randomly allocated to
2          the group where we can offer you (.) a referral (.)
3          to one of the commercial weight loss programmes
4          that run in this a:rea.=
5  Pat:    =Okay.
6  Doc:    For free?
7          (.)
8  Doc:    .tch u::m £so if you'd like to take us up on
9          that offer£ (.) um  we could refer you to (.)
10         I think its Weight Watchers or um >Slimming World
11         in this area<,=
12 Pat:    =Oka[y.
13 Doc:        [Um and you can >participate in the programme<
14         (.) u::m  and hopefully that'll help.
15         (.)
16 Pat:    [Okay.
17 Doc:    [Um with, with any weight loss (.) °<plans>°.
18 Pat:→   Okay, When you say <for free::?>
```

```
19 Doc:    Yeah.
20 Pat:→   Is that just the joining fee:? Cos they (.) some of
21        these things [it-
22 Doc:                [No, Its one full programme,
23 Pat:→   Oh (.) the fu:ll programme.
```

In Excerpt 4.40 the GP has stated the referral is free. As the GP is coming to the projectable end of the announcement of news with her assessment on lines 14 and 17, the patient uses her turn to ask for details about what exactly is free asking "is that just the joining fee:?". The GP states it's the "full programme" and the patient's subsequent 'oh'-prefaced partial repeat, with emphasis on 'full' indicates this was news for her.

To summarise, when the GP hearably stated that referrals were free and the amount of time patients were referred for, 'twelve weeks' or 'a course of sessions', questions about time and cost did not arise in the patient's next turn, as exemplified in Excerpt 4.41, which shows talk moved smoothly from the implicit referral question on lines 1-3, to patient agreement on line 4.

Excerpt 4.41 50-01-03

```
1  Doc:    We can refer you to the local one for a free
2          session of (.) >well a free:< (.)course of
3         sessions. Um-=
4  Pat:    =Okay. We'll give it a go.
5  Doc:    Fantastic.
```

This analysis of how the cost was presented foregrounded the important of placement of this component within the wider referral sequence. So far I have shown 'free' or equivalent occurring as part of the 'news announcement'. However, some GPs placed the cost of referral later in this sequence, exemplified in Excerpt 4.42.

Excerpt 4.42 46-01-96

```
1  Doc:    Which you attend one- you attend one of their
2          classes once a week for twelve weeks:? You get
3          wei:ghed each ti:me, so we can see how things
4          are changing? And on top of that there's lots
5          of education a:nd (.) help.=
6  Pat:    =Yeah.
7         (.)
8  Doc:    And its >not only about sort of< (.) you
```

```
9           know (.) sort of it doesn't mean you can't-
10          (.) you're not allowed to eat, It's trying to get
11          you to eat the right things.
12 Pat:     Yeah.
13 Doc:     Okay. So there's lots of evidence that it works.
14          Would you be interested?
15 Pat:→    Don't really have time to be fair.
16 Doc:     Okay, And is that because of everything that's
17          going on and things?= Yeah?
(OMMITTED 53 SECONDS DISCUSSION OF PATIENT'S PRIVATE LIFE)
18 Doc:     Because this is a research tria::l (.) the
19          advantages of that for you is that we can >fit
20          very much around you<? So you just go back and
21          knock on Sheila's door, And she will(.)can talk
22          to you about all the different programmes that
23          are available, and fit it arou:nd your work
24          therefore. Also because of that you would (.)
25          we'd also do it for free for [you,=
26 Pat:                                  [Oh right,
27 Doc:     =Rather than you having to pay. And they're quite
28          expensive.
29 Pat:     Yeah.
30 Doc:     These sorts of programmes. And so again you do that
31          for free. (.)The other advantage of it that (.)I
32          would then follow you up in a month to see how
33          you're doing.
34 Pat:     Okay.
35 Doc:     And then we'll also, then also the researchers
36          would follow you after that. So, there's lots of
37          things to try and help you to make a change happen.
38 Pat:     Yeah.
39 Doc:     Do you want to give it a go?
40 Pat:     Sounds good.
```

The GP initially delivers the news of referral from lines 1-5. He omits however, to state that the referral is free. The patient, responds with a minimal receipt "Yeah." at line 6, and the GP elaborates on this news. Again, he omits the information that the referral is free. Following the referral question at line 14, the patient responds negatively, stating that she does not have enough time to attend "Don't really have time to be fair". The GP continues elaborating and the patient still does not respond positively to the referral. However, from lines 24-25 the GP delivers the information omitted from the initial news delivery and subsequent elaboration, that the referral is available for free. The patient responds with a news receipt "Oh right," targeting the delayed delivery of free as news-for-her. Following this, when the GP asks the referral question a second time, at line 39, the patient responds positively, with her assessment "Sounds good". Although this is a downgraded assessment "sounds"

good rather than "is" good, this is still hearable as displaying positivity towards the referral. The absence of stating the cost, followed by its later delivery can be seen to contribute to the patient's move from initial tentative account (which may have been part of a rejection trajectory) to acceptance of the referral.

In this section so far I have shown that stating that referrals are free, and the length of time they are available for facilitates a smooth move into next actions. My analysis of Excerpt 4.42 shows it is important that this information is provided early - during the announcement of news. Early placement avoids not only requests for information but also resistance displays that could have been avoided through earlier placement of the cost of the referral.

4.5.1.2.2 Location of referral

In the previous section, I demonstrated that patients commonly asked about the cost of referral, if it was not presented as free. I have also shown that placement of this news delivery component early in the sequence, rather than after the acceptability of CWMS had already been discussed, facilitated a smooth referral sequence. There was one further component of the explanation of referral which was frequently highlighted by patient responses in their next turn. This was the location of referral. I examine how this was communicated in the next two excerpts.

Excerpt 4.43 09-03-07

```
1  Doc:    Would you like to go to to join them to do that.
2          (0.7)
3  Doc:    And ther- there's follow-up questionnaires.
4          [Cos it's (part of the study)
5  Pat:    [Yeah.
6          (.)
7  Pat:→   Will I- will they be faily lo:cal though,
8  Doc:    Oh yes, (.) It's all (.) >it's in Citychester<
9  Pat:    ↑Oh yeah, (.) That's fi:ne then.
10 Doc:    Yeah. Oka:y. Brill.
```

In Excerpt 4.43 the GP has described the referral and, at line 1, asked the referral question. The patient does not respond in their next available turn, displaying some trouble with the question. At line 7 the patient asks if the referral would be "local"

indicating this information is necessary to respond to the question of attendance. The GP states that it will be, and the patient's "↑Oh yeah," indicates positive reception of this news (18, 25). The patient's use of "then" in her turn "That's fi:ne then" targets this information delivery ("it's in Citychester") as supporting decision making. Asking about location, specifically "is it local", was one of the most common questions patients asked if this information was not provided as a component part of the news delivery. Patient's frequently asked "where are they" or entered into longer explanations about difficulties traveling outside of their local area ("I don't drive so::?"). When GPs incorporated information about the location, either through saying "local" or "in the area", patients did not ask further details about location in their next turn. And clinicians could move smoothly to next action. Although no GP used all the components I've highlighted so far, the excerpt below (Excerpt 4.44) illustrates how by consecutively using some of these components – exemplifying with market leaders, and stating cost and duration of referral as part of a news delivery sequence – GPs could smoothly move to the referral question without clarification questions from patients in their next turn.

Excerpt 4.44 07-01-16

```
1  Doc:    And that's felt to be through (.)the sort
2          of commercial organisations such as Weight
3          Watchers,
4          (0.4)
5  Doc:    Rosemary Conley,
6          (0.6)
7  Doc:    >Sort of< Slimming World? And things like that.
8          (1.0)
9  Doc:    And we can (.) refer you: to (0.4) a twelve
10         week course (0.4) for that if you would like.
11 Pat:    Yep.
12 Doc:    Um and that would be free of charge to you:?
13         Do you think that would be something to-=
14 Pat:    Oh I'd love to do it, (.) Yeah.
```

Incorporating these aspects facilitated a smooth referral sequence. Even though it may appear counterintuitive, *providing* details and specificities (rather than avoiding doing so) seemed to expedite these sequences. This meant GPs could move swiftly and efficiently to the referral question (Excerpt 4.44, line 10 and 13). In the next section I examine how these referral questions were formulated in ways which facilitated a smooth sequence.

4.5.2 The referral question

4.5.2.1 'If' and 'would' prefaces to enquiry

Just as aspects of the news announcement offered opportunity to smooth referral sequences, so did the way referral questions were formulated. The referral question is the part of the sequence where the GP asks the patient about attending the referral, and explicitly requests a patient response. There was some variation in how these questions were designed. Although there was variation in their production these referral questions all acted as an enquiry, making a response relevant in their next turn.

Sikeveland and Stokoe have explored the verbs used during initial enquiries to attend mediation services (35), and Huma has also targeted verb use in her analysis of enquiries in business-to-business cold calls (36). However, whilst I was exploring these data it was the initial turn components of the referral question which I found interesting. The most frequently used of these initial turn components were 'would' and 'if', and it is these prefaces to enquiry which I now explore in this section.

In Excerpt 4.45 and Excerpt 4.46 the GPs asks a 'would'-prefaced referral question, at line 1, making a response from the patient directly relevant. In both excerpts the patients respond with short displays of uptake (explored further in the next chapter of this thesis). These types of brief response were common following 'would'-prefaced referral questions.

Excerpt 4.45 43-01-27

```
1  Doc:→  So would you be happy to go along with,
2  Pat:   I would yes, Certainly, Yes
```

Excerpt 4.46 46-01-62

```
1  Doc:→  Would you be interested?
2  Pat:   Yeah. We are interested. Yeah.=
3  Doc:   =Good.
```

In addition to brief responses, patients could respond to 'would'-prefaced referral questions with information requests, as exemplified in Excerpt 4.47.

Excerpt 4.47 08-02-04

```
1  Doc:    Um: hh (0.5) would that be something you
2          might be interested in[:,
3  Pat:                          [Well it depends on
4          where I've got to go for it and all that sort
5          [of thing,
6  Doc:    [.tch oka:y they'll be local.
```

In Excerpt 4.47 the GP omitted stating the location of the CWMS in the news delivery, and the patient in their turn on lines 3-5 orients to the absence of this information as problematic, and requests details on location before answering the GP's 'would'-prefaced referral question.

The type of responses made relevant by 'would'-prefaced questions in the BWeL corpus are generally brief, or information requests that orient to absence of information. Stivers et al's exploration of treatment recommendations as actions places these 'would'-prefaced formulations in the environment of a 'suggestion'; a treatment recommendation that leaves the decision largely in the hands of the patient, whilst nonetheless asserting agency over making the recommendation (37). In doing a suggestion, 'would'-prefaced referral questions emphasise clinical agency, and therefore prefer an affiliative response from the patient. Nevertheless, in these data they do not exert a preference for affiliation strongly enough to prevent patients from requesting clarification in their next turn. 'Would' still presents the suggestion as contingent on the patient's decision, rather than a pronouncement for example, which asserts agreement as the 'correct' course of action (37).

A different pattern emerged in my collection of 'if'-prefaced referral questions. I explore this pattern in the next four excerpts.

Excerpt 4.48 05-01-01

```
1  Doc:→  I can refer you now for free if you'd like,
2  Pat:   Yes.
```

In Excerpt 4.48 the GP formulates an 'if'-prefaced referral question at line 1 "if you'd like,", and the patient responds with a brief affiliative response "Yes.". This is similar to the types of response I observed to 'would'-prefaced referral questions, however this was part of a wider range of actions in next turn than I observed in response to 'if'-prefaces. The second way patients could respond, an extended response over a series of turns, is illustrated below, where I revisit the patient who responded informally to the term 'group':

Excerpt 4.49 02-01-02

```
1  Doc:    Now (.) today as p- as part of this tria:l
2          (.) they're offering a free membership to
3          (0.3) u:m one of those groups, If that's something
4          that you'd like to (.) to take up.
5  Pat:→   .hhh well (.)  I have  got my own little group
6          (.) the Craft Club (.) which I told you about,=
7  Doc:    =↑Yeah?=
8  Pat:    =Which are these kind of geriatric middle-aged
9          mature >gentlemen<.
10         (.)
11 Pat:    There's only five of us in it. Craft standing for
12         (.).hh Can't Remember an Effing Thing. Um and
13         they're all going to give me a tenner each if I
14         go the whole month without drinking any
15         alco[hol.
16 Doc:        [Okay (and then).
17 Pat:    So that is: (.) and they're going to be
18         watching me like a hawk, I can ass(h)ur(h)e yo(h)u.
```

Following the GP's 'if'-prefaced referral question on lines 3-4 of Excerpt 4.49 the patient produces a 'well'-prefaced response. These prefaces typically indicate a response will both be extended (38, 39) and that the response may be "rejecting or negatively valenced" (39). Indeed, the patient's "well" prefaces an extended rejection of the referral, where he states he has support from his own group, who will be 'watching him like a hawk' ensuring he does not have any alcohol. Although the patient does not explicitly reject the referral at this point in the consultation, this extended telling is hearable as an implicit rejection. It was common in this collection of 'if'-prefaced referral questions for patients to provide accounts for forthcoming rejection. Patients could also initiate a troubles telling sequence following an 'if'-prefaced referral question, as exemplified in the next excerpt:

Excerpt 4.50 02-01-09

```
1  Doc:    And u:h toda:y they're offering a u::h
2          a free membership to a group support (.)
3          >something like< Slimming World or Rosemary
4          Connelly.
5  Pat:    Mm.
6  Doc:    Something suitable for you in this this area,=
7          If that's something you'd [like,
8  Pat:                              [Well (.) the trouble
9          is I ha[ve to get people to take me,
10 Doc:           [To do.
11 Pat:    So: you know (.) it's not really fair for me
12         to keep saying to somebody can you run me
13         down or °some (pop) other°.
```

In Excerpt 4.50 following an 'if'-prefaced referral question, this patient also uses a 'well'-prefaced turn to initiate a troubles-telling sequence (40) at line 8. This troubles-telling sequence is hearable as an implicit rejection as she presents a barrier to attending the referral; she is unable to travel there alone. The third way patients responded 'if'-prefaced referral questions is illustrated below.

Excerpt 4.51 20-01-11

```
1  Doc:    U:h what we can offer i- is <free of charge>
2          u:h a- a referral to (.) either °S- Slimming
3          World or Rosemary Connolly°.
4          (.)
5  Doc:→   To help you lose weight, If that's something
6          you're interested in?
7  Pat:    Uh well I do need to lose quite a bit, I mean I'm
8          carrying about (0.3) probably two stone too much.
9          U:m if I'm honest and (.) and it is beginning to
10         affect my knees,= I know that. Um so I yea:h
11         I would like to. U:h I find it quite dif-
12         I >almost get the impression< that my- my
13         tablets um slow my metabolism down so much
14         that .hhh I can't just (.) I just can't shift it.
15  Doc:   Right well we can refer you to one of these groups.
16         (.)
17         Free of charge,
18  Pat:   Yeah, Grea:t.
```

Following the GP's 'if'-prefaced referral question, the patient responds with a 'well'-prefaced turn, foreshadowing a longer response. The patient acknowledges that "I do need to lose quite a bit" and associates her weight with problems with her knees, then uptakes the referral at line 10-11. She then accounts for her acceptance stating that her tablets slow down her metabolism and she has difficulty losing

weight. To summarise, this excerpt demonstrates that 'if'-prefaced questions could be followed by uptake of the offer over a series of turns, which could be followed by an account for acceptance.

I have shown that 'if'-prefaced referral questions could be followed by brief responses, but were often followed by longer responses from patients, over a series of turns. They used these turns to agree, and account for agreement. They could reject, and account for rejection, or reject through an extended troubles telling sequence. I have demonstrated in my analysis that these 'if'-prefaced questions seem to display a preference for longer responses from patients in their next turn, with contrast to *would*-prefacing which preferred shorter responses. The use of 'if' in these enquiries initiates a conditional framing, used to present 'imagined or uncertain situations'. The 'if + you' format used in the BWeL corpus presents the referral as conditional on the *patient's decision*. This foregrounds patient agency over decision-making and presents the referral as contingent on patient choice. Adolphs et al (41) demonstrated that advice-giving sequences can be hedged with an 'if'-prefaced conditional, which functioned to mitigate the advice being delivered. Connabeer has also explored initial turn components to advice giving sequences in lifestyle discussions in primary care (42). In line with Silverman's work she found that 'if' asserts a hypothetical environment (15) presenting advice as contingent on patient decision. To return to Stivers et al's exploration of treatment recommendations as actions (37), these 'if'-prefaced formulations do most of the work of an 'offer' (rather than a 'would'-prefaced suggestion). Although these are not patient initiated requests, as in Stivers' study, these do act to more weakly endorse the recommendation than other formats, and imply patient agency over decision making though use of an *if*-preface. Emphasis on patient agency accounts for the longer responses, characteristic across this collection. In foregrounding patient agency over decision making the preference is for a longer response, making explicit this decision-making process, rather than a brief affiliative response, as was characteristic of 'would'-prefaced enquiries.

These analyses show that the way referral questions were prefaced had clear implications for the length of patient response in next turn. 'Would'-prefacing preferred shorter responses but allowed interactional space for information requests.

Conversely the conditional nature of an 'if'-prefaced response made relevant a longer account from patients. These offer clear implications for GP training in brief intervention delivery as, addressing third objective of this thesis, I have demonstrated that turn design can exert a preference for shorter patient responses. I explore these implications further in section 4.7.2 of this chapter.

In line with my second objective of this thesis, I now take a broader focus and move away from specific components to how the wider sequence is delivered, and the implications of sequence delivery for patient agreement to attend. Following this analysis, I explore these conversation analytic results in relation to patient outcomes to examine if conversational phenomena identified through conversation analysis are associated with patient next action.

4.6 Telling the news in the BWeL trial

My focus in the previous section was not on components that are associated with agreement to attend, rather on components which negate avoidable questions in the patient's next turn that act to expand these sequences. Clinicians want to deliver brief interventions in as short a time as possible. Having identified specific words and phrases likely to contribute to this brevity, I now focus on how news can be delivered in ways which are associated with patient agreement to attend their referral. I take a mixed methods approach in this section. I first present results from conversation analysis. I then quantitatively examine relationships between my findings from conversation analysis and the outcome measures: agreement-to-attend, actual attendance, post-consultation reported satisfaction, and consultation time.

I have already shown how information in the BWeL trial was delivered as 'news'. In these referrals GPs and patients entered into a news delivery sequence, consisting of a preannouncement, announcement, announcement response, and news elaboration, before asking the referral question. News is often delivered with a valence, indicating the *type* of news that is being delivered (25, 43). A valence asserts an evaluative stance toward news delivery, through which interlocutors "orient to information in terms not only of its status as news, but also of its perceived affective

significance for the individuals involved" p.195 (43). Valence can be achieved both lexically (17, 44), and non-lexically, including through use of prosodic features employed during news delivery (43). These lexical and non-lexical features act to propose a "particular affective orientation to the news" p.195 (43).

The way that news was valenced in the BWeL trial followed three clear patterns. These were (1) a positive valence, indicating good news (2) a negative valence, presenting the news of referral negatively, (3) no valence, presenting the news of the referral neutrally. I refer to these ways of asserting a valence towards news as 'news delivery formats'. Certain ways of speaking sound like good or bad news (43) and, in a typical news delivery sequence, some points provide for the understanding of the valence of the news-in-progress more than others (25). In the forthcoming sections I maintain my strongly applied approach to explore how valence is displayed during the news delivery sequence. I consider the preannouncement, announcement, and news elaboration points of the news delivery sequence in the BWeL trial, and demonstrate how valence is both achieved and responded to. Following this, I examine relationships between the valence the GP asserts towards the news, and patient outcomes.

4.6.1 Preannouncements

Before announcing the news of a free referral GPs often engaged in a preannouncement sequence. This acted to occasion the wider news delivery, and to provide information useful for its subsequent interpretation (26). Maynard demonstrated that news can be explicitly valenced from the initial preannouncement as 'good' or 'bad' news (25, 26, 45). In line with Maynard's work, this was where the valence was initially, and most strongly asserted. The excerpts below all show the initiation of the BWeL referral sequences, and how GPs prefaced the announcement of the news of a free referral. I first illustrate how news was presented with a positive valence in this placement, and I then show how GPs asserted a negative valence. Finally, I illustrate a neutral valence in these pre-announcements.

4.6.1.1 Pre-announcement of good news

Excerpt 4.52 04-03-11

```
1  Doc:    Right so .hhh I'm very pleased to say that uh
2          you've drawn uh uh this: this side,
3          (.)
4  Doc:    Because we've got the option to offer yo:u (.)
5          well good opportunity to offer you .hh um .tch
6          the chance to have fully er funded on the
7          en aich es (.) uh tweleve >uh uh sort of<
8          uh Slimming World .hh u:m to help lose weight,
9  Pat:    O:h right,
```

The GP initiates the NDS with a preannouncement which asserts a positive stance towards the upcoming news. The GP uses individual self-reference (46) (personal pronoun 'I') in her statement at line 1 "I'm very pleased to say" asserting a personal stance towards the preannouncement. Framing this turn in Goffamn's terms of 'footing', the GP is hearable as author, animator, and principle of the referral. That is to say, she is hearable as not just active in the role of utterance production, but also as selecting the sentiments being expressed and the words she uses, and as someone whose position is established by the words she has spoken and who's beliefs have been told (47). The 'position' and 'beliefs' that the GP asserts here are shown to be explicitly positive as she completes her 'I'-prefaced turn by indexing an affective stance (48) as "very pleased".

This assertion of affective stance is the first of a series of specific terms in the preannouncement which act as vocal forecasting strategies of the 'news-to-come' (27). "Very pleased to say" explicitly foregrounds the forthcoming news as positive, which the GP reasserts in her next turn at line 5 where she asserts the referral as a "good opportunity" (46, 47).

The GPs non-lexical devices also contribute to asserting positivity. She emphasises key words, such as "option" (line 4), "good" and "offer" (line 5). This highlights, rather than shrouds, important information, and acts as a prosodic feature of good news delivery (43). The preannouncement is brief (lines 1-2), and delivered at a fast pace. These two features act to expedite the delivery of the announcement of news at line 4. This speedy pace, where the news is delivered in close proximity to the start

of the delivery sequence, acts to display 'enjoyment' or 'eagerness' in the telling (49), acting further to assert a positive valence.

A similarly brief preannouncement is illustrated in Excerpt 4.53. Here the GP congratulates the patient at line 2 after opening the randomisation envelope. This display of congratulations acts as a forecasting device, foregrounding that forthcoming information is newsworthy. This also implies that the patient has been successful, and that referral to the support arm is an accomplishment worthy of congratulations (50, 51). This asserts a positive valence towards forthcoming 'good' news.

Excerpt 4.53 01-01-07

```
1  Doc:    Oh I've opened the envelope (.) and uh
2          congratua:ltions you've- .hh you are in the
3          #support arm#,
```

The preannouncements shown in Excerpt 4.52 and Excerpt 4.53 exemplify the most common way a positive valence was asserted in this preannouncement placement. These excerpts show preannouncements were brief, delivered at a fast pace, key words were emphasised, and lexical forecasting strategies explicitly foregrounded the forthcoming news as positive. A rarer pattern is illustrated in Excerpt 4.54. This excerpt illustrates that there were subtler ways of asserting a valence towards forthcoming news.

Excerpt 4.54 03-01-11

```
1  Doc:    ↑You've been randomised (0.4) to the group
2          which is (.) sort of suggesting that (0.4)
3          suppo:rt (.) for losing weight,
4  Pat:    Yeah.
5  Doc:    I- is you know the evidence is showing
6          th- that (0.4) is sort of will positively
7          help you lose weight. (.) And definitely
8          again from blood pressure point of view
9          (0.4) with your blood pressure being
10         a bit bo:rderline,
11  Pat:   Yeah,
12  Doc:   It may be (0.4) if you could lose a
13         bit of weight that will even (0.4) you know
14         that will bring it down (.) so it won't
15         even be bo:rderline anymo:re.
```

When starting the pre-announcement, the GP in Excerpt 4.54 states the patient has been randomised to a group which suggests support for losing weight is effective. She follows this by stating that evidence shows this will help. Her verb "help" at line 7 is modified with an intensifier "positively". Her delivery of this intensifier is strongly emphasised, acting to positively valence this turn. The verb "help" positively presents the referral as supportive or helpful. The GP then topicalises the patient's blood pressure – a condition that could potentially benefit from weight loss- but minimises its status as a problem stating it is a "bit" borderline. Following this downgraded assertion of a potential problem, in her next turn the GP engages in an 'optimistic projection' (40) of its solution, emphasising that weight loss may solve this condition. Just as the GP minimises the patient's blood pressure (a bit borderline) she also minimises the effort the patient will need to undertake to benefit stating the patient could lose "a bit of weight".

The GP presents weight loss not as necessary, but as contingent on the patient's choice through use of a conditional "if" at line 12. As in the previous examples the GP emphasises key words such as "positively" on line 6 and "definitely" on line 7 by 'punching' key syllables, increasing their volume slightly. She talks quickly throughout this pre-sequence, apparently slowing down only to emphasise key words such as "bo:rderline" (5) and "bo:rderline anymo:re" (line 15). This impression of change in speed may be due to the elongated, emphasised, vowel sounds on these key words. This fast delivery and emphasis on key words, convey eagerness or excitement in their telling (43), and contribute to making these conversations hearable as foreshadowing 'good news'.

To summarise, I have shown that preannouncements across this collection were brief, and had shared prosodic features which worked to indicate forthcoming good news. GPs forecasted the news-to-come with intensified adjectives, and word choice which explicitly conveyed positivity. These asserted a personal stance towards the news-to-come as 'good' news. Longer preannouncements were rarer, but when GPs engaged in these they used optimistic projections to present weight loss positively. They also often described the 'benefits' of weight loss, and minimised the effort a patient would have to undertake to gain these. Referrals were presented as helpful,

but not as necessary. Commonly absent were turns establishing that the patient is overweight or mention of their BMI.

4.6.1.2 Pre-announcement of negative news

A second way a valence could be asserted is illustrated in the next two excerpts. Some GPs displayed a negative valence in the preannouncement which presented the forthcoming news as a necessary treatment for a clinical problem.

Excerpt 4.55 09-02-20 a

```
1  Doc:    Ri:ght (.)  so:: (.) when they put you on
2          the sca:les (0.3)  your height weight rati:o,=
3  Pat:    =Mmm.
4  Doc:    Gave you a figure of thirty two::. Now that
5          technically it's not good for you, Being over
6          thirty.
7          (.)
8  Doc:    And these people are running a study to try
9          and en::courage people u::h a:y to >understand
10         the benefits< of being lighter,= Because it's not
11         all about- it has a (.) hu:ge impact   on a lot of
12         illnesses.
13         (.)
14 Doc:    including some of the ones that are relevant
15         to yo:u.
16         (0.3)
17 Doc:    Particularly your blood pressure.
18         (0.6)
19 Doc:    Even possibly your gout.
20         (1.3)
21 Doc:    U:m (0.6) So weight loss (.)controlled weight
22         loss on a healthy diet (.) can be very
23         beneficial to you.
24         (1.6)
25 Doc:    .hhh and the whole impact of this study is
26         basically to get across the <messa:ge,> (2.2)
27         tha:t (0.5) >all the studies show< that (.)
28         weight loss in the group se:tting (0.5)
29         is far more effective tha:n (.) >trying
30         to do it on your own<.
```

The GP starts the preannouncement by saying "when they put you on the sca:les" to refer to the process of weighing by the trial team. This displays that the patient was potentially a passive recipient of weight and has to be passively 'put' somewhere

rather than actively 'getting' on the scales. The GP then re-references previous clinical findings, regarding the patient's high BMI. He does this by first stating the patient's BMI, saying it "gave you a figure of thirty two::". The GP emphasises "thirty two::" with staccato delivery and an elongated vowel sound with an intonation contour moving from high to low. Freese and Maynard identify "stretched vowels with pronounced falling pitch" p.198 (43) as a prosodic feature of bad news delivery. Indeed here, this prosodic feature to highlight the patient's high BMI makes this particular aspect of the preannouncement hearable as displaying a particularly negative valence. Re-citing the evidence in this way has been shown as a common feature of 'bad' news delivery (45). These turns also act to assert the reason behind the referral - the patient's obesity. Pomerantz describes how "people describe their bases or sources" when they perform actions that could possibly be offensive p.607 (52), and yet interlocutors may still feel they should perform. Existing evidence demonstrates that talking about weight is one such sensitive action (6, 53). Through stating the patient's BMI, the GP asserts the evidence for, and reasoning behind, the forthcoming referral. Following this, the GP explicitly asserts that this is a problem, with his turn at line 4 "Now that technically it's not good for you". In this problem statement, the GP asserts an epistemic positioning. Both speakers have an epistemic status – individual 'territories of information'. Knowledge can fall into these territories along a scale as belonging to one more than the other (54). When information belongs to one party and not the other, the first party has an epistemic advantage, and is situated as 'knowing' whilst the other is 'unknowing'. Throughout the rest of this sequence the GP maintains this status as 'knowing', and subsequently informs the patients of the problems associated with obesity, indicating that they are 'unknowing'. I revisit epistemics in further detail in chapter six.

Whereas the GP in Excerpt 4.54 asserts the patient's "bit" borderline blood pressure and presents a "bit" of weight loss as a positive solution, this GP engages in more elaborate pre-sequence. He states the impact of weight on a series of conditions. In contrast to the minimised "bit borderline" in Excerpt 4.54, he states the "hu:ge" impact on a "lot" of illnesses emphasising the problems of obesity, which he then lists. When stating the benefits of weight loss, this GP emphasises the actions the patient will need to undertake to achieve these: "controlled weight loss" and a "healthy diet". Rather than statements which minimised patient effort which

projected a positive valence, this emphasis on patient action implies effort from the patient will be required, acting to valence the referral negatively. Following this, the GP then asserts the evidence base behind the referral at line 27. This elaborate report stating a variety of evidence acts to postpone or delay the announcement of news, but also to display further reasoning behind its forthcoming delivery (27, 55, 56). Whereas the GPs who asserted a positive valence delivered the news of free referral relatively quickly, occasioned with only brief pre-announcements (for example Excerpt 4.52 and Excerpt 4.53), it was usual for news announcements in this collection to be preceded by a longer preannouncement from the GP, as illustrated in the excerpt. These actions of stalling news delivery, forecasting the upcoming referral in the context of treatment for a medical problem, and re-citing existing evidence of clinical problems, have the effect of conveying seriousness and reluctance. These are also common features of bad news delivery in other clinical settings (27).

In doing the actions I outline above (emphasising the problems of obesity, displaying reasoning behind its forthcoming delivery, asserting epistemic primacy, and re-referencing previous clinical findings) the GP delivers a large amount of information. Firstly the patient's BMI (line 4), then the health implications of this (lines 10-19), followed by the details of the type of weight loss that is needed (line 21-22). He then moves on to talk about the study and the evidence behind the referral (lines 25-30). In line with asserting his epistemic advantage he does a series of tellings, and does not explicitly invite the patient's thoughts or opinions at any point. Maynard refers to this large amount of unliterally delivered information in news delivery sequences as an 'information dump' (26), and these were common among deliveries of negative news, as GPs engaged in elaborate preannouncements which stalled news delivery.

This GP repeatedly refers to "these people" or the "study" (line 8 and 25) rather than asserting a personal perspective towards the referral. Returning to Goffman's concept of author, animator, and principle, the GP's avoidance of individual self-reference, or assessment of the acceptability of the referral, makes him hearable as the animator only. The caution involved in doing sensitive actions may be exhibited by "speakers making limited or no claims on their own behalf." (52) and we can see

that here. The GP avoids asserting himself as either the agent behind this referral, or as personally endorsing it through positive assessment. In presenting the study team as the agents behind the referral, the GP may be acting to minimise himself as a locus for potential forthcoming resistance. Studies show clinicians report discomfort and apprehension when discussing weight, and the strategies of 'negative' news delivery align with those observed by clinicians in other settings who must engage in something they do not report wanting to perform, or feel comfortable doing. Clark and LaBeff, for example show that clinicians 'cover' themselves trying to avoid the blame a patient may direct towards them (57).

News was postponed or delayed through the lexical features of these elaborate pre-sequences, but also in the non-lexical features of their delivery. Talk was slow, and often slowed down as utterance progressed. At line 26 the GP pauses mid-TCU "get across the <messa:ge,> (2.2) tha:t". This acts to convey disfluency in the delivery of this preannouncement. Rather than emphasising key words, they were often hastened in their delivery, for example lines 9-10, 27, and 29-30. This acted to shroud (45) rather than emphasise key information, again conveying reluctance or discomfort.

The strategies I have observed of avoiding self-reference, delaying news, hesitance, and disfluency, appear to constitute in-consultations displays of the reluctance GP articulate feeling when having these conversations. This reluctance was evidenced strongly in some consultations where GPs omitted key words related to weight, as I illustrate in the two excerpts below.

In Excerpt 4.56 the GP re-cites the evidence of the patient's obesity at line 1. However, he elongates the adverb "definitely:" and then omits the next projectable word in this turn, which "definitely:" is acting to modify - possibly 'high' or 'too much'. Similarly, in Excerpt 4.57, the GP hesitates during his description of people who are eligible for referral "And so what we're offering >people< who are >sort of<". The next projectable word here is "obese" or an adjective describing the 'people' the GP has made relevant at the start of his turn. Instead he omits this projectable adjective, and continues his turn (with some disfluency).

Excerpt 4.56 11-01-27

```
1  Doc:    You- your weight is definitely: (.)a- and
2          losing weight is (0.3) obviously (.) °helpful°
3         for lots of rea:so:ns,
```

Excerpt 4.57 01-02-02

```
1  Doc:    And so what we're offering >people< um who are
2          >sort of< (.) is u:m,
```

These preannouncements were not the opposite of good news delivery preannouncements. In the good news collection, for example, GPs could occasion the sequence by saying explicitly "so it's good news", congratulating patients, or assessing the upcoming news as positive. Projecting 'bad news' explicitly did not occur here. However, I have outlined how GPs in this collection frequently initiated discussions by *problematising* the patient's weight then presenting a referral as a potential solution. In asserting themselves as 'knowing' GPs asserted patients as 'unknowing' about their own weight, or its associated comorbidities. The features of this news delivery format share many of the features of a 'bad' news delivery. The non-lexical features in particular, including hesitation, disfluency, prosody, and volume, frequently convey 'regret' in their telling (49). However, I am reluctant to call these delivery sequences '*bad* news' deliveries as the referral is presented as a possible solution to a clinical problem (even though it's a clinical 'problem' the GP has opportunistically raised and problematised). Whilst some of these deliveries follow a 'bad news' pattern characterised by "caution, circumspection, or shrouding" (27) we can see this is not always the case in the BWeL trial as the 'news' is 'news of a referral' rather than bad 'diagnostic news'. Rather I have called these 'negative' news delivery sequences. The features of this collection convey negativity but I am unconvinced they go so far as to deliver bad news to these patients. This is evidenced by patient responses, as no patient's orient to this as 'bad news' with "oh no" or "oh dear" announcement receipts. However, in asserting the problems of being overweight, and doing 'being serious', the referral is negatively valenced, and presented as a 'medical treatment' for a 'medical problem'. The GPs' prosody, hesitation, and delays in delivery reinforce this negativity.

4.6.1.3 Preannouncement of neutral news

Preannouncements in the third news delivery format acted to assert neither a positive or negative valence towards upcoming news. The three examples below illustrate how this neutrality was asserted.

Excerpt 4.58 43-01-01

```
1  Doc:    You've (.) received the support line of
2          the u:m >of the study< (.) meaning that
3          um after you've fini:shed with me you go back out
4          and (0.3)  um you will discuss with the researchers
5          um local weight ↑loss programmes. Which
6          might help you to lose some weight.
```

In Excerpt 4.58, there is no preannouncement of news. The clinician starts news delivery with an announcement: "You've (.) received the support line of the u:m >of the study<" and then defers all subsequent details to the researchers, or trial team. The way these a*nnouncements* are constructed is explored in section 4.6.2.3 of this chapter.

If a preannouncement was present, as in Excerpt 4.59, the trial team were commonly asserted as the agents behind the referral. In their turn at line 1 the GPs first says "what they're recommending", followed by "i:s that we", using the plural pronoun 'we' rather than 'I'. This shows potentially dual agents behind the referral. Firstly, the recommendation itself comes from a 'they', an 'other' of which the clinician is not a part, and the suggestion to follow this recommendation is delivered using a collective self-reference (46) "we" which is hearable as including the GP. In terms of footing, the GP is hearable only as the animator of the recommendation (58).

There is no explicit mention of the positivity of the referral, or situating the referral in the negative environment of an information dump or BMI assertion. Prosody also displays no clear valence. There are hesitations at lines 2 and 3 in the preannouncement, suggesting delay in delivery, but news is delivered immediately after this turn, meaning the elaborate preannouncements characteristic of negative news delivery are not present. What marks this out is the absence of all the features

which explicitly valence the preannouncement, and forthcoming news, as 'good' or 'negative'.

Excerpt 4.59 51-01-01

```
1  Doc:    .hhh and what they're recommending i:s
2          that we (.) we suggest (0.4) things that
3          might help you (0.4) lose weight.
```

The final way GPs neutrally preannounce news was to engage in the perspective display series (PDS), which I discussed in section 4.4.2 of this chapter. This was rare only occurring in 6 cases across the BWeL corpus, and exemplified in Excerpt 4.60. In Excerpt 4.60 the GP elicits the patient's perspective from lines 1-2. Rather than assessing, or providing evidence or information, he topicalises weight by asking if the patient has thought about "doing anythink" about her weight, before enquiring if she is interested in slimming clubs. Rather than displaying valence (good or negative) this format requires patients to first assert their own stance towards the referral. This aligns with Maynard's observation that the PDS allows tellers to first elicit a perspective, then tailor subsequent formulation in line with the perspective that has been invited (28). As in the previous excerpts, there is an absence of lexical or non-lexical features which act to assert a positive or negative valence towards forthcoming news.

Excerpt 4.60 25-06-05

```
1  Doc:    Have you ever thou:ght about doing anythink
2          about your weight?
3  Pat:    Yes.=
4  Doc:    =Yeah. Would you be <interested> in using one
5          of the slimming ↓clubs?
6          (1.7)
7  Pat:    No. hhhh
8  Doc:    °No? Not at all,° Even if I said it was free?
```

I have presented my analysis of these pre-announcement sequences in detail. These act as an initial assertion of valence towards the news. Their placement at the start of the sequence acted to situate the forthcoming referral in an environment where 'positivity', 'negativity', or 'neutrality' had already been asserted. They were also where valence towards the upcoming news was most strongly conveyed. Once a valence was asserted it rarely changed following patient response. Many features of

talk I have shown to be present in these preannouncements were used consistently to maintain a valence throughout the rest of the news delivery sequence. I therefore, summarise subsequent results, presenting less detail, as I have already explicated their features in this section.

4.6.2 Announcement

In the announcement turn, GPs stated that a referral was available for patients, for free. In the sections below, I show how a valence could be asserted in these turns, although this was typically far less explicit than during the preannouncement. Some features used in the preannouncement were also evident in these announcement turns.

4.6.2.1 Announcement of good news

Excerpt 4.61 31-04-46

```
1  Doc:    Part of this trial that we're doing is to
2          encourage you to join Weight £Watche:rs:,
3          Slimming Wo:rld,£ And the good thing about
4          doing it through £the trial (.) is you will
5          get that free of charge£?
6  Pat:    Right.
```

The GP uses a collective self-reference "we" when starting the announcement of news, hearable as including the GP. At line 2 her utterance "encourage" presents acceptance of the referral as a preferred course of action. She states explicitly that the "good thing" about the trial is that the referral is free. This acts to valence the referral as generally good, even if not personally assessed as 'good' by the clinician. This is delivered with few hesitations, and with smiley voice towards the end of the announcement.

Explicit lexical devices, illustrated above, to valence news announcements were not used consistently in this collection. However, non-lexical devices in the announcement turn frequently remained consistent with those asserted in the preannouncement, conveying eagerness or excitement in their telling.

4.6.2.2 Announcement of negative news

Excerpt 4.62 09-02-24

```
1  Doc:    So wi:th um (0.3) this study (0.3) >you know<
2          they would in you're your you chosen an arm
3          where they would be prepa::red to offer you
4          free of charge (.) some sessions at a local (.)
5          °club°.
6  Pat:    Mm mmm
```

The GP announces news of the referral from lines 1-5. The announcement is slow with long drawn out vowel sounds at line 1 and 3. There is some disfluency in the delivery with hesitations at line 1, and repeats of "your" at line 2, but the turn is otherwise delivered smoothly. The referral is delivered from a non-personal footing (47), the GP uses "they" to evoke the trial team as the agents behind the referral, avoiding acting as the author or principle of these referrals. The key word, which conveys details of the referral "club" is quieter than the rest of this turn, acting to partially shroud this information. As with positive valence, some features characteristic of negative valence asserted in the preannouncement are used consistently here.

4.6.2.3 Announcement of neutral news

Excerpt 4.63 17-01-29

```
1  Doc:    Um if you're interested (.) we can: do that via
2          um via the study, So you don't have to pay
3          anything. U:m so it's entirely up to [you.
4  Pat:                                          [Do I
5          have to go somewhere?
6          (0.3)
7  Doc:    Entirely up to you.
```

In Excerpt 4.63 the clinician explicitly avoids assessing the acceptability of the referral, or asserting a personal stance. He firstly maintains a non-personal footing, through use of 'we' pronouns, meaning he is hearable as the animator of these referral but not explicitly as the author or principle. The announcement is presented conditionally on the patient's choice "if you're interested" rather than assessed as positive by the clinician (typical of good news), or presented as a necessary solution

to a clinical problem (typical of negative news). Following this, the GP explicitly presents referral as wholly dependent on the patient's decision "it's entirely up to you". Following an information request in response to this news, the clinician repeats his statement, "entirely up to you" again, explicitly avoiding providing further details or assessing the news.

The GP's non-lexical features here are consistent with those explicated during preannouncements of neutral news, conveying neither excitement nor regret in the telling.

This section shows that valence in the GPs announcement turns was mainly achieved by maintaining prosodic features that convey reluctance, excitement, or neutrality in the telling of news. This aligns with existing work which shows the preannouncement is a key sequential placement where a valence towards forthcoming news is most strongly asserted (26). Some lexical features that were initially used during the preannouncement (such as the footing of the delivery, or presenting the referral as a preferred course of action) could also be used in the announcement turns. Neutrally valenced announcements often were not preceded by a preannouncement (section 4.6.1.3) and presented the referral as entirely contingent on the patient's choice.

4.6.3 Announcement response and news elaboration

I have shown so far that GPs delivered news of a free referral. In doing so they employed lexical and prosodic devices to assert a valence towards the news, particularly in the preannouncement turns. Following the GP's announcement of news, patients responded. In their announcement response patients also became involved in exhibiting a valence towards the news that was being constructed. As with any news delivery, recipients in the BWeL trial could support or resist the valence asserted by the GP (45). In the next chapter I focus in detail on patient responses in this sequence. However, in this chapter I show briefly how patients receipted announcements, and how GPs responded when patients supported or resisted the valence which they had asserted.

Using the example of a 'good' news delivery I first show that patients could collaborate in maintaining the valence asserted by the GP, and how GPs responded in their subsequent turn. I then exemplify how patients could resist by asserting their own valence towards the referral, and show how GPs responded.

4.6.3.1 Mutual orientation to valence in news delivery - Maintaining GP-asserted valence

Excerpt 4.64 04-01-01a

```
1  Doc:    As >part of this< trial I can offer you a
2          refe:rral into that at no cost to yourse:lf. So
3          um I think getting weight down would be of
4          um >you know< good benefit, ↑Parti:cularly
5          because of the problem we've been discussing.
6  Pat:    Oh definitely, Yeah.
```

In Excerpt 4.64 the GP asserted a positive valence in her preannouncement, which was maintained through prosody and lexical delivery of her news announcement. In his turn at line 6 the patient displays clear agreement with the GP's statement that weight loss would be of "good benefit", with his turn "Oh definitely, Yeah". This response is delivered soon after the announcement of news, acting further to display affiliation with the stance asserted by the GP. Through this positive response and affiliation display this patient also asserts a positive valence towards the news.

Excerpt 4.65 04-01-01b

```
6  Pat:    Oh definitely, Yeah.
7  Doc:    So £I would very much en:coura:ge£ >to take ↑up<
8          the opportunity.
```

Excerpt 4.65 shows how the GP moves to elaborate the news following this turn. The GP uses a turn initial "So" to index inferential or causal connections between this turn and the previous, and uses a personal footing ("I") and smiley voice to explicitly "encourage" the patient to attend. These features act to maintain the positive valence the GP initially asserted. Maynard states that, during news delivery sequences, tellers' assessments following news delivery typically act to "concretise" p.213 (43) the valence of their original news announcement. Indeed, this excerpt

illustrates that, in the BWeL corpus, GPs often used their news elaboration turns to re-affirm the valence that was initially asserted in the preannouncement.

Over these turns the patient and GP have collaborated to mutually construct the referral as good news. The GP asserts it, it's responded to as such by the patient, and the GP elaborates the good news further.

I have shown 'good' news being received as such by a patient, and elaborated further by the GP. However news is rarely "equal and symmetrical" p.95 (26) in its construction and this became evident as I examined how GPs responded to patients who *resisted* the valence they had asserted. I found that, rather than orienting to patient responses, and tailoring their elaboration accordingly, GPs generally acted to *maintain* a valence thought the news elaboration even if it has not been reciprocated by patients in their announcement response.

4.6.3.2 Enacting Asymmetries of news delivery – resisting GP asserted valence

In this section I continue with the example of good news. I first illustrate how patients resisted the GP-asserted valence. I then exemplify how GPs responded to this resistance.

Excerpt 4.66 17-01-06a

```
1  Doc:    Which we can >if you're interested<
2          which we can refer you to directly
3          through the study.
4  Pat:    Yeah.
```

The GP has asserted a positive valence through her pre-announcement and announcement. At line 4 the patient responds minimally. I explore in the next chapter the specific interactional work that "Yeah." does in this placement, but here we can observe it is not asserting a positive valence, and minimally receipts the news (59).

Excerpt 4.67 17-01-06b

```
4  Pat:    Yeah.
5  Doc:    It is quite fortuitous that you came along.
6  Pat:    Yeah.
7  Doc:    Because it it's free. It doesn't doesn't
8          cost you anything.
9  Pat:    That's fine.
```

In her elaboration turn at 5 the GP upgrades the valence she had initially asserted to explicitly state the patient's visit is "fortuitous". This is received with a second minimal "Yeah." receipt (line 6). The GP then undertakes further news elaboration, emphasising the positive aspects of the referral "it's free" and "it doesn't cost you anything.". This second elaboration at line 7 seem to orient to the patient's prior "Yeah." as a dispreferred response. In continuing news elaboration through asserting the normatively 'good' things about the referral, she seems to be acting to pursue a different, positive, response to her news. The patient receipts this elaboration with a further non-positive valence towards the news "That's fine". "fine" asserts neither a positive nor a negative stance towards the referral, it at most orients to this news as minimally acceptable, and seems to be doing some resistance work to the GP's pursuit of a positive response.

This excerpt illustrates that news is co-created, but also *asymmetrically* constructed. News delivered with a positive valence could be receipted in ways which resisted the positive assertion. However, these responses did not mean that the GP altered the valence they had initially asserted. It was frequently maintained throughout the news delivery sequence. The epistemic asymmetries evident in institutional talk, may make these asymmetries in news delivery more pronounced. The GP's institutional role, and associated status as 'knowledgeable' could account for her ability to maintain her assertion that 'news is good' even if though patient does not receive it as such. Maynard has observed a similar pattern of clinicians persisting with 'good news' deliveries despite patient minimal responses, interpreted by Maynard as resistance displays p.119 (26).

To summarise, in this section I have shown how symmetry and asymmetry towards the GPs valence were enacted. I have used the example of 'good' news here to show that patients could maintain or resist GP-asserted valence in their turns. I showed

that GPs news delivery format in the news elaboration was not contingent on patient responses to the news, but was maintained from their initial valence in the preannouncement.

I now explore *how* news was elaborated and I highlight that the strategies used to assert valence. I demonstrate that the lexical and non-lexical strategies used closely reflect those employed earlier in the sequence, at the point of preannouncement.

4.6.3.3 Elaborating good news

I have illustrated how asymmetries of news delivery became evident in these news elaboration turns. I will now continue with the example of good news to demonstrate how valence was asserted in this placement, and highlight that the same strategies asserted during the preannouncement were used to assert a valence in this news elaboration placement. The pattern was the same for negative and neural news (details and exemplification available in appendix 5).

Excerpt 4.68 30-05-15

```
1  Doc:    So really important that (0.4) we >you kno:w<
2          (0.4) that you do the weight loss (.)and <I'm>
3          ↑I'm really happy that actually you've been
4          (0.4) um given the support arm (0.4) on this,=
5  Pat:    =Good, (.) Okay.
6  Doc:    Okay, So it's really good news,(0.4) Okay.
7          (0.4) .hh and this is where something
8          like this trial will really help.
```

In her news elaboration this GP asserts a clear positive personal stance towards the referral "↑I'm really happy" (line 3). This turn both assesses the referral and asserts a hearably personal stance towards its acceptability and utility. The raised pitch at the start of this turn and the sudden change in pitch at line 3 emphasises the positive delivery. The patient latched to this turn with a speedily delivered 'good' displaying affiliation with the GPs statement (60). In her next elaboration turn, at line 6, the GP explicitly assesses the referral as 'good news', before asserting the helpfulness of the trial. Her speedy delivery conveys eagerness in this elaboration. As with preannouncements of good news, this news elaboration is also brief. This excerpt

illustrates that features present in the preannouncement reoccur in these elaboration turns: first person reference conveying a personal footing; assessing the referral positively; conveying the referral as helpful, rather than necessary; and non-lexical features conveying excitement in the telling.

Post-announcement assessments have been shown to assert a valence towards news. The evidence here aligns with this work showing that valence was asserted during elaboration turns, where GPs commonly assessed the news of a referral. They typically maintained the valence asserted in the preannouncement, and did so using the same conversational features I highlighted in that placement.

Table 4.3 illustrates the lexical and non-lexical devices used by GPs which act to assert a positive, negative, or neutral valence. Following Freese and Maynard (43) I will note that not all of these features were present in each news delivery format. The presence of these lexical and non-lexical features in the sequences presented here worked together to display a valence towards the news in progress.

Table 4.3 Characteristics of news delivery formats in the BWeL trial

Negative news	**Good news**	**Neutral news**
Asserts problems of being overweight	Asserts benefits of weight loss	Neither
Patient activity burden emphasised	Patient activity burden minimised	Patient activity burden not mentioned
Long preannouncement	Brief preannouncement	No preannouncement
No Personal stance	Personal stance	No Personal stance
Referral presented as a preferred course of action, by offering a necessary solution to a clinical problem	Referral presented as a preferred course of action through framing as 'as an offered chance or opportunity'	Referral presented as neither preferred nor dispreferred
Information dump: GP asserts themselves as knowledgeable and the patient as unknowedgeable	GP asserts knowledge through assessing the acceptability of effectiveness of referral	GP presents trial team as knowledgeable
Elaboration of news asserts problems of obesity	Elaboration of news asserts benefits of weight loss	Elaboration of news absent, or defers further information giving to the trial team
	Intensifiers to emphasise positivity	
Slow delivery, hesitation, disfluency, or delay during turns	Fast delivery often with faster delivery towards the end of turns	Steady speed with few changes
Key words often quieter or delivered in creaky voice	Key words emphasised with pitch, prosody, or louder volume	
Vowel sound elongated with falling pitch	'Bouncy delivery' rising and falling pitch. Pitch often higher.	
	Smiley voice	Perspective display series

In exploring how GPs deliver the *same* news, I have shown they can valence it as good news, neutral news, or negative news. My analysis of these sequences highlighted that patients seems more likely to accept the referral, and display positivity in their announcement responses when GPs employed a good news delivery format (I examine in detail in the next chapter - chapter five - what constituted these displays of positive reception).

The presence of these three news delivery formats and patient responses to these raises an interesting question about patient in-consultation response and their next actions - are there relationships between news delivery format used by a GP, and patient acceptance of their referral, and subsequent attendance at it? In the next two sections I examine and discuss associations between the news valence GPs assert and these outcomes.

4.6.4 News valence and outcome measures

4.6.4.1 Quantification point and methods of statistical analyses

In this chapter I have explored the features used by GPs which contribute to communicating a valence towards the news of a free CWMS referral. Conversation analysis showed evidence that patients who received news with a positive valence seemed more likely to display agree-to-attend, and less likely to display resistance to the referral during these sequences. Neutral news seemed to receive minimal responses, whilst negative news seemed to generate agreement or resistance. In the next section I examine patient outcomes following these news delivery formats. These outcomes are: agreement-to-attend; attendance at the referral; post-consultation reported satisfaction; and consultation length. I have explained and justified these outcomes of interest in chapter 2. Before I examine these relationships, I first explain and justify my point of quantification, and outline my statistical methods.

I have chosen the preannouncement of news as my point of quantification. The reasons for choosing this quantification point were developed from my conversation

analysis work. There were firstly, that news is co-created and, very rarely, some GPs downgraded the valence of their news following patient response. Quantifying the valence in the preannouncement shows how news was embarked upon by GPs, even if they later oriented to patient responses and downgraded their valence. Secondly, pre-announcements here, and in the existing literature, are key in exerting a valence, and situate news delivery in this environment of positivity, negativity, or neutrality. Thirdly, subsequent assertions of valence typically acted to "concretise" p.213 (43) the valence of the original pre-announcement, rather than doing a different action. Fourthly, analysis of patient responses (chapter five) showed that patients display positively or negativity to the referral early in the consultation, in the announcement response placement. Therefore, focus on GP action before these responses, which could be likely to generate this positive or negativity, is important. Finally, this part of this sequence was most relevant in terms of GP training resource development – identifying in what ways GPs can initiate news deliveries that are likely to be well received and associated with patient action.

I developed descriptions of the lexical and non-lexical features of good, negative, and neutral news from conversation analysis, which I have shown in Table 4.3, and discussed in the previous section. I then classified all types of news delivery across the corpus as delivered with a 'good,' 'negative,' or 'neutral' valence during the preannouncement of news. A subsection of these were checked by Webb, who agreed with these classifications. Where valence classification was not straightforward Webb and I discussed these excerpts with particular attention to non-lexical features, and agreed upon final classification.

As I detailed in chapter 2, I conducted univariable logistic regression analyses to explore associations between GP-asserted valence and agreement to attend, and then attendance at the CWMS. I calculated odds ratios (ORs) and 95% confidence intervals (CI) for the likelihood of attending, relative to the most common news delivery valence classification which was 'neutral'. I used linear regression to explore relationships between news delivery type and the variables 'patient satisfaction' and 'consultation length'. I then adjusted for participant age and gender as potentially confounding variables, and conducted multivariable logistic and linear regression analyses. I present the results of these analyses in the section below.

4.6.4.2 Results of statistical analyses

In line with results from conversation analysis regression analyses showed that a positive valence was more likely to be associated with agreement-to-attend than a neutral valence (95% vs 72% agreed-to-attend; Univariable OR=7.81 (95% CI=2.27-26.92), p=0.001; Multivariable OR=7.47 (95% CI= 2.14-26.06), p=0.002). There was no difference between negative valence and neutral valence in terms of patient agreement-to-attend (67% vs 72% agreed-to-attend; Univariable OR=0.81 (95% CI=0.43-1.52), p=0.51; Multivariable OR=0.74 (95% CI= 0.39-1.43) , p= 0.37), (Table 4.4).

As well as more likely to agree-to-attend, patients who received news delivered with a positive valence were also more likely to actually attend their referral when compared with patients who received a neutral valence (81% vs 33% attended; Univariable OR=8.33 (95% CI=3.93-17.69), p<0.001; Multivariable OR=10.43, (95% CI= 4.57-23.77), p<0.001). There was no difference between negative valence and neutral valence in terms of patient attendance (34% vs 33% attended; Univariable OR=1.04 (95% CI=0.56-1.92), p= 0.91; Multivariable OR=1.11 (95% CI= 0.59-2.12), p= 0.74), (Table 4.5).

The mean referral length was 109 seconds (s) (SD 79) for patients who received a good news delivery format, compared with 73s (SD 60) in neutral news deliveries (Univariable difference in means=36.93 (95% CI= 15.15-58.70), p=0.001; Multivariable difference in means=41.42 (95% CI= 19.98-62.87), p<0.001). Therefore, good news deliveries took significantly longer (average= 37s) than neutral news deliveries. The mean referral length was 112s (SD 69) for patients who received negative news, compared with 73s (SD 60) in neutral news deliveries (Univariable difference in means =39.68 (95% CI=20.66-58.70), p<0.001; Multivariable difference in means =45.12 (95% CI =26.26-63.99), p<0.001). Therefore, negative news deliveries took significantly longer (average = 36.68) than neutral news deliveries, (Table 4.6).

The mean satisfaction score was 4.43 (SD 4.43) for patients who received a good news delivery format, compared with 4.12 (SD 1.20) for patients who received a

neutral news delivery format, with no evidence of a difference (Univariable 95% difference in means=0.31 (95% CI=-0.03-0.64), p=0.077; Multivariable difference in means=0.28 (95% CI=-0.062-0.62), p=0.11). The mean satisfaction score was 4.19 (SD 0.96) for patients who received a negative news delivery format, compared with 4.12 (SD 1.20) for patients who received a neutral news delivery format, with no evidence of a difference (Univariable difference in means=0.07 (95% CI-0.25-0.40), p=0.66; Multivariable difference in means=0.53 (95% CI=--0.28-0.39), p=0.76), (Table 4.7).

Table 4.4 Relationship between news delivery format and patient in-consultation agreement-to-attend

				Univariable Analysis			**Multivariable Analysis***		
News Delivery format	Agree	Response n(%)	Comparator	Odds ratio	95% Confidence interval	P-value	Odds ratio	95% Confidence interval	P-value
Neutral news**	+	73 (72)	n/a	1	n/a	n/a	1	n/a	n/a
	–	29 (28)							
Good news	+	59 (95)	73	7.81	2.27-26.92	0.001	7.47	2.14-26.06	0.002
	–	3 (5)	29						
Negative news	+	55 (67)	73	0.81	0.43-1.52	0.51	0.74	0.39-1.43	0.37
	–	27 (33)	29						

*Age and gender were adjusted for in these analyses
**Neutral news was used as a comparator

Table 4.5 Relationship between news delivery format and attendance at the referral

				Univariable Analysis			Multivariable Analysis*		
News Delivery format	Attend	Response n(%)	Comparator	Odds ratio	95% Confidence interval	P-value	Odds ratio	95% Confidence interval	P-value
Neutral news**	+	34 (33)	n/a	1	n/a	n/a	1	n/a	n/a
	–	68 (67)							
Good news	+	50 (81)	34	8.33	3.93-17.69	<0.001	10.43	4.57-23.77	<0.001
	–	12 (19)	68						
Negative news	+	28 (34)	34	1.04	0.56-1.92	0.91	1.11	0.59-2.12	0.74
	–	54 (66)	68						

*Age and gender were adjusted for in these analyses

**Neutral news was used as a comparator

Table 4.6 Relationship between news delivery format and consultation length

			Univariable analysis			Multivariable Analysis*		
News Delivery format	Response (n)	Mean referral length (SD)	95% confidence interval	Difference in means	p-value	95% confidence interval	Difference in means	p-value
Neutral news**	102	73 (60)	comparator			comparator		
Good news	62	109 (79)	15.15-58.70	36.93	0.001	19.98-62.87	41.42	<0.001
Negative news	82	112 (69)	20.66-58.70	39.68	<0.001	26.26-63.99	45.12	<0.001

*Age and gender were adjusted for in these analyses

**Neutral news was used as a comparator

Table 4.7 Relationship between news delivery format and post-consultation satisfaction reports

			Univariable analysis			Multivariable Analysis*		
News Delivery format	Response (n)[⊥]	Mean satisfaction (SD)	95% confidence interval	Difference in means	p-value	95% confidence interval	Difference in means	p-value
Neutral news**	99	4.12 (1.20)	comparator			comparator		
Good news	61	4.43 (4.43)	-0.03-0.64	0.31	0.077	-0.062-0.62	0.28	0.11
Negative news	80	4.19 (0.96)	-0.25-0.40	0.073	0.66	-0.28-0.39	0.53	0.76

*Age and gender were adjusted for in these analyses
**Neutral news was used as a comparator.
[⊥]The number of responses reported for 'satisfaction' differs from 'patient responses to news' as not all patient reported post-consultation satisfaction

4.7 Discussion

4.7.1 Summary of findings in the context of current literature

Guidelines recommend that clinicians should discuss weight management with patients. However, there is no evidence base for how to do so, and clinicians state that they require more specific support in delivering these discussions (61). In this chapter I focused on objective two and three of this thesis: to determine the conversational strategies used by GPs in the BWeL trial which were particularly effective or ineffective in producing in-consultation displays of agreement, and post-consultation attendance at CWMS; and to identify how brief interventions could be shortened. I aimed to identify specific aspects of discussing the option of referral which were likely to promote swift and efficient sequences, and to examine aspects of delivery that were likely associated with agreement-to-attend and attendance at the referral.

I first identified how brief interventions for weight loss were delivered in practice in the BWeL trial. I showed that the referrals included a news delivery sequence, which comprised of a preannouncement, minimal acknowledgment, news announcement, announcement response, and elaboration turn. This news delivery sequence was followed by an explicit referral question, response to referral question, and closings, completing the referral sequence. I then highlighted specific actions during news delivery, and their sequential placements, which could facilitate a smooth discussion. I first focused on the announcement of news. I showed patients often displayed trouble with what the referral 'actually is'. My analyses demonstrated that this could be avoided by exemplifying CWMS through stating the market leaders (Weight Watchers or Slimming World), prefaced with 'like', to show these were examples of the type of group to which a patient could be referred. I also demonstrated that the words used when describing commercial weight management were important. Descriptions which sounded 'professional' such as commercial weight management 'organisation', 'programme' or 'service' best facilitated a smooth move to next actions. I next showed that providing details and specificities about the cost and location of the referral seemed to expedite these sequences. I then focused on the referral question. I showed evidence that 'would'-prefaced referral questions acted to discourage longer accounts, as they preferred shorter responses.

These results which highlight specific actions, words, and their sequential placement provide detailed information about how best to deliver referral. This information is mostly absent from current guidelines which only provide general advice. This detailed analysis highlighted one area that is present in current guidelines – talking about the location of referral. NICE guidelines on offering referral do exhort GPs to "provide information on programmes available locally" and to "discuss sources of long term support, such as from a… local support group or weight management programme" (Recommendation 6 (62)). They do not, however, explicitly encourage clinicians to say the term 'local', nor do they state where in a conversation this is best placed. My analyses presented here showed that, if the term local was absent, patients would ask questions about the location of the referral, or present travel as a barrier. Saying 'local' during the announcement of news, rather than later in the sequence, facilitated smooth move to next actions. My results here align with NICE

guidelines, and provide more specific detail on how this recommendation can be best followed.

I finally showed that some ways of talking about the offer of a referral made it sound like good, negative, or neutral news. I explicated how GPs achieved this though examining their lexical and non-lexical features, most specifically during preannouncements and news elaborations. Good news was forthrightly delivered, fast, and emphasised the benefits of the referral. Conversely negative news was delayed, shrouded, and emphasised the referral as the solution to a clinical problem. Neutral news stated that a referral was available without presenting any specific positive or negative valence. I took a mixed methods approach to demonstrate that the way these referrals were valenced had important implications for both their uptake or rejection, and also for patient's attendance at their referral.

News delivery in clinical settings has received some conversation analytic attention. Much of this work has an applied focus, explicating how *bad* news is, and can be, delivered (27, 44, 56, 63). There has been a small body of work exploring how footing can be used to construct neutrality in the telling of news (58), and how good news is delivered in clinical settings (25, 45, 50). However, Frankel has stated that "as education and scholarship in this area continue to develop, important questions about how best to communicate not only bad news but 'good news' and 'no news' will be addressed" p.175(64). In this chapter I offered some additional insight into the features of delivering good news in this particular clinical setting. Excitingly here, clinicians are all delivering the *same* news. Previous studies compare normatively positive or negative diagnostic news, for example communicating that a patient does not have heart disease, or does have cancer (45, 56). Conversely, all GPs in this study communicated the same news, but I showed they could valence this in three different ways. This work aligned with Maynard's work on diagnostic news (26), showing there is not inherent 'goodness' or 'badness' to the news of the offer of referral. The GP acted to assert a valence, communicating positivity, negativity, or neutrality.

Maynard and Frankel have demonstrated that "whether medical information is marked as good, bad, or uncertain matters significantly for both delivery and receipt

of diagnostic news" p.249 (65). My results here align with Maynard and Frankel's studies. I showed that the valence asserted by a GP in the preannouncement influenced the type of response that patients displayed in the consultation. Conversation analysis showed that good news presented an "easier path" p.250 (65) than bad news, as patients seemed less likely to display resistance and often displayed positive reception. Statistical analyses corroborated this, showing that patients were significantly more likely to display in-consultation agreement-to-attend the referral following a good news delivery, when compared to neutral news. This examination offers exciting possibilities for understanding how information is neutral until interlocutors act to valence news as holding some relevant type of meaningfulness.

This mixed methods approach offered additional insights into the longer-term effects of news delivery format. Results showed that the same news packaged as 'good', rather than 'negative' or 'neutral' was more likely to result in actual attendance at the weight management service. This chapter has added to this area of research, demonstrating how news of referral is formatted and receipted, but also how news delivery format can facilitate patient action. I demonstrated that employing a good news valence *in* a consultation had significant *post*-consultation implications for patient attendance at their referral. This is the first study to my knowledge to explore actions after news, and identify a relationship between news delivery format and subsequent behaviour.

This analysis of news delivery formats highlighted a contradiction with a recommended practice in NICE guidelines. These advise clinicians to "Discuss the effort and commitment needed to lose weight and prevent weight regain, and the benefit of receiving long-term support" (Recommendation 7(62)). In my analysis of negative news deliveries, I showed that GPs emphasised 'patient activity burden' or, as NICE guidelines describe 'effort and commitment'. Specifically, GPs used lexical features which emphasised the patient action needed to lose weight, and made weight management sound difficult, long-term, and laborious. Conversely GPs who engaged in a 'good news' delivery, used lexical features which minimised patient effort (such as saying lose a *bit* of weight). Whilst patient effort is needed, a brief intervention may not be the best way of communicating this helpfully and

supportively, as conversations which incorporated discussion of effort and commitment were less effective. The way GPs talked about the effort involved in weight loss, and often the *need* for 'long term' or significant changes, may have put patients off attending, or seeking more information. Many weight management services use effective behavioural techniques delivered by a trained coach and lifestyle changes are implemented gradually in a supportive environment, until they become habit. They are not necessarily as sudden or laborious as they were described in many consultations. These topics may be best left to a trained coach at the effective behavioural service once the patient has attended.

Patients have reported that GP's words and tone matter to them (8) and can be motivational or demotivational. I have examined lexical and non-lexical features of weight management discussions in the BWeL trial, identifying for the first time which 'words and tone' are likely to be motivational. Delivering good news significantly increased patient uptake of, and attendance at, referrals to effective behavioral services without generating resistance, thereby addressing a series of concerns GPs report about intervening to change behaviour (66-68). However, this approach did take longer than delivering neutral news. Whilst my focus here was largely on clinician-talk, in the next chapter I examine patient responses during referral sequences, to identify if these offer clues to shorten brief interventions.

4.7.2 Implications for practice

GPs are reluctant to discuss weight. They express concern that patients will respond negatively, that they will open a 'can of worms' lengthening consultations, and that their advice will be ineffective. Should they intervene on weight clinicians have stated that they need more specific information about how to best do so.

These analyses show that offering a referral to CWMS can be both well received and result in patient action. When delivering a brief intervention for weight loss, GPs can deliver 'good news' through presenting the referral as a positive option, rather than a necessary solution to a medical problem. This type of delivery is effective in generating attendance, and patients rarely responded negatively.

Furthermore, GPs can use specific words or phrases which are likely to contribute to shorter discussions. When asking about attendance, saying *would* you be interested, rather than *if*, resulted in shorter responses from patients, avoiding lengthy discussion. Saying that referrals are both *free* and *local* when first telling patients about the opportunity avoids misunderstandings or spending additional consultation time on answering avoidable questions.

Although GPs may be familiar with the term 'commercial weight management service', as described in guidelines, patients are more familiar with the names of market leaders, like Weight Watchers or Slimming World. When offering such services, GPs can use these names to exemplify the referral in ways which patients understand.

Conclusions from this chapter have been incorporated throughout the GP training resource. The resource provides step-by-step exemplification of these discussions, and is framed around the referral sequence I showed in this chapter. Stakeholder engagement highlighted that delivering 'good news' was the most important result from this thesis and so all examples used for the resource for training (appendix 6) comprise good news delivery. Aspects of specific words and their sequential placement have informed the following sections of the final resource: (1) which encouraged clinicians to be confident, as they are unlikely to upset patients, and (5) which states that the referral question should be 'Would you be interested?'.

During stakeholder engagement people with obesity who commented on the 'good news' approach, which incorporated the words and phrases identified in this chapter responded positively, one saying *"I can't emphasise enough how much I'd appreciate this type of support if offered by my GP and I think you're absolutely right to ensure its delivered in an appropriate manner"*.

4.8 Summary

Brief interventions incorporating the offer of referral need not generate resistance, or take a long time, and they can be effective. I have shown that specific words and phrases in specific sequential placements are likely to contribute to brief discussions. I have also shown that a 'good news' approach, although not the briefest way of offering a referral, was very effective in encouraging agreement-to-attend the referral, and actual attendance. This chapter shows that there are specific words and phrases clinicians can use to intervene on weight briefly and successfully.

4.9 Reflections

My analyses of 'oh'-prefaced responses, which are presented in full in chapter five, led me to begin to conceive of the referral sequences presented here as *news*. It was clear to me from the conversation analysis alone that a 'good news' delivery was more successful. However, the results from quantification which showed just how successful this approach was, were really exciting. I think this really shows the value of my initial unmotivated approach to analysis. I analysed 'oh' because I was interested in the interactional work this utterance was doing, and it led me to the wider practice of good news delivery which has clear clinical implications.

Presenting my results here required careful consideration of the appropriate depth of presentation needed to appropriately justify my conclusions. I finally decided to present the key findings in a way which highlighted their clinical relevance. To identify the specific words clinicians had called for, and the 'ways' of talking patients had referred to in the literature, it was necessary to attend to word choice, and prosody, as well as grammar, action and sequence. I am pleased I took this broad focus on the way I presented results as I was able here to address clinicians' concerns, and make clear recommendations for practice.

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Chapter 5

When to stop a brief intervention: In consultation responses to GP delivered brief weight loss interventions, and subsequent patient action.

5.1 Conferences and Publications

A version of this chapter is published:

- Albury, C., Stokoe, E., Webb, H., Ziebland, S., & Aveyard, P. (2018). GP-delivered brief weight loss interventions: a cohort study of patient responses and subsequent actions, using conversation analysis in UK primary care. British Journal of General Practice. 2018; 68 (674): e646-e653 (appendix 7)

Earlier versions of this chapter have been presented at the following conferences:

- Albury, C., Ziebland, S., Webb, H., Aveyard, P. & Stokoe, E. *Associating patient responses to brief opportunistic interventions for weight loss with long-term outcomes*. 6th International Meeting on Conversation Analysis and Clinical Encounters (CACE), Bristol University, July 2017

- Albury, C., Ziebland, S., Webb, H., Aveyard, P. & Stokoe, E. *Associating patient responses to brief opportunistic interventions for weight loss with long-term outcomes*. PriFor Conference, Memorial University, Newfoundland, Canada, May 2017

- Albury C, Stokoe E, Ziebland S, Aveyard P. '*Yeah' versus 'Oh yeah' – Using conversation analysis to examine patient response to very brief opportunistic behaviour change interventions*. South West Society for Academic Primary Care (SW SAPC), Oxford, February 2017

5.2 Introduction

GPs identify concern about lengthy discussions as a key barrier to delivering brief interventions (1, 2). In this chapter I examine patient responses during the Brief Interventions for Weight Loss (BWeL) trial. In the previous chapter I showed that the most effective way of offering referral took average of 109 seconds, and the least effective 73 seconds. However, my explication of referral sequences showed that patients' responses to the news of a free referral occur early in the sequence. Following patient response to the news of a free referral, GPs often entered into negotiation or further explanations, which lengthened consultations. In this chapter I identify patterns of patient response early in a conversation which can offer clues that further discussion in unnecessary and interventions can be shortened.

In this chapter I focus on patient responses to the announcement of the news of the free referral. I explore two patterns where GPs continued to move through the referral sequence, despite interactional cues that this was unnecessary. In the first part of this chapter (section 5.4.1) I analyse two positive reception displays; displays of marked positive stance, and 'oh'-prefaced responses. In the second part (section 5.4.2) I explore the explicit rejection of the offer of referral. Each type of response occurred within a specific sequential placement during the referral sequence and I investigate how the placement of these responses can offer ways to shorten brief interventions, and reduce potential for resistance displays. In section 5.5 I combine results from conversation analysis with outcome data regarding CWMS attendance, enabling exploration of relationships between patient responses to the CWMS referral and future action. I use data on the timing of responses to identify the possible savings in consultation time if GPs oriented to clues that further discussion was unnecessary, and moved to close a discussion. Identifying responses which indicate referral is well received by patients in-consultation, and which can be associated with future action, could help GPs avoid unnecessary negotiations and to keep the brief intervention discussion appropriately short. In section 5.6.2 I conclude this chapter by drawing out the clinical implications of these interactional phenomena, and how they offer trainable elements which will contribute to the development of an information resource for primary care clinicians.

5.3 Areas of interest

The areas below are examined within this chapter.

- Displays of positive reception
    1. How do patients initially display positive reception to the offer of a brief intervention for weight loss?
    2. What are the associations between initial in-consultation displays of positive reception, and post-consultation attendance at commercial weight management services?
    3. Can the referral sequence be truncated following displays of positive reception without affecting patient-reported post-consultation satisfaction?

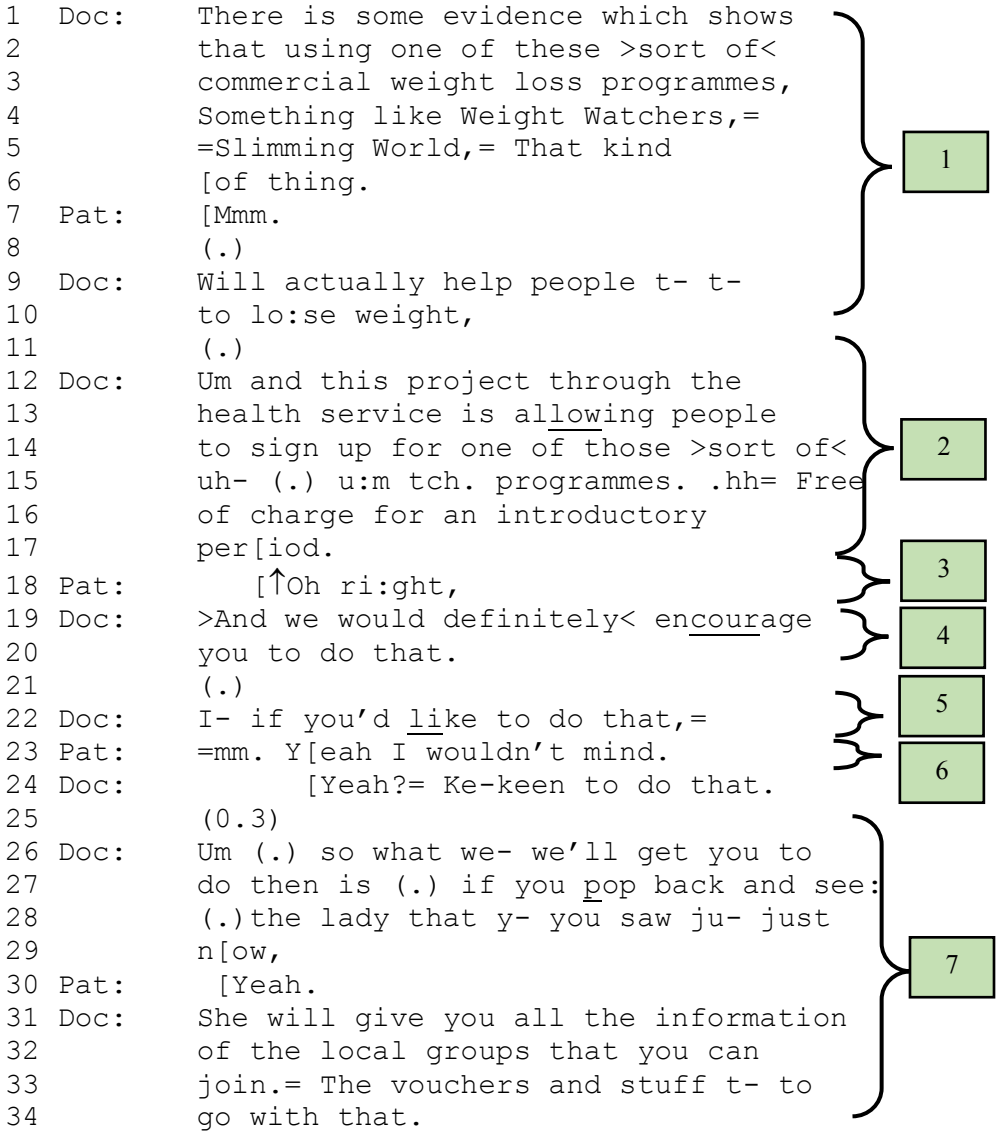
- Explicit rejection of the offer of referral
    1. How do patients explicitly reject the offer of a brief intervention for weight loss?
    2. How do doctors respond to displays of rejection?
    3. Can the referral sequence be truncated following displays of explicit rejection without affecting patient-reported post-consultation satisfaction?

5.4 Analysis

Initial observation led to an interest in what happens at the point in the referral sequence where the patient first responds to the news of a free referral. Excerpt 1.1 illustrates a typical referral sequence. As I explicated in the previous chapter GPs start these sequences with a *preannouncement* which is followed by an announcement of news. Patients produce an *announcement response* which GPs

follow with an *elaboration of news* then an *explicit offer*, which makes a response relevant. *Patients respond* to the offer and GPs move to *closings*. Patients' initial responses occurred either following the announcement of news, or following the explicit referral question, and these two placements (3 and 6, Excerpt 5.1) are the focus of this chapter. As I detailed in Chapter 2, I included audio and outcome data from 226 patients in this chapter. I now briefly explain how I noticed the data presented here, and my placements of interest in this chapter, before presenting my analysis of positive reception displays.

Excerpt 5.1 Actions in a typical referral sequence



Action done at each number in Excerpt 1.1:

1 – Preannouncement

2 - Announcement of news

3 - Announcement response

4 - Elaboration of news

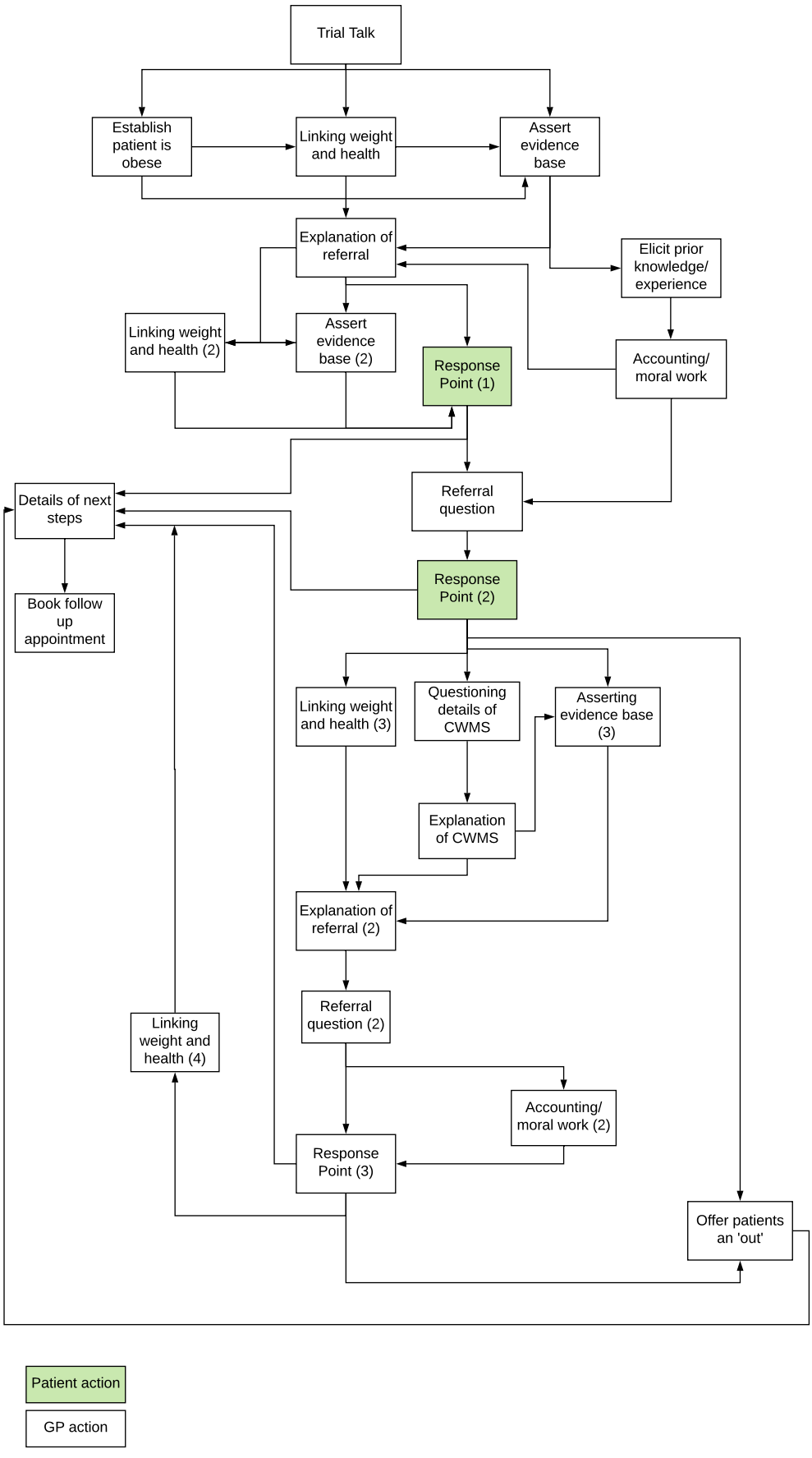
5 - Explicit referral question

6 - Response to referral question

7 - Closings

Each response type presented in this chapter was typically the first response produced by a patient following the completed news announcement. Some were single utterance responses, such as 'oh' or 'yes', whilst others were types of action, such as explicit rejection. The placement of each of these responses within the complete referral sequence are presented in Figure 5.1 which shows where in the detailed action sequence patients first produced responses. Patients produced 15 different verbal responses as their first utterance following news announcement. I initially noticed patients' oh prefaced responses to news announcement, and observed these displayed properties that could be locally oriented to as closing-implicative, but were only rarely responded to as such. I then explored other responses in this placement, and noticed patients' display of a marked positive stance towards the referral. Analysis indicated that both responses functioned to display positive reception to the offer of referral, and in the next section of this chapter I explore these positive reception displays. I also observed explicit rejections of the referral in this placement, which I present in section 5.4.2. These shared characteristics with the positive reception displays; showing potential to be oriented to as closing implicative, but also could be oriented to as sequence expanding. Following conversation analysis, I examined the relationships between patient response and their attendance at the CWMS, which showed evidence that these are cues that could shorten the consultation and have implications for practice.

Figure 5.1 Placement of patient responses within BWeL referral sequence



5.4.1 Displaying positive reception:

I now present two response types produced by patients displaying positive reception.

1. Displays of marked positive stance (MPS)
2. 'Oh'-prefaced announcement receipts

I show when and how patients produced these responses. I then show how GPs responded to these, and demonstrate that these responses provide opportunity to shorten referral sequences. Although I conducted detailed analyses of both of these collections, I will present an overview of my findings on displays of marked positive stance (MPS), as the work these responses were doing was relatively straightforward and consistent with their sematic meaning, before presenting a detailed analysis of 'oh'-prefaced news receipts.

5.4.1.1 Displays of marked positive stance

One response type, produced by 36 patients following the news of the offer of a free CWMS referral, was a statement which went beyond acknowledging the offer of a free referral, but also displayed a marked positive stance as to its acceptability. The excerpts presented below exemplify the production and reception of a marked positive stance (MPS).

Excerpt 5.2 31-01-23

```
1  Doc:    Now (.) this trial really has been all about
2          trying to help people to lo:se weight.
3          (.)
4  Doc:    And there's been a lot of evidence that
5          shows the sort of commercial weight loss
6          programmes (.) things like >Weight Watchers<.=
7          =You kno:w where you go along and you get
8          weighed.
9          (.)
10 Doc:    Measured on a weekly basis. Been well shown that
11         that's a very effective way to ↓lose weight.
```

```
12          (.)
13 Doc:     And the <health service> is trying to see whether
14          it should be putting more money into those ↑kind
15          of programmes.
16 Pat:     Yeah.
17 Doc:     So they're trying to prove whether it does or
18          doesn't work for people.
19          (0.3)
20 Doc:     So (.) what this project is u::h £offering
21          people£ (.) >if you'd like< uh would be
22          a twelve week course through one of these
23          commercial weight loss programmes, paid
24          for by the health service.
25 Pat:→    Lovely.
26 Doc:     If you're keen to do that?
27 Pat:     Yeah. I am.
```

The GP delivers the news of the free referral which also incorporates an implicit offer "if you'd like" from lines 20-24. The patient responds with a display of MPS at line 25, done as an assessment "lovely". This is hearable as an assessment, as it acts to display both alignment and knowledge (3). Assessing the referral as "lovely" explicitly displays a strong positive stance towards its acceptability.

Excerpt 5.3 17-01-12

```
1  Doc:     U:m (.)we know that the >most effective< way
2           to lose weight is through (.) um commercial
3           weight loss programmes, Which (.) i- i:f you're
4           ↑interested (.)we can refer you to no:w, Through
5          the- through the study nurse here for ↑free?= So
6           it won't cost you a ↑bean,
7           (.)
8  Doc:     .hh If you're interested.
9  Pat:→    I- I would do a:nything.
10          (.)
11 Pat:     £Withi(h)n reas(h)on£ hh
```

In Excerpt 5.3 this patient's first response to the referral question is at line 9. They produce a strong display of enthusiasm "I- I would do a:nything." This is produced soon after the GP's turn, and strong emphasis is placed on "a:nything" displaying this patient is keen to lose weight. In her next turn, hearable as a joke, she uses both affiliative in utterance laughter (4) and smiley voice to say "within reason". The patient's response occurs soon after the hearable completion of the news announcement, without any delay in response, indicating positive reception (5, 6).

These two excerpts illustrate that instances in this collection were delivered in close proximity to the implicit or explicit referral question, and usually produced quickly, without hesitation. The pitch was often higher, or delivered with smiley voice, and the turns delivered faster than those the patient had previously produced. These turns displayed clear indication of positive reception, in their placement, prosody, and in the turn design itself. GPs oriented to this frequently, as exemplified below.

Excerpt 5.4 01-01-07

```
1  Doc:    Oh I've opened the envelope (.) and uh
2          £congratulations you've-£ you are in the
3          #suppo:rt arm#, Which means that er you're
4          give- >get given< twelve free sessions at
5          °er° Weight Watchers,= Which I think is
6          in ↑Citychester.
7          (.)
8  Doc:    Is that something that you'd(.)quite fancy
9          doing?=
10 Pat:→   =£Yes plea:se£.
11 Doc:    £Excellent£.= Well we'll pass you forwards to do
12         that.
```

The GP delivers the news of free referral from lines 3-6, followed by another turn explicitly offering referral to the patient. The patient's first response following completion of news delivery is at line 10 where she responds to the explicit offer with "=£Yes plea:se£.". The production of this response, soon after the offer with both an emphasis on the utterance "please" and hearable smiley voice, indicate marked acceptance. The GP orients to the preferred nature of this response with the sequence closing third "£Excellent£.", and then initiates closing immediately after this at line 11-12, saying "Well we'll pass you forwards to do that.".

Responses in this collection were characteristic of preferred responses: their placement was contiguous with the offer, or news of the offer; they were often delivered higher in pitch than surrounding talk - a feature associated with receiving good news (5) - or with a 'smiley voice'; they acted to display affiliation (7), rather than equivocation, or disaffiliation; and they go beyond displaying minimal acceptance to assert a stance as to the acceptability of the offer of free CWMS referral. This response type was frequently oriented to by GPs as a positive reception display, and they regularly initiated closing following its production.

I have provided an overview of my in-depth analysis of these responses here, to demonstrate that some patients in the BWeL trial produced a display of marked positive stance to index clear uptake of the referral, and were responded to as doing so by the GP. However, analysis indicated that a second response type, in the same placement, also displayed positive reception but was rarely attended to as such by the GP. In the next section of this chapter I present a detailed analysis of these responses.

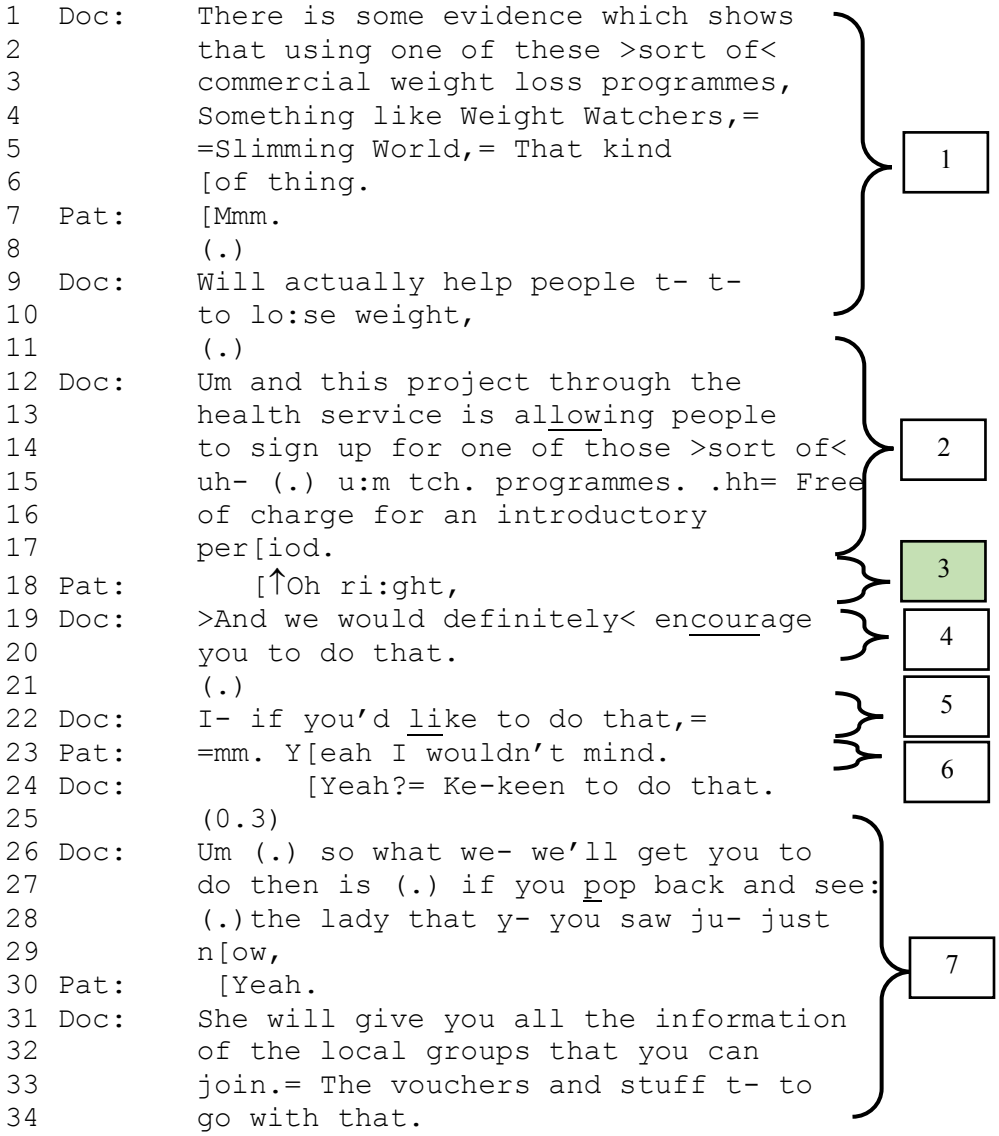
5.4.1.2 'Oh'-prefaced announcement receipts

In this section I examine 'oh'-prefaced announcement receipts. I will first illustrate and exemplify the placement of these receipts within the 'news delivery sequence' (NDS). I then show how patients produced 'oh'-prefaced announcement receipts, and explore the interactional work these achieve. I conclude my qualitative examination of this utterance by identifying how GPs oriented to these responses, and discuss their potential to shorten brief interventions for weight loss in primary care.

5.4.1.2.1 Sequential placement of 'oh'-prefaced announcement receipts

I collected 19 cases where the patient's first response following the news of a free referral was 'oh'-prefaced, or a stand-alone 'oh'. There was some variation in the ways these turns were produced. Excerpt 1.5, below, highlights the typical placement of 'oh'-prefaced turns in my collection in the context of Maynard's news delivery sequence (6) (explored in detail in the previous chapter). This excerpt shows that, following the production of an 'oh'-prefaced announcement receipt, GPs typically elaborated news, then asked an explicit referral question, making a response relevant. Patients responded, and GPs moved to close.

Excerpt 5.1 31-01-39



Action done at each number in Excerpt 1.5

1- Preannouncement

2 - Announcement of news

3 - **Announcement response**

4 - Elaboration of news

5 - Explicit referral question

6 - Response to referral question

7 - Closings

'Oh'-prefaced responses in this collection typically occurred in the proximity of the first projectable TRP following a hearably complete news announcement, as shown on lines 17-18 in Excerpt 1.5. If the announcement of news and explicit referral questions were done as two separate turns (as in in Excerpt 1.5), the 'oh'-prefaced announcement receipt occurred in the placement shown in sequence 1, Figure 5.2. However, if the news announcement and referral question were compounded in their delivery, the 'oh'-prefaced announcement receipt occurred in the placement shown in sequence 2, Figure 5.2. I have shown where 'oh'-prefaced announcement receipts occur within a typical referral sequence, and this is illustrated in Figure 5.3.

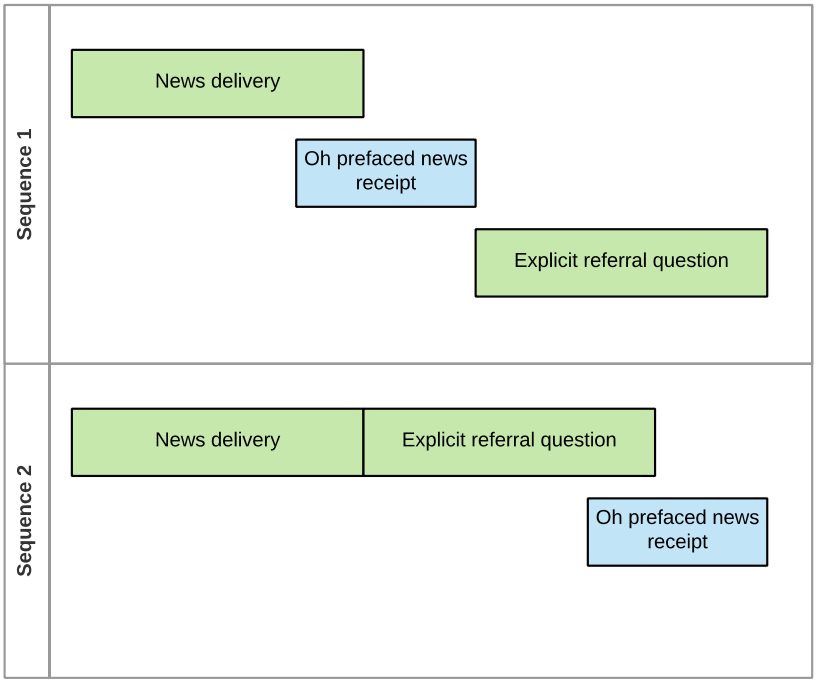
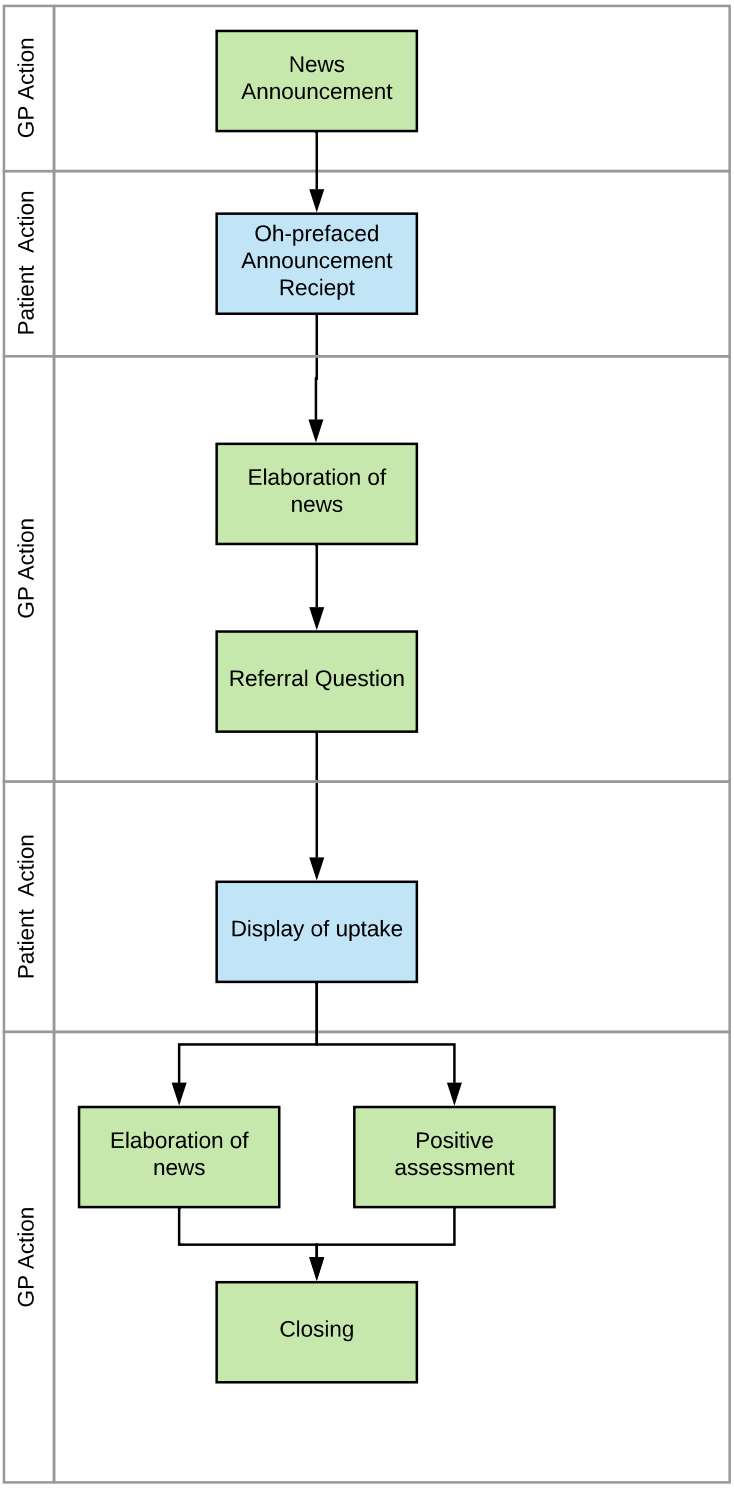


Figure 5.2 Placement of 'oh'-prefaced news receipts

Existing work shows that 'Oh' can have multiple "shadings" p.208 (8) in its production. It frequently does more than one action, often simultaneously conveying a change in awareness, emotional stance, socio-cognitive positioning (affiliation, empathy etc.) and "emotional lamination" p.208 (8) towards news. As Heritage states, the "combinatorial possibilities" of the actions this utterance displays are vast (8), and I now explore the complex work of this utterance in its placement as an announcement receipt.

Although rarely combined with a positively assessing turn component I will explore the conversational evidence that these responses indicate the news of a free referral has been 'good,' and that the consultation sequence can be truncated following their production. 'Oh'-prefaced responses commonly followed a 'good news' delivery. However, whist the previous chapter focussed on these wider news delivery sequence, here I take a tight focus on the patient's response following a complete news delivery, and the subsequent response trajectory, rather than on the GP's actions that may have elicited these responses.

Figure 5.3 Detailed placement of 'Oh'-prefaced announcement receipts in the BWeL referral sequence



5.4.1.2.2 How patients produced 'oh'-prefaced announcement receipts

The extracts presented below exemplify the typical features of 'oh'-prefaced responses to news announcements in my data:

Excerpt 5.2 31-01-39

```
1  Doc:    There is some evidence which shows that using
2          one of these >sort of< commercial weight loss
3          programmes, Something like Weight Watchers,=
4          =Slimming World,= That kind [of thing.
5  Pat:                                [Mmm.
6          (.)
7  Doc:    Will actually help people t- t- to lo:se weight,
8          (.)
9  Doc:    Um and this project through the health service
10         is allowing people to sign up for one of those
11         >sort of< er- (.) erm tch. programmes. .hh= Free
12         of charge for an introductory per[iod.
13 Pat:                                    [↑Oh ri:ght,
14 Doc:    >And we would definitely< encourage you to do
15         that.
16         (.)
17 Doc:    I- if you'd like to do that,=
18 Pat:    =mm. Y[eah I wouldn't mind.
19 Doc:          [Yeah?= Ke-keen to do that.
20         (0.3)
21 Doc:    Erm (.) so what we- we'll get you to do then
22         is (.) if you pop back and see: (.)the lady that
23         y- you saw ju- just n[ow,
24 Pat:                         [Yeah.
25 Doc:    She will give you all the information of the
26         local groups that you can join.= The vouchers and
27         stuff t- to go with that.
```

The GP starts the announcement of news at line 9, saying that this project allows "people" to sign up for free "for an introductory period.". This turn makes an implicit offer of referral. Although the use of "people", at line 10, makes the news seem generally relevant, by delivering this news the GP indicates that it is in some way relevant for this patient. Having already established an understanding of what a commercial weight management service (CWMS) is, and its benefits for weight loss, this subsequent news announcement makes implicitly relevant that the referral is available for this patient. As the news announcement turn is nearing completion, in the projectable environment of a TRP, the patient produces non-lexical discourse

marker “oh” (9) followed by “right” at line 13: “↑Oh ri:ght,”. The production of “oh” in second position here indexes a change-of-state, indicating that the speaker has ‘just now’ moved from a state of not-knowing, to knowing (8-10).

As I stated in chapter one, although most GPs at the time of recording could offer these referrals for free, this was neither common knowledge nor were such referrals usually delivered by GPs, so a change of state here is understandable. However, if all that “oh” is doing is indicating a change of state it could be expected that this response would have been more frequent throughout this corpus. Only 19 from 226 patients produced an “oh” receipt in this placement, but it is unlikely that any patient was expecting the news of referral. The most common response to the news announcement was a minimal response “yeah”, rather than a change-of-state token, as demonstrated in the next two excerpts.

Excerpt 5.7 09-02-15

```
1 Doc:     Well they are quite prepa:red to: (0.3) f-fund
2          through a s- a few sessions,
3          (0.8)
4 Doc:     At one of our local things,
5          (1.1)
6 Doc:     .hh [erm  to help get you back on track.
7 PAT:         [Yeah.
8          (.)
9 Pat:→    Yeah
```

Excerpt 5.8 22-02-03

```
1  Doc:    And (0.4) toda:y (0.6) the researcher is here,
2          (0.4)
3          And uh she is uh (.) giving free vouchers (0.4)
4          for people to join (0.6) exercise programmes and
5          exercise classes like this,
6          (.)
7  Doc:    U::m (.) uh for for people to have successive
8          weight loss,
9          (0.4)
10 Doc:    A:nd (.) usually people have to pay for it. But
11         because (.) because °this is um° something that's
12         available today (.) u:h on the en aich ess.
13 Pat:→   Yeah.
14 Doc:    Is it something that you would be consider- (.)
15         w- #would conside:r#,
```

```
16 Pat:    Yeah.
17         (.)
18 Pat:    Definitley. Yeah.
```

In Excerpt 5.7 and Excerpt 5.8 the GP has completed a preannouncement sequence, which establishes the evidence base for CWMS. Following this they do a news announcement over a series of turns, each with continuing intonation. The GPs signal the completion of news announcement in both excerpts with falling intonation (line 6, Excerpt 5.7; line 12, Excerpt 5.8) and the patients respond with minimal "yeah" receipts. Prior work has shown that the production of an 'oh' receipt is not necessarily associated with the degree to which the answer is unexpected p.309 (10), and this is demonstrated in these data with the relative infrequency of 'oh' receipts, and the frequency of 'yeah' receipts following the completion of the announcement of this unexpected news. The interactional work that 'oh' is achieving then, is likely more complex than just acknowledging a change from 'knowing' to 'not knowing', or indexing a state of 'surprise'(11). Whilst we could observe a number of things about the work achieved by these 'yeah' receipts, at the least they acknowledge that information has been delivered, and do not display a change-of-state in response to its delivery. In avoiding showing a change-of-state they also avoid responding to what has been designed as a 'news' announcement, as *news*. Through avoiding production of an announcement response in this placement recipients can reject the newsworthiness of what has been designed as a news delivery. Additionally, these minimal receipts both avoid affiliating with the telling or asserting a stance towards its acceptability, whilst still following an interactional preference for progressivity (12). In avoiding acknowledging information as 'news' these minimal receipts foreground the work that an 'oh' in this placement may be doing, and I explore this in the next four excerpts:

Excerpt 5.9 01-01-04

```
1  Doc:    Hi it's nice to see you, Thanks fo:r (0.3)
2          opening your envelope, (.) .hh a:nd e:r
3          you're in the support group.
4          (.)
5  Doc:    Which means if you wanted to: (.) .hh you could
6          get twelve (.) free: u:h (.) >weight watch< (.)
7          management classes ↑i:n Citychester.
8  Pat:→   O:h well ↓done,
9  Doc:    If that's what you wanted to do.
```

```
10          (0.3)
11 Doc:     <Is that something> that would interest you?
12 Pat:     Ye:s, I interested in?=
13 Doc:     =Excellent.
14          (.)
15 Doc:     U::m (0.4) after four weeks when you've been
16          going could you come back and see me, And
17          tell me how you're getti[ng on?
18 Pat:                             [Ye:s. Of course,
19 Doc:     Excelle[nt.
20 Pat:            [h hhh hh
```

The news announcement occurs from lines 5-7, compounded with an explicit offer "if you wanted to". The patient responds in the first TRP following the announcement of news with her 'oh'-prefaced turn "O:h well ↓done,". As this is the first time the patient speaks we cannot tell if it is higher in pitch than her previous talk, however it is likely to be so, as her prosody drops near the end of this turn, and remains lower throughout her subsequent talk.

What are designed as news announcements can be responded to as 'news' by a second speaker or can be acknowledged as merely 'information' by withholding from doing so. By producing an 'oh' in this placement (line 8), following news delivery, the patient acts to explicitly mark the prior announcement as "news-for-them" p.7 (13). In doing so, this receipt confirms the "presupposition, relevance, and upshot of the prior informing" p.304 (10). By marking prior talk as 'news', the patient's 'oh'-prefaced announcement receipt orients to this talk as both significant, relevant for the hearer and, therefore as news*worthy*. The GP follows this 'oh'-prefaced turn with an explicit offer, which is not responded to. He then reformulates his offer from a conditional 'if' formulation to an 'is' prefaced question to which the patient responds positively "Ye:s, I interested in?". This uptake of the referral when it is explicitly presented acts to confirm the personal relevance of referral for this patient, displayed through her earlier 'oh'-prefaced turn.

Whilst 'yeah' receipts act to avoid responding to what has been designed as a news announcement as 'news', and reject the newsworthiness of the telling, 'oh'-prefaced announcement receipts act to explicitly mark the prior telling as 'news'. In doing so they align with the GPs project of 'telling the news', by acknowledging that news

has been received, and collaborating in the production of the ongoing news delivery sequence.

Therefore, the production of these receipts highlight not just that information is 'new' but that it is relevant for the hearer, or newsworthy. This provides some evidence that patients are displaying the referral has been positively received (and the news that has been delivered is 'good') as they are acknowledging the information as 'news' and confirming its personal relevance, rather than withholding from doing so.

5.4.1.2.2.1 Placement, timing and prosodic features of patients' 'oh'-prefaced announcement receipts

Further evidence of 'oh' as a display of positive reception of the referral is displayed in the specific placement of a number of these 'oh'-prefaced receipts.

Excerpt 5.10 05-02-07

```
1  Doc:    And as part of this study:,
2  Pat:    Yes.
3  Doc:    You get a free  (0.4) membership, (0.6)
4          [for twelve weeks?
5  Pat:→   [Oh right. Yes.
```

Excerpt 5.11 06-07-21

```
1  Doc:    .hh so if you wanted to do that as part of the trial
2          toda:y.
3          (0.4)
4  Doc:    .hh um (.) we can refer you for a twelve week free
5          (0.6)[um.
6  Pat:→         [↑Oh.
7  Doc:    U:m (.) >membership<.
8  Pat:    Right.
```

The 'oh'-prefaced announcement receipts occur on line 5 in Excerpt 5.10 and line 6 in Excerpt 5.11, both during the projectable completion of the news announcement. These 'oh'-prefaced announcement receipts are not just displaying that news has

been responded to as personally relevant, but they are also acting to target the particular point of the prior telling at which the change has occurred. They are explicitly foregrounding the aspect of the news delivery which is news*worthy* (14). In these cases, they foreground normatively 'good news' components such as 'free'.

In Excerpt 5.11 (above) the patient orients to the projectable completion of news delivery, following the GP's utterance 'free' with an overlapped 'oh' receipt. This occurs in overlap with the GPs' talk at line 6, shortening the distance between the news and news response, indicating good news receipt (5). This turn is also markedly higher in pitch than this patient's prior talk, which is a prosodic feature of positive reception of news (5). In addition to foregrounding 'free' as a potential 'good news' component, the elements of the delivery of these 'oh'-prefaced announcement receipts provide further substantiation for their role in indexing 'good news' in these data, as exemplified below:

Excerpt 5.12 31-4-14

```
1  Doc:    And the: u::m (0.3) the advantage of u:h u- (.)
2          of- of this trial is   that uh we can offer
3          that programme free of charge,= uh- (.)
4          and encourage you to do that.
5  Pat:→   ↑Oh right.
6  Doc:    If you're interested in- in doing that?
7  Pat:    Yes. I think u:h £yeah£.
```

The GP does a news delivery from lines 1-4 in Excerpt 5.12. The news delivery is hearable as complete after line 4 as the GP ends the sentence with the pronoun 'that', carrying turn terminating properties. At line 5 the patient produces an 'oh'-prefaced announcement-receipt '↑Oh right'. This is markedly higher in pitch than the patient's previous talk. This turn also remains high in pitch throughout, only falling slightly to indicate turn completion. Higher pitch following news announcements is a prosodic feature which have been demonstrated in other settings to display receipt of 'good' news (5). Furthermore, the patient produces this turn soon after the GP has finished their turn, without hearable delay in its production. This placement carries affiliative properties (15) and the production of announcement receipts soon after the announcement turn have also been shown to receive 'good' news (5). The GP

initiates a conditional referral question at line 6, “if you’re interested in doing that.”. I have shown in chapter four of this thesis that this question design carries a weaker preference for a preferred response, such as ‘yes’. Despite this conditional formulation from the GP, the patient does respond with a “Yes”, further evidencing their earlier ‘oh’-prefaced announcement receipt as a marker of ‘good’ news receipt. The patient starts their subsequent turn with “I think”, however this turn’s trajectory - potentially an assessment of the potential referral or personal stance marker - is abandoned and restarted after a slight hesitation, for a second affirmative response “Yeah”. This position of the patient’s “yeah” following both an explicit referral question, and a previous “Yes” response, makes this response hearable as an affirmative one, albeit downgraded. Although the additional turn component following “oh” in this excerpt is “right” which does not overtly carry ‘good’ news receipt properties (such as “Oh lovely”, or “Oh good”), this turn carries features of both prosody and placement which display good news receipt (5), and assert an affiliative stance to the GPs telling.

The instances in this collection shared common timing and prosodic features, occurring soon after, or in overlap with a GPs turn, and were usually markedly higher in pitch than the patient’s prior utterances, similarly acting to display an affiliative stance towards the news and index reception of ‘good’ news.

In summary, I have presented evidence so far that ‘oh’-prefaced announcement receipts do a range of interactional work beyond indexing a change-of-state. They can be used to orient to the referral as personally relevant and news*worthy*; foreground particular elements of a telling as particularly ‘good’ news; display both alignment and affiliation with the GPs news announcement; and share similar features in their prosody and timing which indicate the news that has been announced is responded to as ‘good news’. Rather than doing just one action ‘oh’ seems to convey these multiple shadings (8) in its production. From these analyses we can see this utterance may act to display the GPs’ news announcement is well received. Whilst the complexities of this utterance, and its role in displaying positive reception, were clear from my initial collections, this function was not always evident to GPs when engaging in the referral sequence.

5.4.1.2.3 GP Reponses to 'Oh'-prefaced announcement receipts

I will now demonstrate the two ways that GPs responded to a patient's 'oh'-prefaced announcement receipt, and the implications of these responses for wider referral sequence. I first show that some GPs entered into a news elaboration following an 'oh'-prefaced response, but that patients often indicated this was unnecessary. I then illustrate how some GPs moved to close following 'oh'-prefaced announcement receipts, and discuss the properties of 'oh' which they may have oriented to as closing implicative.

5.4.1.2.3.1 Orienting to 'oh'-prefaced announcement receipts as occasioning news elaboration

Excerpt 5.13 26-01-04

```
1  Doc:    U:m (0.8) it would be a very good idea for you
2          to (.)lose some weight,=
3  Pat:    =M[hm.
4  Doc:    [and today I am able to offer you the chance
5          hh erm for us to do you a referral,
6          (.)
7  Doc:    So you can have some help doing th[at.
8  Pat:→                                     [O:h ye:ah!,
9  Doc:    Because we know that if you have he:lp using
10         a (0.6) a programme be it >°Weight Watchers°<
11         or something like th[at.
12 Pat:                        [Mhm=
13 Doc:    = You're much more likely to succeed.
14         (.)
15 Doc:    So (.) do you feel you'd like [t-
16 Pat:                                  [Oh-ho y(h)es
17         plea:(h)se, .hh [hhh
18 Doc:                    [Go ahead with that. Okay,=
19         =That's fabulous, I ticked the right box then?
```

The patient produces an 'oh'-prefaced response at line 8 "O:h ye:ah!". This highlights the newsworthiness of the announcement. The patient places strong emphasis on this overlapped turn, starting each utterance at a higher pitch and moving down each word. This emphasis makes the patient's response hearable as displaying enthusiasm towards the referral, and receiving good news (5). The placement of this enthusiastic receipt at the hearable completion of news

announcement also marks news as complete, as enough information has been received to display a response. Despite this display from the patient, in the GP's next turn they enter into a news elaboration, which acts to account for the offer; asserting the evidence base and likely outcomes of attendance. This elaboration provides further information which was absent from the first news announcement, but receives only an acknowledgement token "mhm" during its production. In producing this minimal response, the patient avoids responding to this elaboration of news as relevant or necessary, further evidencing that news delivery has already been marked as complete by the patient.

At line 15 the GP initiates what is projectable as an explicit referral question "So (.) do you feel you'd like t-" and the patient responds in overlap with marked agreement at line 16 "Oh-ho y(h)es plea:se hh hhh". The placement of this response, which projects the referral question before it has been articulated, also acts to indicate that a referral question was unnecessary. Furthermore, the 'oh'-preface to this polar question acts as a marked confirmation which also indicates the question is in some way inapposite or unnecessary (8). This indicates agreement to this response may have already been implied earlier in the consultation. The laughter during delivery and marked 'y(h)es plea:se" act as a strong display of agreement and affiliation, indicating this offer has been positively received. The GP responds to the patient's explicit agreement at line 16 as agreement to go ahead with referral and positively assesses his decision "That's fabulous". In this excerpt (Excerpt 5.13) the additional turn component in the patient's 'oh'-prefaced announcement response "O:h ye:ah!," does not explicitly assess the news as good, potentially accounting for the GP's news elaboration in their subsequent turn. However, GPs also responded to explicitly positively assessing additional turn components as requiring news elaborations, as I illustrate in Excerpt 5.14 .

Excerpt 5.14 25-04-09

```
1  Doc:     So (.) we're opening the onvelope and it
2           (.) the- it shows that- of the categories of
3           treatment we've got for you (.)we can
4           offer you .hh erm (0.3) a referral to (.)
5           a local(0.3) .tch u::m weight management
6           >sort of< weight watchers type of programme.=
7  Pat:→    =Oh good,
```

```
8  Doc:    Oka:y?
9          (.)
10 Doc:    U::m (.) so when you go back out, you need to
11         take this form with you to see the to see the
12         researcher. And she'll talk through the
13         details of that.
14         (.)
15 Doc:    The reason we're doing this >and the importance
16         of this< is we know that (.) helping people
17         to reduce their we:ight <if they're a bit
18         overweight< (.) helps to reduce risks of    (.)
19         diab[etes,
20 Pat:        [Diabetes,=
21 Doc:    =And hea:rt disease. And >those sorts of things<.
22         (.)
23 Doc:    So (.) it is impo:rtant.
24         (.)
25 Doc:    And there are some lifestyle changes that
26         (.) they'll go through with you, As part of
27 Doc:    this treatment programme.
28         (.)
29 Doc:    U:m (.) >and the intention and the aim really<
30         is to try and help you lose a bit of that
31         extra weight that [you've go[t at the moment.
32 Pat:                      [Yeah,    [Yeah, yeah.
```

The GP starts the announcement of news at line 2 stating that he is able to offer a referral to CWMS to the patient, who responds to this news with an 'oh'-prefaced response. This turn acts as a news receipt. It receives news ("oh"), and assesses it ("good"), and it's 'assess-ability' marks the news announcement as complete (16, 17). The GP seems to orient to this response as acknowledgement of the offer, as he does a sequence closing confirmation receipt "Oka:y?", before initiating a typical closing. He sign-posts to the patient that they need to see the researcher on their way out who will "talk through the details of that". However, instead of concluding the consultation, the GP re-opens the referral sequence with an elaboration of news from lines 15-21, which accounts for why the offer has been made, and which asserts the benefits and importance of weight loss. The patient's late-placed anticipatory co-completion at line 20 displays affiliation and collaboration with the GPs account (18, 19). Her repeated "Yeah, Yeah" at line 32 acts to display a 'no problem' agreement (20), highlighting that this part of the discussion may be unnecessary. We can observe that the 'oh'-prefaced response asserts a stance which is maintained thought the rest of the consultation through affiliation and agreement markers. It also acts to mark news delivery as complete. Despite patient indication that no further news is

required, I have shown that GPs frequently oriented to these receipts as requiring further information, and patients responded showing this was not required. However, this was not always the case. Some GPs oriented to the patient's 'oh'-prefaced announcement receipts as closing implicative.

5.4.1.2.3.2 Orienting to 'oh'-prefaced announcement receipts as closing implicative

Excerpt 5.15 01-01-04

```
1  Doc:    Hi it's nice to see you, Thanks fo:r (0.3)
2          opening your envelope, (.) .hh a:nd e:r
3          you're in the support group.
4          (.)
5  Doc:    Which means if you wanted to: (.) .hh you could
6          get twelve (.) free: u:h (.) >weight watch< (.)
7          management classes ↑i:n Citychester.
8  Pat:→   O:h well ↓done,
9  Doc:    If that's what you wanted to do.
10         (0.3)
11 Doc:    <Is that something> that would interest you?
12 Pat:    Ye:s, I interested in?.=
13 Doc:    =Excellent.
14         (.)
15 Doc:    U::m (0.4) after four weeks when you've been
16         going could you come back and see me, And
17         tell me how you're getti[ng on?
18 Pat:                            [Ye:s. Of course,
19 Doc:    Excelle[nt.
20 Pat:           [h hhh hh
```

I previously showed how this patient responds to the news of a free referral. In the first TRP following the announcement of news she displays an 'oh'-prefaced response "O:h well ↓done" (line 8). As in Excerpt 5.14 this news receipt assesses the announcement and does not request further information. The GP orients to this and truncates the news delivery sequence in response. Rather than entering into an elaboration of news, he follows the 'oh'-prefaced turn with an explicit offer (line 9-11), which the patient uptakes (line 12). The GP positively assesses this at line 13 "Excellent" and moves to the closing part of the referral sequence. Whilst Excerpt 5.15 shows the GP truncating following an explicit positive assessment, these sequences could also be truncated without the presence of an explicitly assessing turn component.

Excerpt 5.16 04-03-11

```
1  Doc:    Right so .hhh I'm very pleased to say that uh
2          you've drawn uh uh this: this side,
3          (.)
4  Doc:    Because we've got the option to offer yo:u (.)
5          well good opportunity to offer you .hh um .tch
6          the chance to have fully er funded on the
7          en aich es (.) uh tweleve >uh uh sort of<
8          uh Slimming World .hh u:m to help lose weight,
9  Pat:→   O:h right,
10 Doc:    Would you like to do that.
11 Pat:    U:h: (.) yeah?
12 Doc:    Yeah?
13 Pat:    h [hhh h h
14 Doc:      [Very good.
```

The news delivery is hearable as complete at line 8; as the nature of the offer, and its price and function have all been laid out (lines 4-8). The patient responds with an 'oh'-prefaced announcement response at line 9 "O:h right,". Although 'right' does not explicitly assess the news as 'good', it also does not explicitly request further information, therefore acting as a news receipt (10). As in Excerpt 5.15 the GP truncates the referral sequence following the 'oh'-prefaced news receipt, and omits the news elaboration. He moves to do an explicit offer at line 10, which receives minimal agreement. Following this excerpt, the GP moves to close the consultation.

The literature on 'oh'-prefaced responses to news announcements has also observed the sequence expanding or closing properties of this utterance. 'Oh'-prefaced announcement receipts, when produced in environments where news is hearable as complete, or almost complete, have been observed to have three characteristics. *News receipts* receive news and discourage its elaboration, marking news announcements as complete; *news marks* encourage elaboration, marking news announcements as potentially incomplete; and *standardised 'oh'-prefaced assessments* (SOPA) are more ambiguous, and can be oriented to either implicitly encouraging or discouraging elaborations of news (6, 21). In marking news as complete, or incomplete, and encouraging or discouraging elaboration of news, we can see these announcement responses have sequence terminating, or sequence expanding properties.

Table 5.1, below, illustrates the additional turn components in this collection. Whilst they may be news receipts, or SOPAs, none of these act as a news marks, explicitly requesting further information (e.g. “Oh really?”(6)).

Table 5.1 Additional turn components of ‘oh’-prefaced news receipts

Number	Response	Frequency
1.	oh right	7
2.	oh yes	2
3.	oh	2
4.	oh yeah	1
5.	oh good	1
6.	oh brilliant	1
7.	oh well	1
8.	oh I see	1
9.	oh I'd love to do it	1
10.	oh okay	1
11.	oh well done	1
Total		**19**

Previous research has observed that while SOPAs and news receipts do not explicitly request further information, the key difference between the two is that SOPAs are ‘weaker’ in their sequence terminating properties (6, 22). However, I have observed that “oh right” produced with similar placement, timing, and prosody can close sequences in some consultations and expand them in others. In these data the difference likely lies in how these responses are responded to by the GP, not necessarily in how they are produced. When responded to as indicating completeness of news, and therefore as closing implicative, these ‘oh’-prefaced announcement receipts facilitate truncation of the news delivery sequence. If oriented to as requesting further information and therefore sequence expanding, patients sometimes displayed that the news elaboration was inapposite or unnecessary (Excerpt 5.13). There were no instances of a patient displaying interactional difficulty, or requesting further information, when a GP oriented to their announcement receipt as indicating

completeness of telling, and sequences were truncated. Therefore, patient responses following an 'oh'-prefaced announcement receipt can be seen as marking news as both complete and positively received.

5.4.1.2.4 Patient response trajectory following 'oh'-prefaced announcement receipts

I have shown that patients asserted a positive stance towards the referral through their production of 'oh'-prefaced announcement receipts. In the next three excerpts I illustrate that this stance was maintained when the referral question was asked explicitly.

Excerpt 5.17 56-02-03

```
1  Doc:    So (0.9) what we know about losing weigh[t,(.)=
2  Pat:                                               [Mhm.
3  Doc:    =Is that the best way is to go through one
4          of the commercial weight (.) management
5          programmes.
6  Pat:    Okay,
7  Doc:    So u:m °like Weight Watchers°,
8  Pat:    Yeah.
9  Doc:    And if you're happy with that um we've got
10         a free um twelve week trial for that.
11 Pat:    Oh brilliant,
12         (.)
13         Yes plea:se.
14  Doc:   U:m (.) so if you want to do that (.) if you just
15         go back to the researcher, She'll put you in
16         contact. Arrange everything for you.
17 Pat:    Oh gre:at, Yeah.
18 Doc:    And then (.) um (.) that >might be< brilliant.=
19         = And help you with your weight.
20 Pat:    Yeah, ↑Oh I'd really welcome that.
21         (.)
22 Pat:    Its >actually something< that I did speak to a
23         doctor about pre:viously.
```

The patient produces an 'oh'-prefaced announcement receipt at line 11 "oh brilliant", in response to the GP's news announcement. This response, combined with a positively assessing additional turn component, explicitly receives the news as 'good'. This asserts a positive stance towards the referral, which is maintained as the

patient accepts the offer in their next turn "Yes plea:se". The GP then outlines next steps from lines 14-16 and re-topicalises the referral at line 18, with an assessment "That >might be< brilliant.= And help you with your weight.". The patient displays further positive responses at line 20 "↑Oh I'd really welcome that", and states she has previously discussed weight loss with a doctor. The patient asserts a positive reception of the offer with her initial 'oh'-prefaced turn and this is maintained through the subsequent sequence. Although this patient's announcement receipt (*oh*) is combined with a positively assessing turn component (*brilliant*), the pattern was similar when this was not the case, as I show in Excerpt 5.18:

Excerpt 5.18 23-04-14

```
1  Doc:    We do know that the best way for you to lose
2          weight is actually having had- being part
3          of a kind of commercial weight management
4          <se:rvice>, Things like Weight Watchers
5          and Slimmer's World? And people actually
6          do really well for that.
7          (.)
8  Doc:    And I can actually now refer you for free
9          if you'd like,
10 Pat:→   ↑Oh,=
11 Doc:    =And it's a programme of <twelve weeks>, And
12         you get twelve weeks free?
13         (.)
14 Doc:    .hh um and um (.) we'll follow you up >as well<
15         in about a month. Just to review how
16         you're >getting on<.
17 Pat:    That sounds goo:d,
18 Doc:    £It do:es sound good doesn't it£,
19         (.)
20 Doc:    It's [excellent £LUCKY YO:U: ITS ABSOLUTELY=
21 Pat:         [ye:ah .hh hh .hh
22 Doc:    =BRILLIANT. YA:H!£=
23 Pat:    Yea[h .
24 Doc:       [So bonus for coming today,
25 Pat:    Yeah.
```

The GP announces the news on lines 8-9 using "actually" to indicate this may be contrastive to what was expected (23) "And I can actually now refer you for free if you'd like,". This turn both delivers the news of the free referral ("and I can actually now refer you for free") and explicitly offers it to the patient ("if you like"). The patient responds on line 10 with a free-standing 'oh' receipt which is higher in pitch than their prior talk. I have observed that this marks news delivery as complete, and

orients to the telling as 'good news'. The GP then enters into news elaboration from lines 11-16, and the patient responds on line 17 with a positive assessment of this referral question "That sounds goo:d,".

Some patients asserted a positive stance, which they subsequently maintained, as in the previous two excerpts, I now illustrate that others upgraded their display of positive reception towards the referral when the referral question was done explicitly.

Excerpt 5.19 26-01-04

```
1  Doc:    U:m (0.8) it would be a very good idea for you
2          to (.)lose some weight,=
3  Pat:    =M[hm.
4  Doc:       [and today I am able to offer you the chance
5          hh erm for us to do you a referral,
6          (.)
7  Doc:    So you can have some help doing th[at.
8  Pat:→                                    [O:h ye:ah!,
9  Doc:    Because we know that if you have he:lp using
10         a (0.6) a programme be it >°Weight Watchers°<
11         or something like th[at.
12 Pat:                        [Mhm=
13 Doc:    = You're much more likely to succeed.
14         (.)
15 Doc:    So (.) do you feel you'd like [t-
16 Pat:                                  [Oh-ho y(h)es
17         plea:(h)se, .hh [hhh
18 Doc:                    [Go ahead with that. Okay,=
19         =That's fabulous, I ticked the right box then?
```

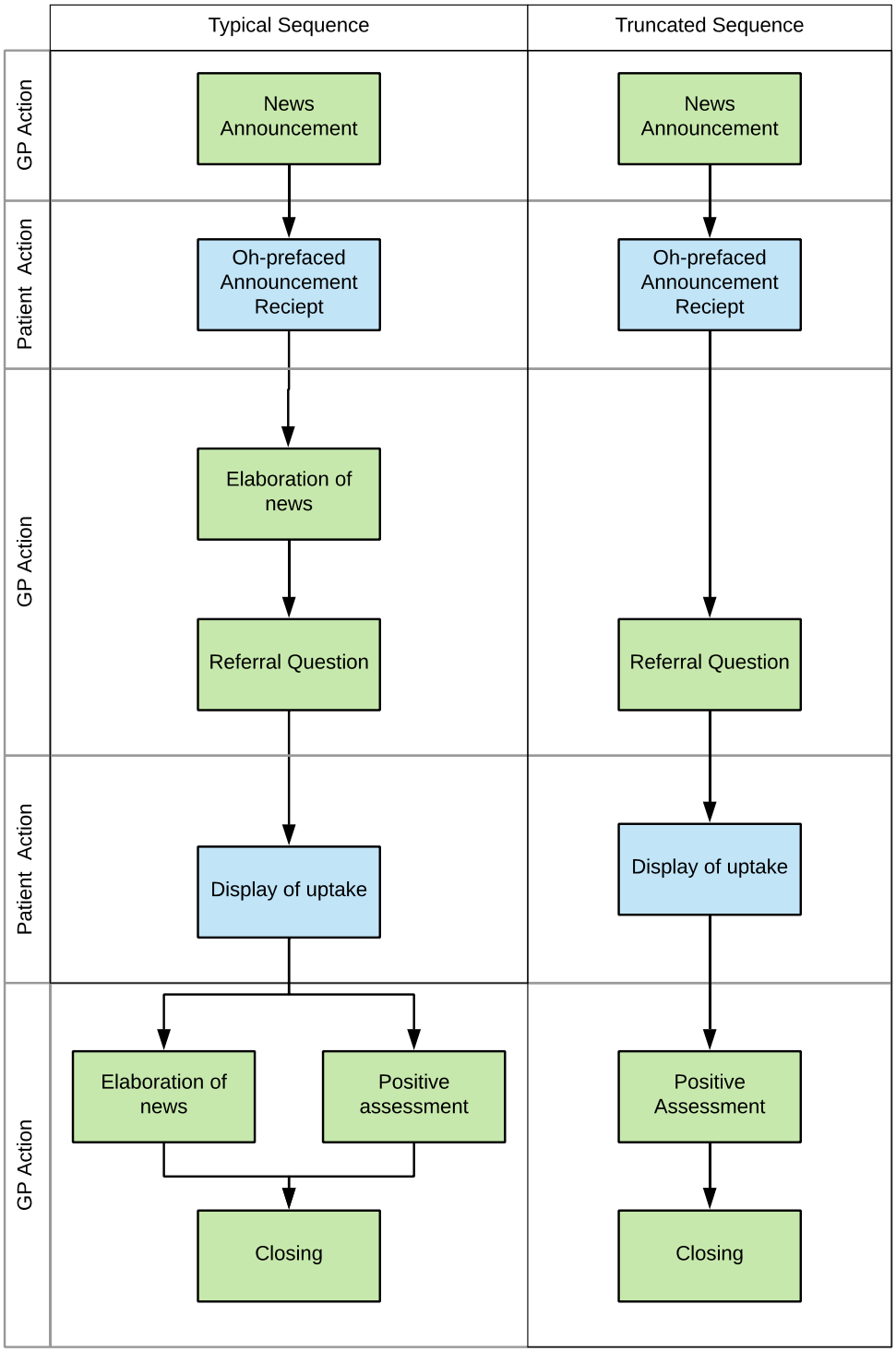
In Excerpt 5.19, above, I return to the patient whose first response following the announcement of news is "oh" followed by "yeah" (a turn component which does not explicitly act to display positively towards the referral). This turn is strongly emphasised, with wide intonation contours moving from high to low, and occurs in overlap with the clinician's announcement. I have already observed that this type of response production marks news delivery as complete, and orients to the telling as 'good news'. The GP then enters into news elaboration from lines 9-13 before delivering the explicit referral question at line 15. Here the patient upgrades from their initial response to "oh-ho y(h)es plea:se hh hhh" following the explicit referral question. The "yes please" asserts stronger uptake of the offer than the initial enthusiastically delivered "O:h ye:ah!,". The patient's stance towards the telling,

initially displayed through her 'oh'-prefaced announcement receipt at line 8 is upgraded at this later point in the sequence and expressed explicitly with her positively assessing turn.

I have illustrated in these three excerpts that once a stance was asserted in these data it could be maintained or upgraded. There were no instances where an 'oh'-prefaced response at news delivery was followed by rejection of the referral. 'Oh'-prefaced turns explicitly or implicitly display that a referral has been positively received, foreshadowing subsequent acceptance. In doing so, they indicate further news elaboration is unnecessary and indicate that referral sequences can be truncated. Figure 5.4 illustrates this truncated sequence.

In section 5.5 I analyse these results quantitatively. I explore relationships between positive reception displays (displays of marked positive stance, and 'oh'-prefaced news receipts) and patient agreement-to-attend in the consultation; post consultation satisfaction score; and attendance at their free referral. In line with my objective of shortening interventions I also explore how much time could have been saved if GPs had oriented to positive reception displays and moved to close. Before presenting these quantitative analyses, I qualitatively explore a further response type which also had potential to offer a cue to close the consultation.

Figure 5.4 Truncated referral sequence following 'oh'-prefaced announcement receipts



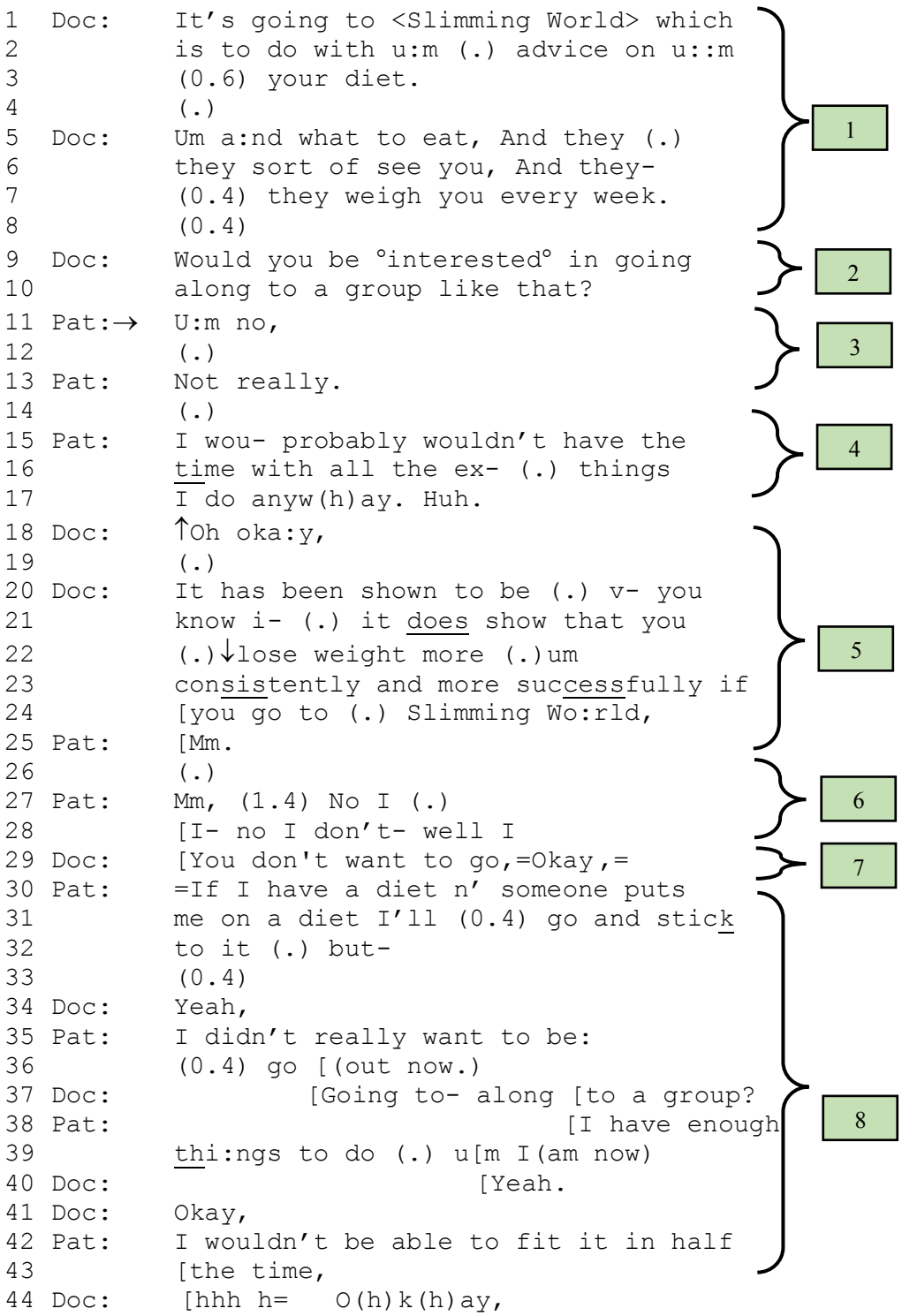
5.4.2 Rejection of the offer of free referral

I found these 'oh'-prefaced receipts of great analytical interest, as the interactional work they were doing was rich and multi-faceted. I now present a second response type, in a similar placement which did less complex interactional work, but which showed great potential for clinical practice.

I collected 26 cases where the patient's first response after the news of the offer of a free referral was a hearable rejection such as "No" or "No, Not interested". A number of responses may indicate *potential* rejection of the referral. For example, silence following news may display some trouble with the news itself or that way the offer was formulated (24, 25). However, the focus of this analysis is 'actual' rejection displays (24). These are responses which are hearable as doing *explicit* rejection, such as "No" or "No, Not my cup of tea." I will now identify the placement of these displays within the news delivery sequence (NDS). I will then explore the interactional work achieved by these displays of actual rejection, and their implications for the wider referral sequence.

5.4.2.1 Sequential placement of displays of actual rejection

Figure 5.5 Placement of displays of actual rejection within the news delivery sequence



Action done at each number in Figure 5.5:

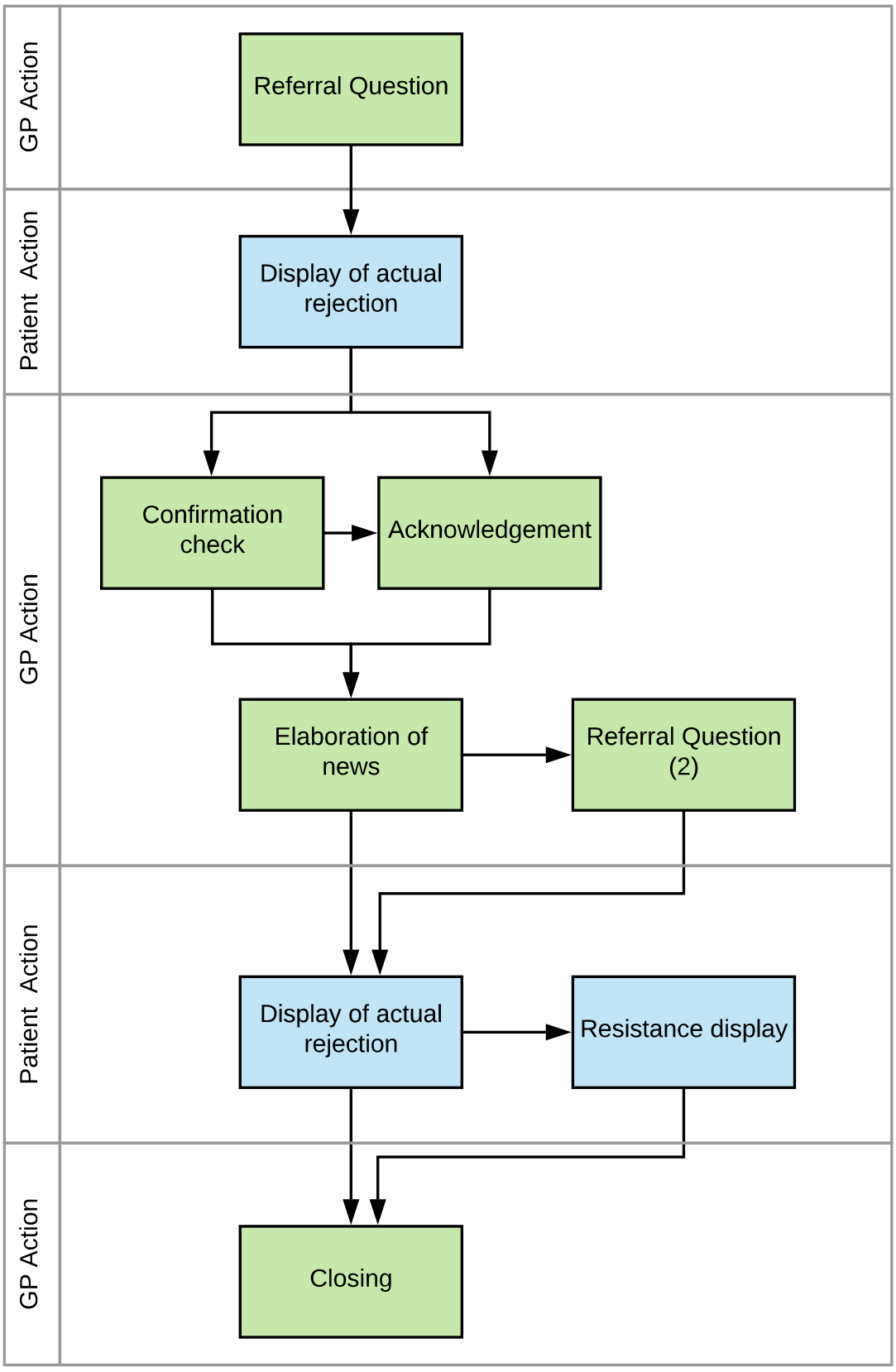
1 - Announcement of news	5 - Elaboration of news
2 - Referral question	6 - Display of actual rejection
3 - Display of actual rejection	7 - Acknowledgment
4 - Account for rejection	8 - Account for rejection

Displays of actual rejection can be taken as displaying "trouble with or inadequacy of the invitation or offer" and, as such, in every-day talk they are often followed by attempts to remedy the source of the trouble, and then by a subsequent offer p.153 (24). In the BWeL data displays of actual rejection followed a similar pattern. As with 'oh'-prefaced announcement receipts they were the first response produced after the complete announcement of news. However, whilst 'oh'-prefaced receipts usually occurred immediately following the completed news announcement, patients who displayed actual rejection typically produced no verbal response following the news announcement (line 4, Figure 5.5). Their first verbal response occurred following an implicit or explicit referral question (line 9-10, Figure 5.5). GPs commonly followed displays of actual rejection with subsequent versions of the offer, or delivery of additional news components which may have been absent from the first news announcement. Some GPs would then do the referral question a second time, which was consistently rejected. Often this second rejection was followed by marked resistance displays from patients, and the GP would then move to close the consultation.

Figure 5.5 summarises this pattern. It illustrates that patients could reject the referral, where displays of actual rejection were placed within the news delivery sequence, and how GPs responded. Figure 5.1 in section 5.4 of this chapter mapped how offers can be formulated a series of times in one referral sequence, and places these rejections within wider sequential context. Figure 5.6, illustrates the actions in typical rejection sequence in detail. In the next section I explore the conversational evidence that these responses indicate the free referral has been negatively received and the implications for these responses on the wider referral sequence. Following this, I explore my findings from this chapter quantitively.

Whilst my focus here is on how patients display actual rejection following the news of a free referral and how GPs respond, I will note that the pre-sequences preceding the news announcement often followed Maynard's perspective display series (examined in the previous chapter). Just as displays of marked positive stance and 'oh'-prefaced announcement receipts commonly occurred following a 'good news' delivery, these actual rejections occurred following a bad news delivery or a neutral news delivery which incorporated the perspective display series (26). As I stated in the previous section, whilst the previous chapter focussed on these wider news delivery sequences, here I take a tight focus on the patient's response, rather than on the GP's actions that may have elicited these rejections.

Figure 5.6 Typical rejection sequence



5.4.2.2 How patients produce displays of actual rejection

I have shown where displays of actual rejection are placed in the referral sequence. In this section I exemplify how patients produced displays of actual rejection. Following this I examine how GPs responded to these.

Excerpt 5.20 30-05-13

```
1  Doc:    It's going to <Slimming World> which is to do
2          with u:m (.) advice on u::m (0.6) your diet.
3          (.)
4  Doc:    Um a:nd what to eat, And they (.) they sort of
5          see you, And they- (0.4) they weigh you every
6          week.
7          (0.4)
8  Doc:    Would you be °interested° in going along to a
9  Doc:    group like that?
10 Pat:→   U:m no,
11         (.)
12 Pat:    Not really.
13         (.)
14 Pat:    I wou- probably wouldn't have the time with
15         all the ex- (.) things I do anyw(h)ay. Huh.
16 Doc:    ↑Oh oka:y,
17         (.)
18 Doc:    It has been shown to be (.) v- you know i-
19         (.) it does show that you (.)↓lose weight more
20         (.)um consistently and more successfully if
21         [you go to (.) Slimming Wo:rld,
22 Pat:    [Mm.
23         (.)
24 Pat:    Mm, (1.4) No I (.) [I- no I don't- well I
25 Doc:                       [You don't want to go,=
26         =Okay ,=
27 Pat:    =If I have a diet n someone puts me on a diet
28         I'll (0.4) go and stick to it (.) but-
29         (0.4)
30 Doc:    Yeah,
31 Pat:    I didn't really want to be: (0.4) go [(out now.)
32 Doc:                                        [Going to-=
33         =alon[g to a group?
34 Pat:         [I have enough thi:ngs to do (.) u[m I(am now)
35 Doc:                                          [Yeah.
36 Doc:    Okay,
37 Pat:    I wouldn't be able to fit it in half [the time,
38 Doc:                                         [hhh h=
39         =O(h)k(h)ay,
```

The GP does the announcement of news from lines 1-6. At the TRP at line 7, it is potentially relevant for the patient to produce a continuer, or announcement receipt. I showed earlier in this chapter, in my exploration of positive reception displays, that these often occur in this placement. Instead, there is a gap in the talk of 0.4 seconds, potentially indicating some forthcoming troubles (25). The GP then takes another turn, asking the referral question at line 8-9 "Would you be °interested° in going along to a group like that?". The patient does an actual rejection of the offer at line 10 "U:m no,", and then accounts for this rejection from lines 14-15. The GP acknowledges this at line 16 "Oh oka:y". In his next turn the GP orients to some potential problem in understanding the news, as he elaborates on the news of a free referral by asserting the evidence base for CWMS, and the weight loss success of people who attend. The patient acknowledges this, but maintains his previous stance towards the offer at line 24 through a series of hedged "No" responses. The GP acknowledges these, affiliating with the patient through anticipatory completions at line 25 and 32 (18, 19), and affiliative in-utterance laughter at line 39 (27). Following line 39 the GP moves to closings.

To summarise, this excerpt illustrates that patients could explicitly reject the referral. They usually withheld a response at the completion of the news announcement and then explicitly rejected following the referral question. Rejections could be a standalone 'no' or, as illustrated in Excerpt 5.20, could be hedged and accounted for. As was common in this collection, the GP elaborated the news following rejection, and asserted the evidence base behind the referral, emphasising its effectiveness. Both of these actions seem designed to pursue a change in response from the patient, acting to convince or persuade them to agree. The patient, however, maintained his stance towards the referral.

5.4.2.3 GP response to actual rejection and patient response trajectory

As I showed in my analysis of Excerpt 5.20, it was common for GPs to elaborate on news in their next turn, and there could be interactional implications when they did so. In the excerpts below, I identify three ways GPs could respond to actual

rejection, and explore the implications of these for patients' response trajectories throughout the referral sequence.

In this section I explore how clinicians responded to actual rejection displays, and the implications of these responses for patients' response trajectory. I first show the most common way clinicians responded to displays of actual rejection, which was provision of further information that was not included in the original news delivery, elaborating the news. This was done either by asserting the evidence behind the referral, or through asserting the benefits of weight loss. The second way clinicians responded was to engage in a motivational interviewing-style sequence, asking patients to identify their barriers to attendance, and collaborating to assert solutions. The third way was to acknowledge patient responses and move to close.

5.4.2.3.1 Responding to actual rejection with news elaborations

Excerpt 5.21 31-04-39

```
1  Doc:    Okay. Would you be interested in that sort of
2          thi::ng,= Or not. Particularly?=
3  Pat:→   = h Not really.=
4  Doc:    =Not really.
5  Pat:    No:.
6          (.)
7  Doc:    Not thought about losing wei:ght? Not thought
8          about  [c- (cr(  ))    health.
9  Pat:           [E::r yea:h I've thought  about losing
10         wei:ght but having had sort of four or five knee
11         operations and the knees are shot,
12 Doc:    Yeah,
13         (0.3)
14 Pat:    Which (.) <cancels out (.) serious exerci:se>.
15         (.)
16 Pat:    Erm my a:ge, °I don't particularly drink that
17         much°,
18         (.)
19 Pat:    I don't smoke, Pfff. °You know°.
20         (.)
21 Pat:    Do I really want to then start going on a di:et?
22         An:::d I've seen these programmes and that (.)
23         but (.) °I don't know°.
24         (.)
25 Doc:    .tch ↑There is evidence that shows that it i-
26         is >a good way< to help people lose
```

```
27          we[ight,
28 Pat:       [I thin[k so.
29 Doc:             [(exactly)if exercise is ↓difficult.=
30          =[Uh.
31 Pat:      [You also- >you also< categorise people into
32          .hh (0.3) e::r a category that maybe: (0.4) m:y
33          size and frame isn't necessarily the same as your
34          size and frame a::nd,
35 Doc:     >I appreciate that<,
36          (.)
37 Doc:     =[Uh.
38 Pat:     [#(°U::h°)# I just get angry about it >°to be
39          quite honest°<.
40 Doc:     Yea- #e:- i:- e:-# .hh which is where sometimes
41          it- this (.) conversation can- [can be delicate.=
42 Pat:                                    [Yeah that's fine,
43 Doc:     =And [that- th- and that that's why the,
44 Pat:          [#I- I- I- I'm# not against it.=
45 Doc:     = Ye[a:h,
46 Pat:         [I'm not against it, I know people that have
47          been on diets for forty odd years °and (0.5)
48          you know°.
49          (1.3)
50 Doc:     The choice is there [if you,
51 Pat:                         [Oka:y. No that's fi:ne.
52 Doc:     It's your choice e::r whether you e::r #ar#
53          want to take up the offe::r- >offer or not
54          really.<
55 Pat:     No. I think- [I think-,
56 Doc:                  [We would- we [would encourage you,
57 Pat:                                [I- I- I could do that
58          off my own back (I think).=
59 Doc:     =We would encourage you to- to do so.
60 Pat:     Okay.
61 Doc:     That's all I'll tell you about °(that)°.
```

Following the patient's response to the referral question, "Not really" at line 3, the GP frames the patient's weight loss in terms of his health. The patient then engages in moral work (28), stating he has had operations and his "knees are shot" which prevents him from exercising. He then justifies his lifestyle as a healthy one, stating he does not smoke, or drink "that much", hearably resisting the referral. The patient's non-lexical "pfff" at line 19 conveys exasperation (29). This is followed by a hypothetical question at line 21, "Do I really want to then start going on a diet?". Following this resistance display the GP asserts the evidence base for CWMS from lines 25-29. When doing so, he orients to the patient's previous statement that he cannot exercise by saying that CWMS are especially helpful when exercise is difficult. In providing further information following the patient's rejection this GP is

potentially orienting to the rejection as inapposite, and elaborating in order to pursue a different (positive) response.

The patient then moves from a resistance display that asserted a healthy lifestyle, to an upgraded display explicitly resisting the "category", possibly that of being obese or overweight. He asserts that his "size and frame" are different from the GP's size and frame, potentially implying that he looks more obese because of his body shape, rather than actually weighing more. Following the GP's acknowledgement of this the patient says "I just get angry about it >°to be quite honest°<.". The GP orients to this upgraded display by acknowledging that these conversations can be "delicate". The patient then mitigates his previous display saying he is "not against" it. The GP then states "the choice is yours", which the patient acknowledges. Next, the GP again states it is the patient's choice, to which the patient responds with another actual rejection "no". He begins what is projectable as account following this "I think-", but the GP overlaps this turn, explicitly encouraging the patient to take up the referral, again displaying pursuit of a positive response, although the patient has now rejected the referral twice. The patient restarts his abandoned turn saying "I can do it off my own back" at line 57-58, and the GP again states he would encourage the patient "to do so". This turn is hearable as a restart of the GP abandoned turn at line 56, which was encouraging CWMS attendance, and is not preceded by any acknowledgement of the patient's turn suggesting self-directed weight loss. Therefore, the placement of this turn, makes "do so" hearable as still referring to CWMS attendance, rather than the self-directed weight loss the patient mentions. The patient responds minimally with an "Okay" and the GP terminates the conversation with "That's all I'll tell you about °(that)°.".

To summarise, in this excerpt (Excerpt 5.21) we can observe the patient rejects, and displays resistance. Response is then pursued through delivery of additional information, which receives a strongly upgraded resistance display. The referral question is done a second time, and rejected, and the GP tries again to pursue a response, explicitly encouraging the patient to accept, despite consistent resistance from the patient. A similar pattern of resistance, pursuit, and further resistance is illustrated in the next excerpt. Whereas pursuit in the excerpt I have just discussed

(Excerpt 5.21) was done through asserting the evidence base for the referral, the subsequent excerpt illustrates how agreement could be pursued through a different type of news elaboration - informing the patient of the benefits of weight loss.

Excerpt 5.22 08-03-03

```
1  Doc:    U:m we can offer you um at the moment (.) we
2          we can refer you to one of these classes, (.)
3          You can choo:se where you go.
4          (.)
5  Doc:    U:m you can choose which one you ↓go to, >Whether
6          you want to go to Rosemary Connelly, (.) or
7          whether you want to go to the Weight Watchers
8          o:ne<, It's completely up to you:.
9          (.)
10 Doc:    U:m (.) and we can (.) refer you to that,
11         For you to attend it free of charge.
12         (0.3)
13 Pat:→   U::m no.
14 Doc:    Is that- (.) you would not be interested at all.
15 Pat:    [I've not-
16 Par:    [(inaudibl[e)
17 Pat:              [SHH. ↓I can lose weight.
18 Doc:    Ye[ah.
19 Pat:      [Any time I want to.
20 Doc:    Okay.
21 Pat:    Because (.) I can go up and down.
22 Doc:    Y[eah?
23 Pat:     [Weight wise.
24 Doc:    Okay.
25 Pat:    From different- >season to season<.
26 Doc:    Yeah. (.) S[ure.
27 Pat:               [And I can ↓lose it.
28 Doc:    Righ[t.
29 Pat:        [Quite easily.
30 Doc:    Ok[ay.
31 Pat:      [On my own.
32         (.)
33 Doc:    Well (.) as we were talking about earlier o:n (.)
34         with your blood pressure- .hh u:m (.) we would
35         certainly suggest that you lost some weight
36         becau:se of your blood pressure at the
37         moment as we:ll,
38 Pat:    Okay.
39 Pat:    So how about if you come back and see me: in
40 Doc:    about a month's time and I can weigh y[ou.=
41 Pat:                                         [Yeah.
42 Doc:    =Again.Th[en. And we can see if you've managed=
43 Pat:             [Okay.
44 Doc:    = to (.) lose any.
45 Pat:    °Okay, (.) Yeah°.
46 Doc:    Okay and then we can have another chat about what
```

```
47          >sort of< (.) further plans that you might have
48          (.) to help you lose weight, Or whether we need
49          to >sort of< rethink things then.
50 Pat:     That's fine.
51 Doc:     >And then I can check your blood pressure again
52          [then as well<.
53 Pat:     [Okay.          That's fine.
54 Doc:     Is that all right?=
55 Pat:     =That's fine.
56 Doc:     So if you'd like to make an appointment for a
57          month's ti:me,
58 Pat:     Okay.=
59 Doc:     =Okay.
60 Pat:     Yep. Fine.
61 Doc:     And now I'm going to switch this thing off.
62 Pat      Good.
63 Par:     hh hhh [hh h hhh hh
64 Doc:            [hh hh h h
```

In Excerpt 5.22 the GP (Doc) is delivering a referral to the patient (Pat) and the patient's partner (Par) is also present. The patient's first response following completion of the news delivery is a display of actual rejection, hedged with an "U::m" preface delaying the production of the dispreferred response "no" (line 13). Following this, at line 14, the GP says "is that- you wouldn't be interested at all". This may act as the GP confirming she has heard correctly, or as a challenge to the patient's response. However, whether a conformation check or a challenge, this turn displays some sort of questioning of the patient's response (and, with an understanding of the action this type of response is doing, it will be called a confirmation check throughout this chapter). The patient initiates a response which is cut off, "I've not-" and his partner starts to speak inaudibly. The patient forcefully "sh"s her, acting to cut off her turn and to display some frustration, or annoyance. He then produces an extended account which acts to assert his ability to lose weight without support. His use of hardened consonant sounds, and short turns, act as a further display of frustration, or annoyance. Despite these displays from the patient, the GP, from lines 33-37, elaborates on the news through informing the patient of the medical benefits of weight loss (a practice examined in detail in chapter six of this thesis). Following this, the patient's responses become short, unmarked, acknowledgements.

Even though the patient rejected the offer of referral at line 13, the GP invites him to come back, not for a review appointment (which they were trained to offer all patients in the trial), but to weigh him "to see if you've managed to lose any". This implies that she expects him to lose weight, despite his refusal of the offer of support to lose weight. She then says that at this appointment they can also review what plans "you might have" to lose weight. The use of 'you,' rather than collaborative 'we' here indicates she expects the patient to have a plan in place for weight loss at the next consultation. She also says that they can "rethink" things then, seemingly ignoring his extended account from lines 17-31 where he strongly asserted he did not want help. This turn is responded to by the patient with a clipped "**Th**at's **f**ine." which he repeated with the same prosody over his two subsequent turns, acting to display frustration, and move the sequence forwards without displaying agreement to the proposal that has been made. He responds to the GP's confirmation checks with "Ye**p**. **F**ine." which act as a display of passive resistance to the prior talk (27), specifically the GP's offer to make an appointment in a month. Resistance has built throughout this sequence from an initial account, to clear displays of annoyance. On line 61 the GP says "I'm going to switch this thing off" (which can be understood as referring to the audio recorder), and the patient responds immediately with a clipped "**Good**.". The patient's partner starts to laugh at line 63, which the GP joins, but the patient does not take part in this sequence, further evidencing his display of frustration throughout this conversation.

In summary, this excerpt exemplifies how pursuing agreement following displays of actual rejection, by delivering further information about the benefits of weight loss can result in displays of resistance. The patient's "**Good**." at the end is particularly marked in its clear display that terminating the recording, and thus the consultation, is a very welcome action. The most common response GPs displayed following displays of actual rejection was the one shown in this excerpt (Excerpt 5.22). GPs would follow a display of actual rejection (or a subsequent account) with turns which acted to assert the acceptability of the offer, or of weight loss in general. These acted to lengthen the consultation and, in some cases, to produce marked resistance displays which were upgraded from the initial actual rejection.

I have shown clinicians' delivery of further information orients to the patient's rejection as inapposite. Additional information could either pertain to the evidence base behind the referral or the benefits of weight loss. Either type of information delivery was part of a sequence of pursuit which resulted in escalating resistance displays from patients. Despite the frequency of these attempts to convince or persuade patients to attend CWMS following actual rejection there were no examples in this corpus of a patient doing an actual rejection and then changing their stance following 'convincing' or 'persuading' turns where a GP delivered additional information. Instead, these sequences were likely to generate resistance displays, and still end in actual rejection.

5.4.2.3.2 Responding to actual rejection by eliciting and addressing the patient's barriers to attendance

Another pattern following actual rejection displays was for the GP to elicit the patient's barriers to attendance, and address these directly. These sequences demonstrate an approach similar to the initial stages of motivational interviewing, where patients were asked to identify their own barriers to action, as exemplified below:

Excerpt 5.23 46-01-43

```
1  Doc:    What do you feel about going to one?
2  Pat:    ↑Not very keen, >I'll be quite honest with you<.
3  Doc:    ↑Okay. And what's the- what's the barrier for
4          that?
5  Pat:    Partially laziness, Partially embarrassment.
6  Doc:    Okay. >That's good<. I mean the- in the programme
7          here (.) I can offer you it (0.3) free.
8          (.)
9  Doc:    From the point of view u::::m (.) what the
10         advantages a:re u::m,
11 Pat:    >Can I take< this coat off?
12 Doc:    Course you ca:n.
13         (0.5)
14 Pat:    >Carry on,= Carry on.<
15 Doc:    So (.) partly- so (.) t- to address your >thing<
16         so (.) from the point of view of u::m o::ur
17         health, we know - from the point of view >you
18         said< laziness.
```

```
19 Pat:    Yes.
20 Doc:    So (.) ↓we:ll that's ultimately something you
21         have  to be motivated about.
22 Pat:    Yeah.
```

In the discussion prior to the fragment shown in Excerpt 5.23 the GP has established the evidence base for CWMS and established that the patient has not attended one before. The sequence here is different from those typical in this collection as the GP's turn at line 1, "what do you feel about going to one?" is hearable as the referral question, done in the place of the news announcement (part of a perspective display series). The patient responds with an actual rejection display, "↑Not very keen, >I'll be quite honest with you<.". The GP acknowledges this and then asks "what's the barrier for that?". This is typical of a 'motivational interviewing' sequence opening, which uses an open ended question to elicit barriers to behaviour change (30), and collaboratively identify solutions. In contrast to a brief intervention, motivational interviewing takes a longer time to deliver (31). The patient responds that it is a combination of laziness and embarrassment that prevents him from attending CWMS, and the GP assesses this response ">That's good<". The implied meaning is that the GP is assessing the provision of the response 'It's good that you told me' rather than the response itself, 'It's good that laziness and embarrassment are preventing you from attending CWMS'. The GP then announces the news "I can offer you it (0.3) free" and the initiates a turn which indicates he will next talk in further detail about the advantages of the CWMS. The patient orients to this turn as such, saying ">Can I take< this coat off?". The placement of this turn following an announcement turn indicates the patient orients to this as indicating the consultation will go on for longer than he expected when he left his coat on. In taking his coat off the patient is doing 'preparing for a longer discussion'. And, indeed the GP at line 15 addresses the barriers outlined by the patient. The GP follows a motivational interviewing-type pattern throughout the remainder of this consultation, taking a further 5.5 minutes following this excerpt. At the conclusion of this consultation the patient does agree to attend CWMS, and no active resistance is displayed in the discussion.

The details of how the motivational interviewing-style turns progress will not be explored here. This is because, whilst the interactional details of how motivational

interviewing-style discussions are crafted are of great analytical interest (32), my focus here is on delivery of *brief* interventions for weight loss. We can observe the GP's motivational interviewing-style turn at line 3 initiated this longer sequence of identifying and addressing barriers, acting to extend the consultation. This method of pursuit following rejection does not generate the further resistance displays seen in Excerpt 5.22 but does act to significantly lengthen the consultation, such that it is beyond the remit of a brief intervention (33).

5.4.2.3.3 Responding to actual rejection by moving to close the referral sequence

I have shown that GPs responded to displays of actual rejection through delivering further information, or by eliciting and addressing the patient's barriers to attendance. Neither pattern observed so far acted both to avoid generating resistance displays, and also kept brief discussions appropriately brief. The third pattern of GP response to displays of actual rejection was relatively rare, but highlights the potential for brief discussions which do not generate resistance. I exemplify this approach in the next two excerpts.

Excerpt 5.24 25-06-05

```
1  Doc:    Have you >ever thought about< doing anything
2          about the ↓weight?
3          (0.4)
4  Pat:    Yes=
5  Doc:    = Yeah. Would you be <interested i:n> (0.6)
6          using one of the ↑slimming ↓clubs?
7  Pat:    No.
8  Doc:    No? °Not at all°, (.) Even if I said it was free?
9  Pat:    No.
10 Doc:    Nope, Not interested?=
11 Pat:    =No.
12 Doc:    Oka:y. That's fine.
13         (.)
14 Doc:    So °what we have to do i::s°,
15         ((sound of pen scribbling))
16 Doc:    £There ↑we ↑↑go£?
```

The GP topicalises weight at line 1, asking "Have you ever thought about doing anythink about the weight?". The patient at line 4, after a pause, with a preferred

response “Yes”. The GP then asks if the patient would “be <interested i:n> (0.6) using one of the ↑slimming ↓clubs?”, potentially acting to “test the water” for an upcoming news delivery (34), through eliciting the patient’s perspective (26). The patient produces a dispreferred response to this with a delay and a “no” response. The GP then does a confirmation check (“No. Not at all.”), and delivers the news that the slimming club would be free. The patient produces a second “no” response at line 9, which acts as actual rejection of the offer. This is followed by a confirmation check from the GP “Nope, Not interested?” which received a second “no” response. The GP acknowledges this with an “okay”, assesses the patient’s response as “That’s fine”, and can be heard to fill out the paperwork for the trial, followed by a closing implicative “£There ↑we ↑↑go£?”. The move from rejection to closings is quicker, and smoother than observed in the previous excerpts. This pattern is further exemplified in Excerpt 5.25.

Excerpt 5.25 07-02-13

```
1  Doc:    Would you be interested in doing something
2          like that or no:t?
3  Pat:→   No.= Not really.  I've (0.4) no:. [It's-
4  Doc:                                      [You don't
5          don't feel as though you >want to do that,< (.)
6          at the moment.
7  Pat:    No.
8  Doc:    Oka:y, [That- th- that's fa:ir enough..hh u::m,
9  Pat:           [(°Okay. Okay.°)
10         (.)
11 Doc:    What (.) I would suggest to you (.) we- u:m is
12         that maybe you come back i:n about a month's
13         ti:me ,
14 Pat:    Yea[h.
15 Doc:       [Okay? A:nd (.) e:::r (0.3) we could see how
16         things are in a month's [time.
17 Pat:                           [Yeah.
18 Doc:    E:rm and just have a look at the weight side of
19         things again.= In about a mon[th.
20 Pat:                                 [Okay.
21 Doc:    ↑Is that all ri[ght?
22 Pat:                   [That's fi:ne, Yes.
```

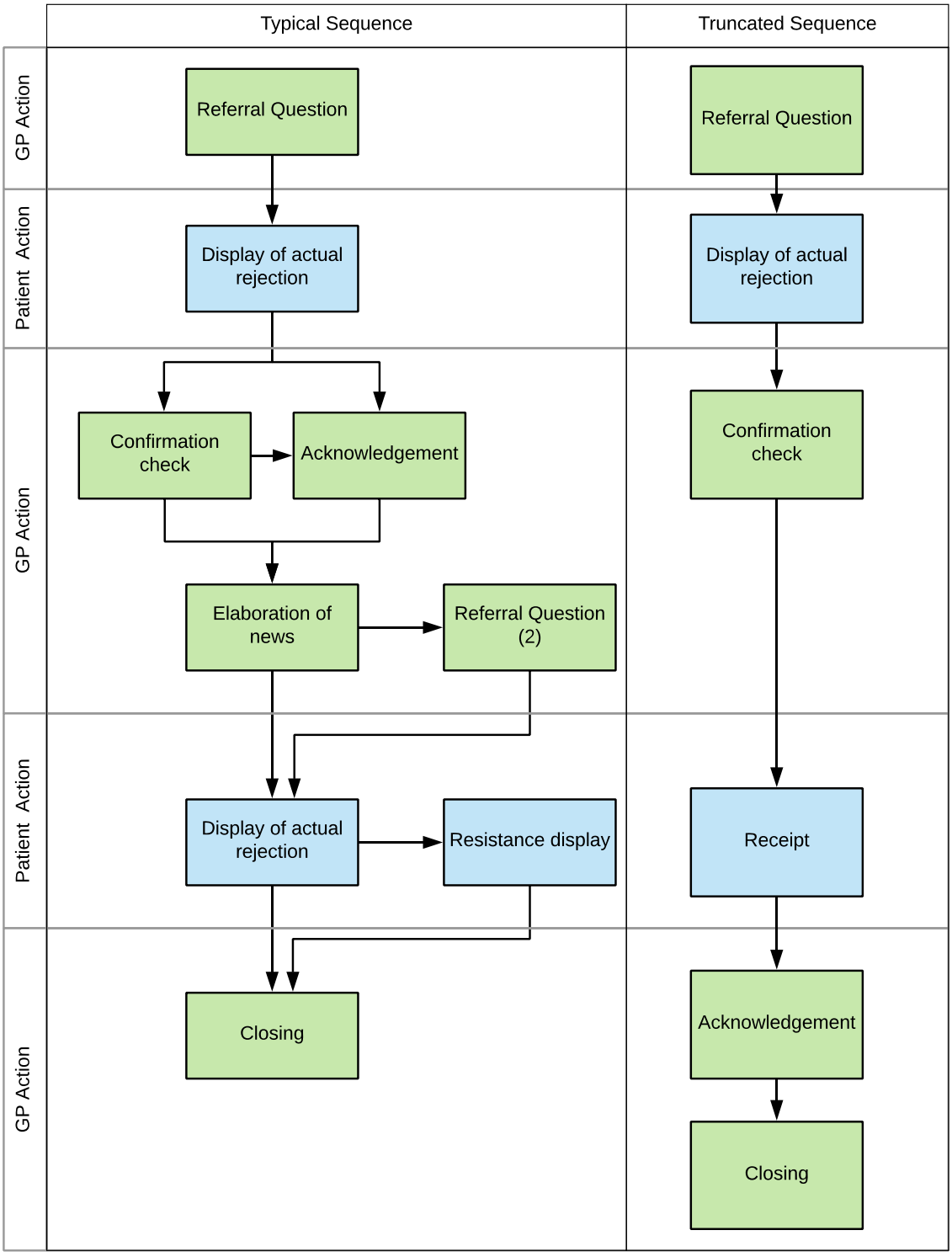
In the excerpt above the GP has done the preannouncement, topicalising weight and establishing CWMS as the best way to lose weight, and announced the news of a free referral. At line 1 he starts the referral question. This is ambiguously designed in terms of response preference “Would you be interested in doing something like that

or no:t.", as the use of a tag question "or no:t." makes either a 'yes' or 'no' response potentially relevant. The patient produces an actual rejection display at line 3 "No". This is followed by a mitigator "Not really". The patient then initiates another turn "I've" pauses and their restarts her turn with a second display of actual rejection "no:.". The patient potentially initiates an account at line 3 following her displays of actual rejection "it's" however this overlaps with the GP's confirmation check: "You don't feel as though you want to do that at the moment.". Rather than restarting her abandoned turn, the patient responds with a preferred "No" response, and the GP acknowledges this at line 8 saying "Okay". In the GPs next turn, he assesses this response with a sequence closing "that's fa:ir enough.", and then initiates closings by arranging another appointment in a month. The patient produces minimal responses throughout the closing sequence, however these have affiliative characteristics in their placement in overlap with the GP's talk, and they act collaboratively to move the sequence to a close (15).

To summarise, Excerpt 5.24 and Excerpt 5.25 illustrate that GPs who did a confirmation check following a display of actual rejection, acknowledged the patient has rejected the referral, and moved to closings, neither generated resistance displays nor produced lengthy consultations. Evidence from conversation analysis indicated that the revised sequence, Figure 5.7, could smoothly allow GPs to deal with displays of actual rejection and move to closings without taking unnecessary time, or engendering explicit displays of resistance.

I next present a quantitative analysis of these results, identifying the positional time saved if clinicians had oriented to the phenomena explored in this chapter - displays of positive reception or actual rejection - as implicative of closing, as well as examining associations between production of these responses and patient attendance and post-consultation satisfaction reports.

Figure 5.7 Truncated sequence following displays of actual rejection



5.5 Patient responses and outcome measures

5.5.1 Quantification point and methods of statistical analyses

I examined the association between patient response and consultation length, acceptance, and initial attendance at the weight management programme, as outlined in Chapter 2. I first coded each participant's first verbal response following completion of the announcement of the news of a free referral into a series of categories. I then conducted univariable and multivariable logistic regression analyses to explore associations between these conversational patterns and agreement to attend, and attendance at the CWMS, calculating odds ratios (ORs) and 95% confidence intervals (CI) for the likelihood of attending, relative to the most common response which was 'yeah'. I used univariable and multivariable linear regression to explore relationships between patient response type and the variables 'patient satisfaction' and 'consultation length'. Age and gender were adjusted for in all multivariable logistic and linear regression analyses.

Some clinicians oriented to patient responses and moved to close, whilst some expanded news delivery sequences by elaborating the news. I calculated how much time could be saved if clinicians oriented to a specific response which had been identified through conversation analysis as displaying further information was unnecessary, such as 'oh', and moved to close. I did not feel that an average difference between these consultation lengths accurately represented the time GPs saved by moving to close, as they may have also been other points in the conversations where they were briefer or more elaborate. Therefore, I did this by first identifying where the phenomenon of interest was placed in the conversation. I then calculated where clinicians initiated closing and the closing length. I then added the closing length to the transition relevance place (TRP) where it would have been relevant for the GP to acknowledge the patient response and move to close. This meant that the time used during a 'negotiating sequence' was removed. This provided an estimate of the potential time that could have been saved in these consultations. I then calculated if there were differences in patient reported satisfaction in sequences where GPs moved to close, or where they provided more

information, through conducting further linear regression analyses to identify any difference between these two groups.

5.5.2 Results of statistical analyses

In line with results from conversation analysis, statistical analysis showed that, compared to patients who said 'yeah,' patients who displayed a marked positive stance (MPS) were more likely to agree-to-attend (100% vs 90% agreed; Univariable OR=1 (95% CI=n/c), p=n/c ; Multivariable OR=1 (95% CI=n/c), p=n/c), and attend their referral (79% vs 45% attended; Univariable OR=4.50 (95% CI=1.60-12.62), p=0.004; Multivariable OR=4.28 (95% CI=1.51-12.17), p=0.006) (Table 5.2 and Table 5.3).

Consultations where patients displayed a MPS were significantly shorter than those were patients produced a 'yeah' in this placement (65 seconds vs 84 seconds; Univariable difference in means=-19 (95% CI=(-35.49--2.96) p=0.021; Multivariable difference in means=-21 (95% CI=-37.33- -3.93), p=0.016) (Table 5.5). This aligns with results from conversation analysis which showed GPs frequently oriented to displays of MPS, truncated the referral sequence, and moved to close.

Initial comparison of intervention delivery times between consultations where patients displayed a MPS and the doctor truncated, or did not truncate, the brief intervention discussions indicated no significant difference (59 seconds vs 84 seconds; Univariable difference in means=25 (95% CI=-0.13-51.36), p=0.051; Multivariable difference in means=26 (95% CI=1.47-52.57), p=0.26) (Table 5.6). Detailed analysis of the timing of utterances within the consultation showed that, whilst the mean time for brief intervention discussions which included a MPS was 65 seconds (range 15-458 seconds), the MPS itself was produced at a mean of 39 seconds (15-105 seconds). GPs in these conversations took an average of 10 seconds to close discussions. Recognising these utterances as PRDs, and moving to close, could have saved a mean of 15 seconds per consultation (Figure 5.8).

The mean satisfaction score for brief intervention discussions which included a MPS was 4.58 (Table 5.4). There was no evidence of difference between truncated and non-truncated consultations (4.58 vs 4.56; Univariable difference in means=-0.018 (95% CI=-0.43-0.39), p=0.93; Multivariable difference in means=0.18 (95% CI=-0.40-0.44), p=0.93), providing additional evidence that it was acceptable to shorten interventions following these responses.

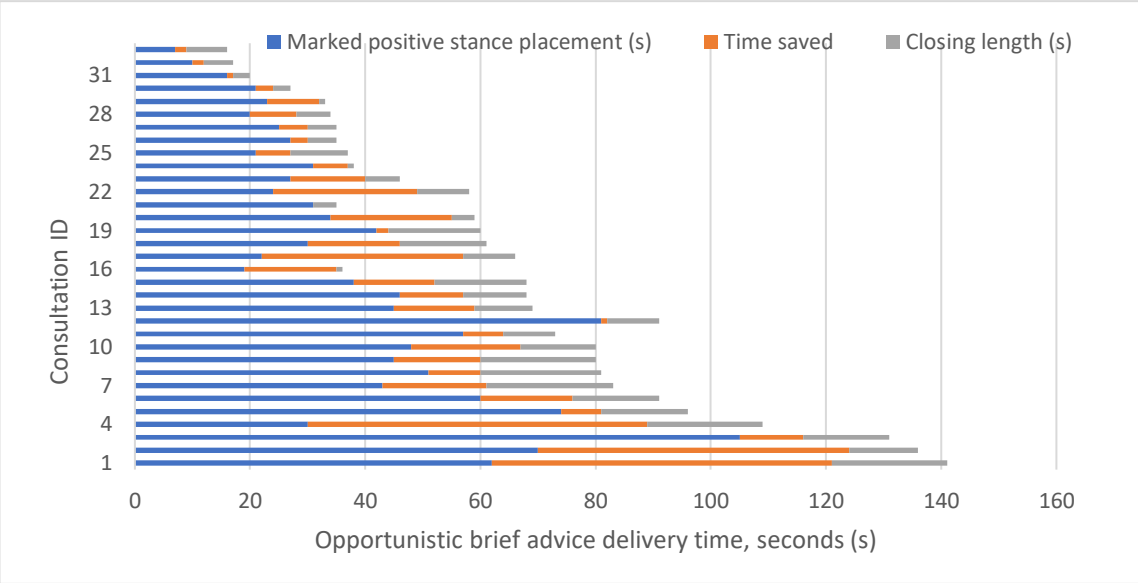


Figure 5.8 Placement and timing to marked positive stance within the consultation
Each 'Consultation ID' number represents a patient within this group. The number assigned is an arbitrary one which does not represent the sequence in which these consultations were delivered.

Conversation analysis showed that patients who produced an 'oh'-prefaced response were displaying positive reception. Statistical analysis corroborated these results showing that, although patients who displayed an 'oh'-prefaced response were no more likely to agree-to-attend than patients who said 'yeah' (95% vs 90% agreed; Univariable OR=1.89 (95% CI=0.20-18.19), p=0.58; Multivariable OR=1.27 (95% CI=0.12-15.22), p=0.85) (Table 5.2), they were more likely to attend their referral (85% vs 45% attended; Univariable OR=6.46 (95% CI=1.63-25.53) p=0.008; Multivariable OR=4.98 (95% CI=1.14- 21.85), p=0.033), compared to patients who said 'yeah' (Table 5.3).

Intervention discussions which included an 'oh'-prefaced announcement receipt took an average of 89 seconds, compared with 84 seconds, when patients said 'yeah', showing no significant difference (Table 5.5). Conversation analysis indicated 'oh' offered opportunity to truncate discussions. Comparison of consultation times between truncated and non-truncated discussions indicated a significant difference in consultation time in univariable analysis but not in multivariable analysis (35 seconds vs 99 seconds; Univariable difference in means=64 (95% CI=1.55-126.40), p=0.045; Multivariable difference in means=64 (95% CI=-3.61-131.60), p=0.062 (Table 5.6). However, it is reasonable to assume that this small sample size (N=3) provided insufficient power to detect significance in this multivariable analysis. Detailed analysis of the timing of utterances within the consultation showed that, whilst the mean time for brief intervention discussions which included an 'oh'-prefaced response was 89 seconds (range 29-199 seconds), the 'oh'-prefaced response itself was produced at a mean of 36 seconds. GPs in these conversations took an average of 18 seconds to close discussions. Recognising these utterances as PRDs, and moving to close, could have saved a mean of 32 seconds per consultation (Figure 5.9).

The mean satisfaction score for brief intervention discussions which included an 'oh'-prefaced response was 4.34 (Table 5.4). There was no evidence of difference between truncated and non-truncated consultations (4.26 vs 4.67; Univariable difference in means=-0.10 (95% CI=-0.78-0.58), p=0.76; Multivariable difference in means=-0.051 (95% CI=-0.76-0.65), p=0.88), providing additional evidence that it is acceptable to shorten interventions following this response (Table 5.7).

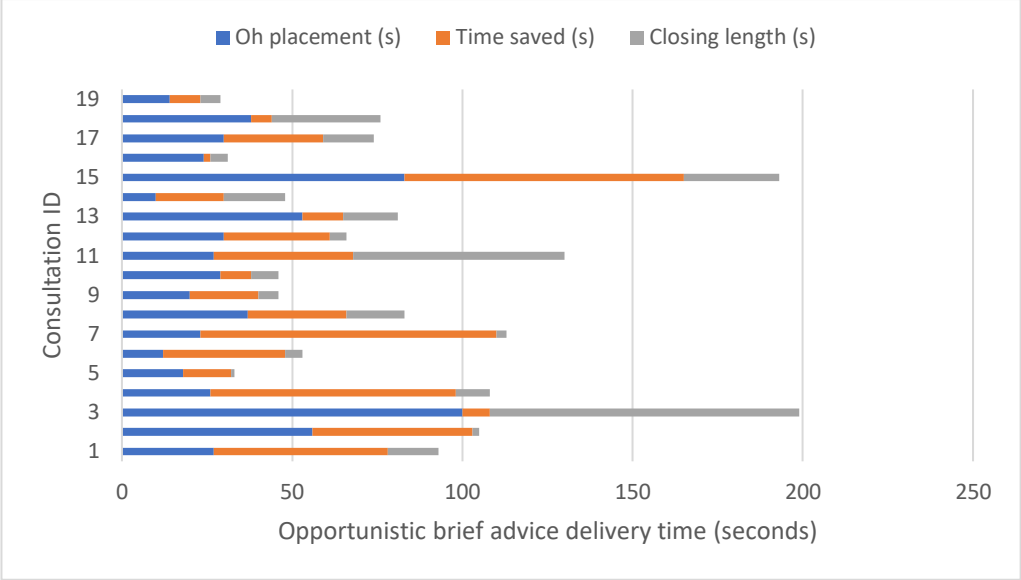


Figure 5.9 Placement and timing to 'oh'-prefaced responses within the consultation
Each 'Consultation ID' number represents a patient within this group. The number assigned is an arbitrary one which does not represent the sequence in which these consultations were delivered.

In line with results from conversation analysis, statistical analysis showed that, compared to patients who said 'yeah', patients who displayed an actual rejection were significantly less likely to agree-to-attend (14% vs 90% agreed; Univariable OR=0.020 (95% CI=0.0043-0.084), p<0.001; Multivariable OR=0.18 (95% CI=0.0037-0.084), p<0.001) (Table 5.2), and attend their referral (12% vs 45% attended; Univariable OR=0.16 (95% CI=0.041-0.61), p=0.007; Multivariable OR=0.15 (95% CI=0.038-0.58), p=0.006), (Table 5.3).

Intervention discussions which incorporated an actual rejection took an average of 118 seconds, compared to 84 seconds for when patients said 'yeah', showing no significant difference (Table 5.5). Comparison of consultation times between truncated and non-truncated discussions which included an actual rejection indicated a difference in consultation time (46 seconds vs 171 seconds; Univariable difference in means=121 (95% CI=59.17-190.45), p=0.01; Multivariable difference in means=121 (95% CI=51.62-190.86), p=0.002 (Table 5.6). Whilst the mean time for brief intervention discussions which included an actual rejection was 118 seconds (range 15-458 seconds), the actual rejection itself was produced at a mean of 47

seconds (range 12-145). GPs in these conversations took an average of 25 seconds to close discussions. Recognising these utterances as indicating no further discussion is needed, and moving to close, could have saved a mean of 46 seconds per consultation (Figure 5.10).

The mean satisfaction score was 3.58 (SD 1.43) for those who displayed actual rejection compared with 4.18 (SD 1.11) for patients who said 'yeah', with no evidence of a difference (Univariable 95% CI=-2.23-0.02, regression coefficient=-0.61, p=0.06; Multivariable 95% CI=-1.21-0.07, regression coefficient=-0.57, p=0.08) (Table 5.4). There was evidence of difference between truncated and non-truncated consultations (3.62 vs 4.26; Univariable 95% CI=0.10-1.18, regression coefficient=0.64, p=0.021; Multivariable 95% CI=0.11-1.21, regression coefficient=0.67, p=0.021). This result differed from results from conversation analysis which showed patients displaying increasing frustration as GPs pursued the topic of referral (Table 5.7).

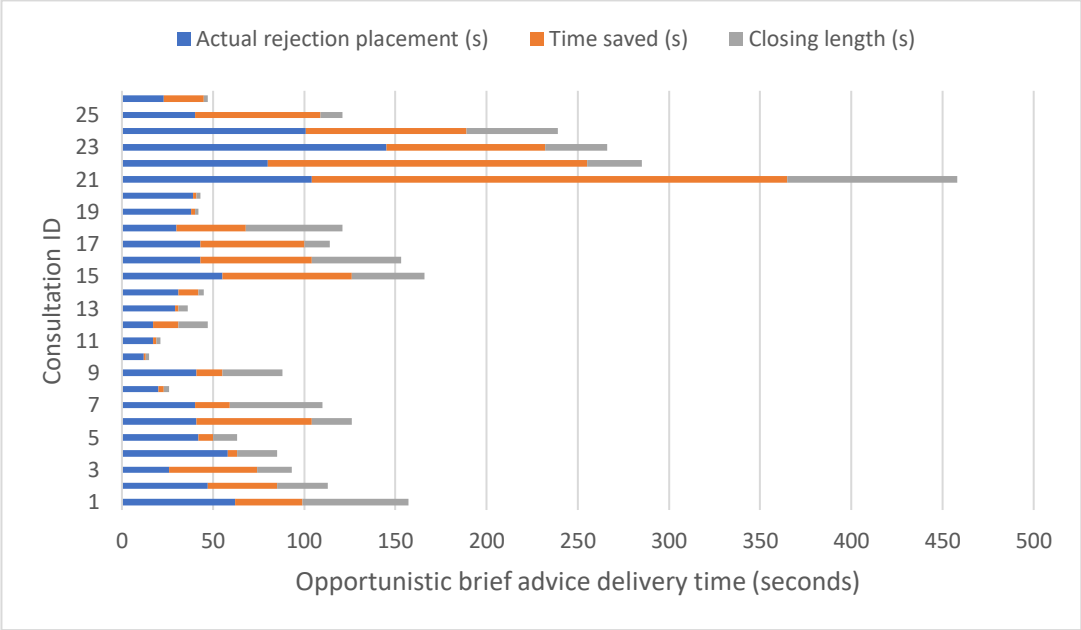


Figure 5.10 Placement and timing to actual rejection within the consultation
Each 'Consultation ID' number represents a patient within this group. The number assigned is an arbitrary one which does not represent the sequence in which these consultations were delivered.

Table 5.2 Relationship between utterance and agreement-to-attend across most common response types

			Univariable Analysis		Multivariable Analysis*	
Utterance	Number of consultations	Agree-to-attend	Odds ratio (95% Confidence interval)	P-value	Odds ratio (95% Confidence interval)	P-value
Yeah**	42	38 (90%)	-		-	
Marked positive stance	33	33 (100%)	1	n/c	1	n/c
Actual rejection	26	4 (15%)	0.020 (0.0043-0.084)	<0.001	0.18 (0.0037-.084)	<0.001
Okay	20	17 (85%)	0.60 (0.12-2.96)	0.53	0.46 (0.085-2.50)	0.37
Equivocal	21	12 (57%)	0.14 (0.036-0.54)	0.004	0.15 (0.034-0.62)	0.009
Oh	19	18 (95%)	1.89 (0.20-18.19)	0.58	1.27 (0.12-15.22)	0.85
Mm	18	11 (61%)	0.17 (0.041-0.67)	0.012	0.11 (0.023-0.54)	
Yes	16	16 (100%)	1	n/c	1	n/c
Right	12	10 (83%)	0.52 (0.084-3.30)	0.49	0.48 (0.070-3.29)	0.46

*Age and gender were adjusted for in these analyses
**Comparator

Table 5.3 Relationship between utterance and attendance across most common response types

			Univariable Analysis		Multivariable Analysis*	
Utterance	Number of consultations	Attend	Odds ratio (95% Confidence interval)	P-value	Odds ratio (95% Confidence interval)	P-value
Yeah**	42	19 (45%)	-		-	
Marked positive stance	33	26 (79%)	4.50 (1.60-12.62)	0.004	4.28 (1.51-12.17)	0.006
Actual rejection	26	3 (12%)	0.16 (0.041-0.61)	0.007	0.15 (0.038-0.58)	0.006
Okay	20	8 (40%)	0.81 (0.27-2.38)	0.70	0.76 (0.25-2.32)	0.64
Equivocal	21	5 (24%)	0.38 (0.12-1.22)	0.11	0.33 (0.10-1.17)	0.087
Oh	19	16 (84%)	6.46 (1.63- 25.53)	0.008	4.98 (1.14- 21.85)	0.033
Mm	18	4 (22%)	0.35 (0.10-1.23)	0.10	0.30 (0.078-1.11)	0.072
Yes	16	8 (50%)	1.21 (0.38-3.83)	0.75	1.03 (0.30-3.48)	0.96
Right	12	8 (67%)	2.42 (0.63- 9.29)	0.20	2.08 (0.52-8.26)	0.30

*Age and gender were adjusted for in these analyses

**Comparator

Table 5.4 Relationship between utterance and patient reported satisfaction across most common response types

			Univariable analysis		Multivariable Analysis*	
Utterance	Response (n)	Mean satisfaction (SD)[⊥]	Regression coefficient (95% CI)	p-value	Regression coefficient (95% CI)	p-value
Yeah**	41	4.18 (1.11)	-		-	
Marked positive stance	33	4.58 (0.49)	0.38 (-0.022-0.81)	0.063	0.39 (-0.040-0.81)	0.075
Actual rejection	26	3.58 (1.43)	-0.61 (-2.23-0.022)	0.058	-0.57 (-1.21-0.069)	0.080
Okay	20	4.43 (0.71)	0.24 (10.30-0.79)	0.38	0.21 (-0.36-0.77)	0.47
Equivocal	20	4.43 (0.49)	0.24 (-0.28-0.76)	0.36	0.30 (-0.25-0.84)	0.28
Oh	19	4.34 (1.16)	0.16 (-0.47-0.78)	0.61	0.19 (-0.53-0.91)	0.60
Mm	18	4.06 (1.21)	-0.13 (-0.77-0.52)	0.70	10.11 (-0.79-0.57)	0.75
Yes	16	4.28 (1.22)	0.10 (-0.59-0.77)	0.77	0.10 (-0.59-0.79)	0.77
Right	12	4.46 (0.62)	0.28 (-0.40-0.95)	0.42	0.26 (-0.44-0.96)	0.47

*Age and gender were adjusted for in these analyses

**Comparator

[⊥]The number of responses reported for 'satisfaction' differs from 'patient responses' as not all patient reported post-consultation satisfaction

Table 5.5 Relationship between utterance and consultation time across most common response types

			Univariable analysis		Multivariable Analysis*	
Utterance	Response (n)	Consultation time (s) (SD)	Difference in means (95% CI)	p-value	Difference in means (95% CI)	p-value
Yeah**	42	84 (36.65)	comparator		comparator	
Marked positive stance	33	65 (32.56)	-19 (-35.49 --2.96)	0.021	-21 (-37.33- -3.93)	0.016
Actual rejection	26	118 (100.58)	34 (-0.12-68.66)	0.051	32 (-3.15-66.79)	0.074
Okay	20	101 (45.81)	17 (-5.79- 39.06)	0.14	14 (-8.31-36.94)	0.21
Equivocal	21	130 (93.15)	46 (12.48-78.56)	0.008	44 (9.02-78.91)	0.015
Oh	19	89 (51.61)	5 (-18.24-28.28)	0.67	-2 (-28.62-24.34)	0.87
Mm	18	119 (62.71)	35 (9.15-61.24)	0.009	27 (1.00-53.17)	0.042
Yes	16	80 (70.17)	-4 (-32.65-24.26)	0.77	-3 (-33.10- 25.27)	0.79
Right	12	121 (66.13)	36 (6.86-65.75)	0.017	33 (2.42-62.99)	0.035

*Age and gender were adjusted for in these analyses
**Comparator

Table 5.6 Differences in consultation time between truncated and non-truncated consultations

				Univariable analysis		Multivariable Analysis*	
Utterance	Sequence type	Response (n)	Consultation time (s) (SD)	Difference in means (95% CI)	p-value	Difference in means (95% CI)	p-value
Marked positive stance	Non-truncated	8	84 (41.98)	25 (-0.13-51.36)	0.051	26 (-1.47-52.57)	0.26
	truncated	25	59 (27.08)				
Oh	Non-truncated	16	99 (49.95)	64 (1.55-126.40)	0.045	64 (-3.61-131.60)	0.062
	truncated	3	35 (9.29)				
Actual rejection	Non-truncated	15	171 (102.95)	121 (59.17-190.45)	0.001	121 (51.62-190.86)	0.002
	truncated	11	46 (23.84)				

*Age and gender were adjusted for in these analyses

Table 5.7 Differences in satisfaction between truncated and non-truncated consultations

				Univariable analysis		Multivariable Analysis*	
Utterance	Sequence type	Response (n)	Satisfaction (SD)	Regression coefficient (95% CI)	p-value	Regression coefficient (95% CI)	p-value
Marked positive stance	Non-truncated	8	4.56 (0.42)	-0.018 (-0.43-0.39)	0.93	0.18 (-0.40-0.44)	0.93
	truncated	25	4.58 (0.51)				
Oh	Non-truncated	16	4.57 (0.53)	-0.10 (-0.78-0.58)	0.76	-0.051 (-0.76-0.65)	0.88
	truncated	3	4.67 (0.29)				
Actual rejection	Non-truncated	15	4.26 (0.50)	0.64 (0.10-1.18)	0.021	0.67 (0.11-1.21)	0.021
	truncated	8	3.62 (0.74)				

*Age and gender were adjusted for in these analyses

⊥The number of responses reported for 'satisfaction' differs from 'patient responses' as not all patient reported post-consultation satisfaction

5.6 Discussion

5.6.1 Summary of findings in the context of current literature

In this chapter I have explored three response types that were typically produced to display positive and negative reception in a patient's first turn following the news of the free referral. Positive reception was exhibited through displays of marked positive stance, and 'oh'-prefaced responses. 'Oh'-prefaced responses were delivered in second position, responsive to the announcement of the news of the offer of the free referral. These responses occurred in the first TRP available to a patient following news announcement. Negative reception, displayed through actual rejection, typically occurred following the explicit referral question and was also usually the first verbal response patients produced following the news announcement. Displays of positive stance and actual rejection may seem to have little in common, both indicating polar opposites of the range of responses that were produced in this placement. However, I demonstrated that orienting to both positive and negative responses can offer important clinical implications.

Conversation analysts have used patient responses to identify the 'success' of particular types of practitioner talk. For example, through exploring the types of responses patients produced in the turns following non-recommendation of antibiotics Stivers identified ways which practitioners could recommend treatment which were less likely to result in resistance displays (35, 36). Whilst use of the next-turn proof procedure (37) in this way can highlight practitioner talk, and has clear training implications, patient responses themselves are receiving increasing focus and have been used for novel analyses. Recent work has explored patient responses as a diagnostic tool to support differential diagnoses in possible epileptic seizures, and in functional memory disorders (38-44), and foregrounds that a detailed focus on patient responses in clinical settings has much to offer clinical practice. This chapter builds on existing work that highlights patient responses as indicating more than just the success or failure of the previous turn and is the first to my knowledge to explore direct associations between specific patient responses, and their subsequent actions.

I first explored displays of marked positive stance. I showed GPs frequently oriented to these responses as displaying positivity towards the referral, and moved to close soon after their production. This aligns with existing work on progressivity in interaction. Sacks (45) and Heritage (46) have both shown that, when turns prefer agreement and they receive this agreement, sequences tend to expedited "without internal delays and without extended accounts" p.368 (12). My examination of consultation time showed that displays of MPS offered least opportunity to save consultation time as GPs regularly took this opportunity to truncate referral sequences.

I next examined the placement of 'oh'-prefaced announcement receipts in the news delivery sequence, and found that interlocutors produced 'oh'-prefaced announcement receipts to mark an announcement as 'news-for-them' p.7 (13). I observed that, through avoiding production of an announcement response in this placement, the recipient can reject the newsworthiness of what has been designed as a news delivery. Therefore, the production of these receipts highlight not just information is 'new' but that it is relevant for the hearer, or news*worthy*. The expression of an 'oh'-prefaced announcement receipt shows that this news has been accepted, not rejected, and indicates this utterance potentially works to display positive reception in this setting, as the worthiness and relevance of the prior utterance, and its status as 'news' are acknowledged. I highlighted that 'oh'-prefaced responses to news frequently occurred in the proximity of the word 'free'. Here the production of an 'oh'- prefaced response specifically targeted the point at which the change of state has taken place, explicitly foregrounding this normatively 'good news' aspect of the news delivery as newsworthy (13), and evidencing 'oh' as receiving 'good' news. Further evidence was provided by the timing and prosodic features these turns shared (5). 'Oh'-prefaced responses were usually produced soon after the GP has finished their turn, without hearable delay in production, or in overlap with the GPs turn. They were markedly higher than surrounding talk and were often emphasised, or vowel sounds were elongated, displaying characteristics of receiving good news (5, 6, 21). Finally, I observed that 'oh'-prefaced announcement receipts frequently foreshadowed marked agreement when an explicit offer was made. No patient who produced an 'oh'-prefaced announcement receipt declined the offer of a free referral, and no patients produced an 'oh' receipt

followed by a negative stance marker (e.g. ‘oh no’, or ‘oh, definitely not’). ‘Oh’ in other settings has been shown to have affiliative properties (15), and to foreshadow acceptance of advice (47). Its close proximity to explicit displays of agreement in this corpus, affiliative design of subsequent turns, and its absence as an explicitly negative news receipt, further indicated that, not only does ‘oh’ indicate prior information is ‘news’, but also asserts an affiliative stance towards the news, foreshadowing its future acceptance. Furthermore, I showed that some explicit displays of acceptance following ‘oh’-prefaced announcement receipts oriented to the potential inappositeness of the referral question, potentially orienting to the fact that agreement had already been displayed.

My results here build upon other conversation analytic work, particularly on ‘oh’ as indicating prior news has been good (12), and foreshadowing future acceptance of advice (15), by also identifying associations between ‘oh’ and acceptance of a free referral. My work here offers additional comment as statistical analysis also showed patients who displayed an ‘oh’-prefaced response went on to attend their referral. This is a new insight into the relationship between in-consultation displays and post consultation action. Lynch (48), and Macbeth and Wong (49, 50) have recently commented that approaches to epistemics, and ‘oh’ seem to take a cognitivist, rather than a conversation analytic approach. Heritage countered this argument by stating that his work “places response cries unambiguously” p.25 (51) within the category of *displays* rather than *mental events*, and this was the approach I took with my qualitative analysis. Additional quantitative findings however, do indicate that these ‘oh’s may be displaying intrinsic motivation, evidenced by patient attendance at their referral.

The association between ‘oh’ and attendance, whilst analytically exciting, may not appear to be explicitly clinically relevant. However, considering this relationship between ‘oh’ and attendance, one property of these responses which I identified becomes of greater relevance – ‘oh’ in this placement can indicate a ‘completeness’ of telling, and index news delivery as complete. Having shown that patients: (a) display ‘oh’ early in the consultation, (b) indicate with this utterance that they require no further information, and (c) go on to attend their referral, offers great potential to shorten brief interventions. Previous work has shown that the production

of ‘oh’-prefaced announcement receipts can either mark news as complete, or request further information, carrying sequence terminating, or sequence expanding properties (6). Indeed, the ‘oh’ receipts in my collection could either expand referral sequences or move them to closing. Although no responses in this collection acted as news marks, specifically requesting elaboration (such as “oh really?”), GPs still did orient to some as sequence expanding. In this collection, as in ordinary talk (22), there was no consistency in which types of responses were oriented to as sequence closing news receipts, or ambiguous standardised ‘oh’-prefaced assessments. “Oh right,” for example was oriented to as both sequence expanding and sequence closing in different consultations despite similar placement and prosody. I believe that it was the way that GPs responded to these utterances which gave them sequence expanding or terminating properties - an utterance must be responded to as sequence closing for it to act to close a sequence. I have shown that GPs in this collection were able to respond to ‘oh’-prefaced receipts as sequence closing news receipts, indicating no further news was required. Orienting to these responses allowed GPs to truncate the news delivery sequence, omitting an elaboration of news, and move smoothly to the explicit referral question and closings. Analysis of consultation times aligned with results from conversation analysis, showing that moving to closing following oh- prefaced announcement receipts offered tangible savings to brief intervention delivery time at an average of 32 seconds per consultation. Furthermore, analysis showed that shortening consultations after an ‘oh’ did not affect patient’s post-consultation reported satisfaction scores. This indicates that these shorter referrals were equally acceptable to patients.

Whilst oh- prefaced responses displayed in-consultation positivity, providing opportunity for clinicians to shorten the discussion, actual rejections displayed negativity towards the referral and yet offered similar opportunity to shorten interventions. In this chapter I demonstrated how patients in the BWeL trial display ‘actual rejection’, and three ways that GPs responded to these displays. These actions were hearable as explicit rejections of the referral ‘no’ or ‘no, not really’. Doing a refusal is typically delicate work, often mitigated with accounts, delays, hedges, or ‘palliatives’(52) (apologies, hedges, delayed acceptance etc.) which act to moderate the rejection being done. The typical pattern of doing rejection or refusal outlined by Kitzinger and Firth is the following:

"*delay* in responding, some kind of *prefacing* of the refusal (with words like, 'well', or 'ahhh . . .'), a *palliative* remark, and some kind of *account* aimed at softening, explaining, justifying, excusing, or redefining the rejection." p.302 (53)

Whilst the wider literature states that refusals are regularly followed by explanations or justifications p.86 (54), this pattern was not always observed in these data. Whilst actual rejections could be mitigated though delayed responses (u::m no) or followed with accounts to avoid blame for refusal (55) "I probably wouldn't have the time..", they could also be stand-alone actual rejections ("no").

Other studies in clinical settings have found variability in the production of rejections. Heritage and Sefi showed that actual rejection of advice was rare in institutional talk (47), and rejections were more likely to be resisted passively through asserting competence, or through production of unmarked acknowledgements. Rejection was more frequent in Stivers' study of pediatric antibiotic prescribing in the USA. She demonstrated that parents could employ a range of resources to resist treatment recommendations against antibiotics for their child (36), including active resistance where parents question or challenge the doctor's treatment recommendation, implicitly or explicitly rejecting the proposed treatment and requesting another. The existing literature has shown that the 'usual' way to do a refusal involves some form of mitigation, and that actual rejections can be responded to as rude, or argumentative (46, 53).

In avoiding mitigations, patients in the BWeL corpus may be clearly asserting they do not wish to engage in further discussion. Actual rejection displays were relatively uncommon, with only 26 in the collection. This was usually done with a 'no' response. In producing these rejections without mitigations, patients in the BWeL corpus show that they are able to reject the GP's advice without explaining their decision. A potential reason for these displays of actual rejection in these data lies in the tension between what is or is not 'doctorable' and in whose epistemic domain health behaviours are situated. Patients refuse recommended treatment in a way that may not be done, for example, when visiting the doctor for symptomatic, traditionally medicalised presentations. Patients' ability to reject so explicitly potentially asserts the perceived un-doctorability of obesity, and therefore combats

the clinician's claims to epistemic dominance - patients have no need to account for their rejections because they do not need to justify their decision to a medical professional, as this is not a medical problem. This raises interesting points about how obesity is framed in these discussions. In the previous chapter I showed that a key component of a good news delivery was to frame weight loss as a benefit, rather than obesity as a problem. I continue this discussion around the medicalisation of obesity in the next chapter, and discuss wider perspectives on obesity in Western society in the final chapter of this thesis.

I observed that clinicians frequently pursued responses from patients following displays of actual rejection. Opel et al's study of vaccine hesitant parents found that, if rejections were pursued by clinicians, around half of parents who initially resisted would agree (56, 57). In the BWeL trial, I identified two ways a GP could pursue a response. Either through news elaboration – delivering information that could rectify troubles in understanding – acting to 'convince' or 'persuade' patients following a displayed actual rejection; or through 'motivational interviewing' turns where barriers to weight loss were elicited and addressed. In contrast to Opel's work, only two patients in this collection move from initial resistive responses to displays of agreement. These occurred following extended 'motivational interviewing' discussions led by the same GP. This GP followed a motivational interviewing patterns with three of his patients. It was not something the GP training from the trial team included, however, the skill they demonstrated in moving from resistance to acceptance indicates this GP potentially may have been trained in this method. Engaging in motivational interviewing turns was not shown to generate resistance displays. Two out of three patients moved from initial displays of actual rejection to minimal uptake at the conclusion of the motivational interviewing-style sequence. However, the three examples I have of this strategy took 7 mins 38 seconds; 4 mins 59 seconds; 4 mins 28 seconds. These are not characteristic of a brief intervention, and the tightly time limited constraints of a primary care setting would not enable this strategy to be delivered opportunistically to all patients with a BMI$\geq$30. Time constraints are a leading limitation expressed by GPs to delivering either brief interventions (58) or motivational interviewing strategies (31) to address health behaviour change. This strategy did display evidence of effectiveness in producing minimal agreement from patients, and further analysis could reveal the structures

behind this approach in this setting. However, the use of motivational interviewing does not meet my objectives in this thesis to identify how to shorten delivery of *brief* interventions.

Whilst motivational interviewing-style interactions were rare, entering into news elaboration was the most common pattern observed in this collection following displays of actual rejection. As in ordinary talk, rejection was taken as displaying "trouble with or inadequacy of the invitation or offer" and, as such were often followed by attempts to remedy the source of the trouble, and then by a subsequent offer (24). However, rather than acting to remedy displays of trouble, these attempts to pursue agreement though news elaboration and subsequent versions of the referral question could escalate initial rejection displays. These findings align with the literature reviewed in Chapter 2 review of this thesis where data from my systematic review indicated that pursuing responses after resistance displays often resulted in further displays of resistance. In the BWeL trial, initial displays of actual rejection had potential to result in marked displays of resistance following elaboration of news. Attempts to convince or persuade patients to attend after initial rejection potentially implied that their decision was the wrong one. This work is potentially face threatening and questions the agency of the patient in the decision-making process, if their rejection can in turn be rejected by their GP. It is understandable then, how these sequences of 'rejecting a rejection', even if achieved through persuading or convincing turns, could result in the escalating displays of marked resistance I have observed. Statistical analysis showed that patients who displayed actual rejection were unlikely to attend their referral. This rejection was displayed early in the consultation, offering potential time savings for clinicians. Some GPs in the BWeL trial demonstrated that they could respond to actual rejection in ways which did not generate resistance displays and expedited closing. Evidence indicates that acknowledging a rejection, doing a confirmation check, and assessment of the patient's response (e.g. "Okay, You don't want to go. That's fine."), then moving to close, did not generate resistance displays. Through presenting the option for referral but acknowledging that some patients do not want to attend, the patient's role as an agent in the decision-making process was acknowledged. NICE guidelines encourage GPs to do this. They state that GPs should "Recognise that this may have been raised on numerous occasions and respect someone's choice not to discuss it

further on this occasion." (NICE, Recommendation 6 (59)). I have shown that GPs did not always follow this advice. Doing so, however, shows evidence of both avoiding resistance displays and saving consultation time.

The evidence from conversation analysis indicates that moving through this news elaboration sequence following actual rejection is time consuming, potentially harmful and does not result in a change in the patient's initial response. Just as I have observed positive stances were maintained through a referral sequence, negative stances also rarely reversed polarity once they were expressed, but they did have potential to upgrade to marked resistance displays. Evidence from conversation analysis indicated that omitting attempts at convincing or persuading patients could smoothly allow GPs to deal with displays of actual rejection and move to closings without taking unnecessary time, or engendering explicit displays of resistance. Statistical analysis showed that acknowledging a rejection and moving to close could have saved an average of 46 seconds per consultation.

My analyses of positive and negative reception display in this chapter has shown that, once a positive or negative stance towards the referral is asserted, pursuing further response is unnecessary (and, in the case of actual rejection, potentially risky). In displaying a positive stance, or actual rejection, patients indicate that they do not want or need further information. Orienting to these displays as asserting a sustained stance towards the referral and subsequently moving to close offers great potential to shorten brief interventions and avoid unnecessary attempts at persuasion. This work foregrounds that clinician action in the early stages of the news delivery sequence is key in soliciting agreement to attend.

In the previous chapter (chapter 4) I showed that a 'good news' delivery was the most effective strategy in terms of patient agreement-to-attend, and attendance. However, I also showed that this took more consultation time than the least effective strategy which was a neutral news delivery. The displays of MPS and 'oh'-prefaced responses examined in this chapter commonly (although not ubiquitously) followed a good news delivery. The results in this chapter, which highlight how to shorten referral sequences, demonstrated that the preferred strategy of 'good news' delivery can be very brief if GPs attend to patient responses.

5.6.2 Implications for practice

GP consultations are short, typically 10 minutes, raising concerns that there is insufficient time for brief opportunistic interventions to be included. These analyses show that through attending to clues in what patients say, GPs can shorten delivery significantly. When delivering a brief intervention for weight loss, GPs can attend to displays of marked positive stance, and turn initial 'oh' receipts, as indicative that the referral has been positively received. These occur early in the consultation and are clearly associated with uptake and attendance. Similarly, GPs can attend to displays of actual rejection, as displays that an offer has been negatively received. Trying to convince or persuade following a 'no' response was not successful and could be harmful, generating further disagreement from patients. When patients refuse referral, evidence shows that the best course of action is to accept this refusal. This does not generate further resistance displays, avoiding potential threats to the doctor-patient relationship, leaving the door open for further discussion another time.

These phenomena, particularly displays of MPS and actual rejection, are easily recognisable, and do not need detailed knowledge or training to recognise. In fact, many GPs did recognise these displays and move to close, and the training resource highlights how GPs in the BWeL trial did so (see appendix 6).

Conclusions from this chapter have been incorporated into the GP training resource in the following sections:

- Recognising a 'yes'
- How to deal with a 'no'

Attending to these clues can avoid unnecessary negotiations and significantly shorten the delivery time of brief interventions for weight loss, thereby addressing one of the main concerns GPs report about intervening to change behaviour (1, 2, 58).

5.7 Summary

I have shown that brief interventions in primary care can be very brief when GPs attend to specific reception displays. Understandably, GPs frequently attended to 'yes' or 'yeah' as positive responses to the announcement of the offer of a free CWMS referral, yet I have observed that such responses neither acted as positive reception displays within the consultation, nor were they associated with subsequent attendance at the CWMS. I have identified two types of participant response (displays of marked positive stance and 'oh'-prefaced announcement receipts), which displayed that an offer was positively received. Statistical analysis demonstrated an association between these responses and future action and established that in-consultation displays of positive reception were associated with participant attendance at weight management services. Furthermore, there was no significant difference in patient attendance or satisfaction rates between GPs who oriented to these displays, and moved to closing, and those who did not. Displays of marked positive stance and 'oh'-prefaced responses occurred early in the consultation. Recognising these could have saved an average of 15 and 32 seconds respectively per consultation.

GPs acknowledged displays of actual rejection (such as "no" or "not really, no"), and often attempted to convince or persuade a patient to attend. These attempts at persuasion did not change the patient's initial response but could engender resistance displays and took up further consultation time. Displays of actual rejection occurred early in a consultation. Orienting to actual rejection and moving to closings could have saved an average of 47 seconds per consultation.

5.8 Reflections

This chapter documents one of the first practices I observed when undertaking my initial period of 'unmotivated looking' during data analysis, and was my first experience of applying CA to clinical settings. When initially exploring the data, it

was patient responses to the doctors' talk, rather than the doctors' talk itself, which I because interested in. 'Oh'-prefaced responses to the offer of a free commercial weight management service were my first collection, as I was really interested in finding out the interactional work achieved by 'oh'-prefaced responses. It was exciting whilst analysing the data in this chapter to see how finding a phenomenon of interest, and conducting a detailed fine-grained analysis could generate genuinely novel findings of clear clinical interest.

I learnt a lot during the process about the strengths and challenges doing conversation analysis. An initial challenge was the discovery that 'oh'-prefaced responses work differently depending on whether advice or information preceded them. I concluded that the 'ohs' in my collection were responding to the same thing repeatedly, and whether this was advice or information (or advice as information, or information as advice) (60, 61) did not need to be a key focus of analytic interest. Rather the function and placement of the 'oh'-prefaced responses; how GPs oriented to these; and what patients did next could be a focus, with an understanding that information and advice are neither easily separated, nor easily defined. What mattered for these analyses was that the information or advice was *news* to the patients, and framing the responses within Maynard's news delivery sequence led to my conceptualisation of the whole interaction as a news delivery sequence, and to my next steps of thinking about 'good' and 'bad' news. 'Oh'-prefaced responses my first finding and helped me to unravel what was happening in these consultations. By identifying what aspect of a news delivery 'oh'-prefaced responses foregrounded as 'good news' I was able to start to identify the components of a 'good news' delivery and explore associations between how news was delivered and subsequent patient action, as presented in the previous chapter.

5.9 References

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Chapter 6

The impact of linking weight with health in the BWeL trial

6.1 Conferences

Earlier versions of this chapter have been presented at the following conferences:

- Albury, C., Webb, H., Stokoe, E., Ziebland, S., & Aveyard, P., *The impact of linking weight with health on patient outcomes in a brief intervention for weight loss*. SPCR Research Showcase 'Working Better Together'. University of Oxford, September 2017

- Albury, C., Webb, H., Ziebland, S., Stokoe, E. & Aveyard, P., *Strategies for linking weight with health in the BWeL Trial.* 6th International Meeting on Conversation Analysis and Clinical Encounters (CACE), Bristol University, July 2017

6.2 Introduction

In chapter one I outlined how guidelines exhort GPs and other primary care clinicians to deliver brief interventions for weight loss which incorporate the offer of referral. Although these guidelines rarely specify how, a common theme across resources recommends that GPs emphasise the "health benefits" of weight loss. NICE guidelines on brief intervention delivery, for example, recommend articulating an association between a patient's weight and their health (1, 2). RGCP guidelines also encourage clinicians to talk about weight in the context of both a patient's future health and their presenting complaint, as well as stating that GPs should present weight-loss in the context of "wider health benefits" (3). Reports of their own practice from primary care clinicians align with these recommendations. Primary care clinicians state that they are most likely to discuss weight in relation to a

patient's existing condition (4-6), and often report that they think it is most appropriate to do so (7). Some GPs in the BWeL trial stated that they found it easier to link weight and health when delivering brief interventions, and that they thought patients found this approach helpful (Wheat, 2018. Personal correspondence).

Despite this recommendation, and alignment with current practice, no study has examined how weight and health are linked in brief interventions for weight loss, and how patients respond to this practice. Clinical guidelines recommending associating weight and heath are developed from expert opinion, rather than evidence of effective practice (8). Furthermore, whilst clinicians report finding this strategy 'effective', a small body of work relating to health behaviour change talk has indicated that this practice may not be as effective as guidelines and post-consultation reports claim. In Chapter 3 I presented the evidence on linking health behaviour change to a medically relevant concern (9-13). Evidence from weight-loss (13) and smoking cessation (11) discussions indicated that 'linking' is a delicate strategy which can be successful if the linked concern is salient for a patient, or if there was already a shared understanding of the relevance of health behaviour change for a particular health concern. However, these studies also showed that linking has strong potential to generate resistance displays. My systematic review and thematic synthesis in Chapter 3 highlighted some conflicting evidence from Freeman's USA primary care study (10), which also explored weight management and smoking cessation discussions. In contrast to other conversation analytic work (11, 13), this study stated that linking health behaviour change with a well-known illness condition was the 'least disruptive' pattern observed (10). I outlined that the excerpts shown in Freeman's study demonstrated a GP linking behaviour change with seemingly salient concerns, but that how linking was achieved was not a key focus of her work.

Existing conversation analytic work suggests that linking is a delicate strategy to employ, with potential to generate resistance from patients. However, there are a number of knowledge gaps; the effect of this strategy in brief interventions for weight loss has yet to be explored in detail, and no existing study has explored associations between linking in-consultation and patients' longer-term actions. In this chapter I address these knowledge gaps. I first, in section 6.4.1, explore how

GPs in the BWeL trial linked weight with health, and in section 6.4.2 I examine where linking occurred in the referral sequence. Next, in section 6.4.3 I present several ways that a link between weight and health can be articulated. I then focus in detail on one type of linking and explore the responses this was likely to generate from patients (section 6.4.4). I discuss how this type of linking was used in a series of ways, each with the potential to motivate different responses in a patient's next turn. In section 6.5, to address the current knowledge gap regarding longer-term associations between linking and patient action, I identify quantitatively the effects of different types of linking on patient in-consultation agreement to attend a commercial weight management service (CWMS), subsequent CWMS attendance, and post-consultation satisfaction reports. Then, in line with my objective of identifying how brief interventions could be shortened, I explore the effect of linking weight with health on the overall length of a brief intervention. Finally, I discuss the clinical implications of linking weight with health in brief interventions for weight loss, and draw out recommendations for practice.

6.3 Areas of interest

To summarise, I address the following areas in this chapter:

- How was weight linked with health?
- How did patients respond when their GP linked weight and health?
- What was the effect of linking weight with health on patient outcomes: agreement-to-attend and attendance at their free referral, post-consultation satisfaction reports, and consultation length?

6.4 Analysis

6.4.1 Making links explicit – GP turn design in linking sequences

Clinicians explicitly associated a patient's weight and their health in 110 out of 246 brief weight loss interventions in this corpus despite the training which recommended explicitly not to do this. In this section I exemplify 'linking weight with health' and explicate how GPs deigned their turns to make hearable associations between these. Having defined 'linking' in this section, I examine the placement of linking within the referral sequence in the next section, before looking in detail at how linking is delivered and responded to.

When initially analysing the BWeL referral sequence I noticed that GPs often topicalised the patient's weight in the context of their wider health, as exemplified in Excerpt 6.1:

Excerpt 6.1 43-01-15

```
1  Doc:    So Joan (.) the: u:m (.) thank you for
2          joining this study::, U::m (.) in essence you have
3          been randomised into what we call the support
4          arm, Which basically means that um you go back
5          and see the nurse in a moment.= .hhh Um you'll
6          be offered the opportunity to lose weight
7          through a- a sort of dedicated weight
8          loss programme.
9          (.)
10 Doc:    Now we know that that is the best um way
11         of people losing weight and keeping that
12         weight o:ff.
13         (.)
14 Doc:    Um and you know all the °benefits of losing
15         weight are°.= U:m .hh in terms of cardiovascular
16         risk, U::m reducing your risk of developing
17         diabete:s, Reducing the (.) you know the
18         strain on your joints,
19         (0.3)
20 Doc:    You know- you know it's all mani- it's
21         pretty manifest what the >you know< what the
22         implications of losing weight are.
```

In Excerpt 6.1 the GP makes explicit associations between the patient's health and their weight from lines 14-18. He initially discusses reduction of risk of future

conditions, including cardiovascular risk, and risk of developing diabetes. He then links to a health concern - reducing "strain on your joints". This excerpt illustrates how GPs could articulate a link between a patient's current health condition, or the risk of future health problems. Therefore, I defined the action of 'linking weight with health' as:

"Articulating an explicit association between a patient's existing or potential health concern and their weight"

I will now discuss briefly how these associations were *made* explicit in GP talk. Following this I show where these links were placed in the referral sequence. The most frequent way that GPs initially linked weight and health was through two consecutive turn constructional units (TCUs). The first TCU was commonly the last TCU in a multi-TCU turn. These turns topicalised, or re-topicalised weight or weight loss (Lines 10-12, Excerpt 6.1). This was usually explicitly saying 'weight', the evidence for losing weight, or stating the patient's BMI.

The second TCU acted to provide a reason for weight loss - either to benefit health, or reduce chance of disease (lines 14-16, Excerpt 6.1). Whilst this was usually a single TCU turn, it was sometimes the first in a series of turns which mentioned different health conditions or disease risk, illustrated in Excerpt 6.1, lines 16-18.

The second TCU usually contained a connective discourse marker in turn-initial position. This was most commonly *and* (line 14, Excerpt 6.1), and more rarely *so* or *now*. These act to indicate a relationship between the first TCU and the next. The work these discourse markers do in associating each turn with the next differs slightly. And-prefacing, for example, acts to display speaker continuation (14, 15), and continuity and coherence with the information delivered in the previous TCU. *So* indexes inferential or causal connections between the first TCU and the second (16), whilst *now*, "guides the hearer's linkage of an utterance to an appropriate context" p.2128 (17). These TCU initial components make the link explicit in their role as indexing a connection between the first TCU, which foregrounds the topic of weight, and the second, which evokes health.

Very rarely, links were also articulated without a discourse marker. Instead, conjunctive adverbs (specifically, 'because' and 'especially') acted as TCU initial components. These did similar work to indicate relationships between TCUs. 'Because' acts as a "continuation signal" p.127(18), and 'especially' acts to both signal continuation and emphasise the relatedness between the two TCUs.

Although, as I have stated, weight and health were most commonly linked in two consecutive TCUs. They could be linked within a TCU which mentioned both weight and health. For example, "There's lots of evidence that losing weight really helps with your general health", and "With all the problems you've had losing a bit of weight would help". However, these same-turn associations were not used frequently.

To summarise, weight and health were most commonly linked through two consecutive 'and'-connected TCUs. However, there was some variation in how GPs linked weight and health. Links are first made explicit in (1) their proximity to topicalisation, or re-topicalisation of weight or weight loss in same or next TCU, and (2) in turn-initial lexical devices which indexed connectivity between these two TCUs. Listing of medical conditions in the GP's subsequent turns are then hearable in this environment as linked with weight. Following Pilnick and Coleman (11), I now refer to this action as 'linking'.

6.4.2 Placement of linking within the referral sequence

I have shown that GPs articulated a link between weight and health, and explicated how these links were constructed. In addition to 110 GP-initiated instances, there were 4 discussions where a patient initiated linking themselves before the GP had done so. Most consultations where weight and health were linked were initiated by a GP. This action was done in a number of sequential positions in the BWeL referral sequence, and some GPs linked in more than one of these placements. The descriptions of each placement are presented below, and illustrated in Figure 6.1:

- **Placement 1 (**85/110 consultations**)**

GPs linked weight and health in the pre-sequence, before delivering the news of a free referral.

- **Placement 2 (**9/110 consultations**)**

GPs followed the news of a free referral with a link between a patient's weight and their health.

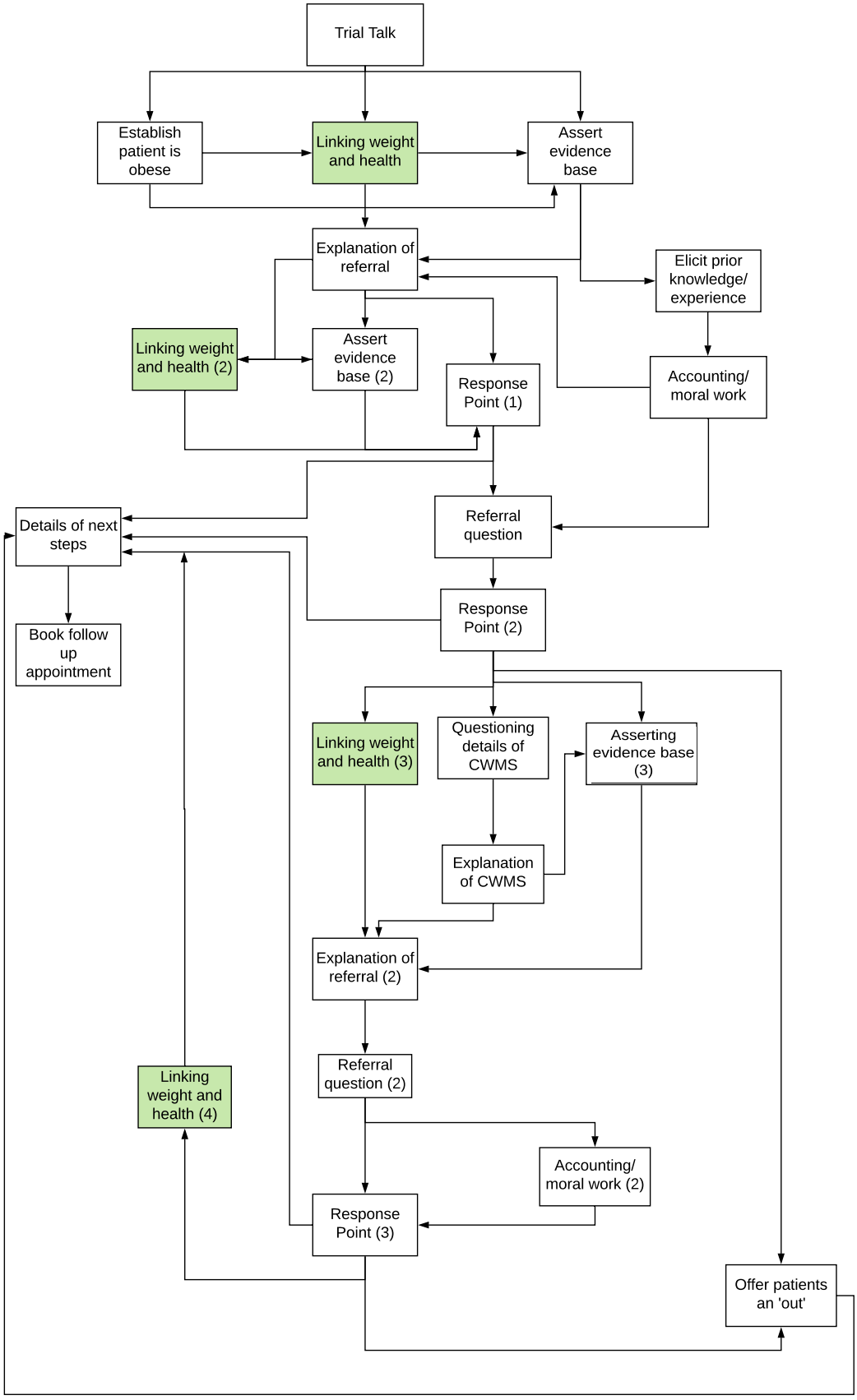
- **Placement 3 (**8/110 consultations)

GPs linked following the patient's initial response, when this response displayed equivocation, resistance, or rejection.

- **Placement 4 (**8/110 consultations)

GPs linked during closings in consultations where a patient had already agreed to referral.

Figure 6.1 Placement of linking within the BWeL referral sequence



As I was aiming to understand the impact of linking on subsequent action, I examined linking in placements 1 and 2, and present this analysis in this chapter. Figure 6.1 illustrates that linking in these placements typically occurs before a patient has initially responded to the referral question. I have shown in the previous chapter that patients display positive or negative reception early in these referral sequences and, once a stance towards the acceptability of referral is asserted, it is maintained throughout the sequence. It is likely that GP action early in the sequence may generate these positive or negative reception displays. Therefore, my focus on linking early in the discussion will be helpful to inform future strategic decision making about how best to communicate in these crucial early stages of the referral sequence. The majority of cases of linking occurred in placements one and two, and I had a collection of 94 consultations where linking was done in these early stages of the consultation. This large collection provided opportunity for statistical analysis to explore relationships between linking in these early stages, and patient attendance.

Linking in placements 3 and 4 are not explored here because I found no evidence which showed they work to produce displays of agreement. Linking in placement 3 occurred when patients had already responded to the referral question and displayed equivocation, resistance, or rejection. Linking acted as a device to pursue a different (positive) response. However, I have already shown in the previous chapter that attempts to convince or persuade are largely unsuccessful, and escalated resistance displays. In line with these results, linking in this placement worked to escalate resistance. An emerging trainable from the previous chapter was not to pursue a different response from patients. Therefore, a detailed exploration of how GPs pursued responses though linking (in placement 3) has no further relevance for training. Linking in placement 4 occurred at the very end of the consultation, after patients had already agreed to referral. They usually did so through a positive reception display, or a series of positive reception displays. Therefore, linking in this position performed no function in generating agreement-to-attend, and is not presented here.

In the next section I first show how linking was achieved, and I illustrate the actions in a typical linking sequence. I then explore GP initiated linking, highlighting the

diversity of this practice. I follow this with a detailed examination of one particular way of linking weight with health.

6.4.3 Types of linking in the BWeL trial

I have exemplified and classified what I refer to as 'linking' in this chapter. I have also shown where these links occurred in the BWeL corpus. Previous research has identified 'linking' health behaviour and health as a phenomenon in behaviour change talk (10, 11, 13, 19). However, my analysis of the BWeL corpus showed variability in both *who* initiated this practice, and in line with Pilnick and Coleman's work (11), *how* personally relevant linking was designed to be. I now examine these types of linking.

Excerpt 6.2 30-02-29

```
1  Doc:    U::m is that something that you would be
2          in[terested in doing?
3  Pat:    Yes. I would be.=
4       →  = Cos I could do with >losing a bit<, Because,
5  Doc:    Yes, £Okay.=G[reat£.
6  Pat:→                  [I've got so many conditions now
7          actually tie >with- with polycystic ovaries<
8          it's hard with weight loss anywa:y.
```

As I have stated, linking could be patient-initiated, although this was extremely rare (N=4). This occurred in the environment of placement two, usually as an account for accepting the referral. In Excerpt 6.2 the patient, during her acceptance of the referral, says "I could do with losing a bit" and accounts for this with self-articulated link between conditions that "tie" with weight, including her polycystic ovaries. This type of linking could carry some moral elements, where patients evoke existing conditions known to cause weight gain to "defend their moral status" (20) and avoid personal responsibility for a high BMI. For example, in this excerpt rather than associating a *behaviour* with her high weight, the patient here links with a condition that is known to be associated with weight gain – her polycystic ovaries. In doing so this patient asserts her weight as a medical problem, rather than a behavioural one. She also asserts her own knowledge of the relationship between her existing

condition and difficulties with weight loss, morally asserting herself as a 'good' patient (20). I classified this as 'patient initiated linking'.

It was more common for GPs to initiate linking. They could do so as part of a negative news delivery sequence (see chapter four), preceded by asserting the patient's BMI. Alternatively, they could link without first signalling bad news. I will now focus on GP initiated linking and explore this practice in more detail. I observed a number of ways GPs did 'linking' within this sequence. These were linking to a current condition in ways which were hearable as personalised for a particular patient, or non-personalised for 'patients in general', and ranged from talking about a specific problem, to general health. GPs could also link to a potential future condition through articulating risk. I discuss each of these practices in the five excerpts presented below. These have been chosen as they exemplify each way linking could be achieved:

Excerpt 6.3 03-01-11

```
1  Doc:    And basically th- y- you've been randomised
2          (0.4) to the group which is (.) sort of
3          suggesting that (0.4) support (.) for
4          losing weight.
5  Pat:    Yeah.
6  Doc:    I- is you know the evidence is showing
7          th- that (0.4) is >sort of< will positively
8          help you lose weight.
9          (.)
10 Doc:→   And definitely (0.4) again from blood
11         pressure point of vie::w, (0.4) With
12         your blood pressure being a bit bo:rderline,
13 Pat:    Yeah,
14 Doc:    It may be (0.4) if you could lose a bit
15         of weight that will even (0.4)> you know<
17         that will bring it down.=So it won't even
18         be bo:rderline anymo:re.
19         (0.3)
20 Pat:    Yeah.
```

Following topicalisation of weight the GP in Excerpt 6.3 initiates linking using a connective discourse marker 'and' to indicate a relationship between her turn from lines 6-8 and lines 10-12, where she mentions blood pressure. This acts to and craft a link between weight and borderline blood-pressure. In linking weight and this patient's borderline blood-pressure, the GP asserts a link between weight and a

specific current condition that is hearable as personally relevant for this specific patient. I have classified this action as 'specific personalised linking'.

Excerpt 6.4 04-01-19

```
1  Doc:→  We know a lot of um (0.4) health problems a:re
2         (.) connected with weight? And if you get
3         weight do:wn (.)- y- you know the (0.4) outlook
4         is often better (.) for [things like blood pressure.
5  Pat:                           [Oka:y.
6         (.)
7  Doc:   Blood pressure would get ea:sier to control if
8         you get your weight do:wn.
9         (.)
10 Doc:   So (.) I would strongly encourage that to you, The
11        (.) u:m (.) so um >by going along to a group< you
12        get information. You get suppo:rt, They >weigh you<,
13        On a weekly basis.
14        (0.4)
15 Doc:   There are clinics around in the area.
```

In Excerpt 6.4 the GP links weight with health from lines 1-8. She initiates the link with "we know a lot of health problems are connected with weight" at lines 1-2. Although she uses "you" at line 2 this is not followed by any other personal pronouns and is combined with a hypothetical "if". Therefore, this turn is delivered as such that it is not directly hearable as relevant for this patient. In this instance "you" can be heard as referring to "speaker, or recipient, or someone, or everyone" (21), as I observed in chapter three (22). This hypothetical talk refers to a specific condition (blood pressure) but is not explicitly delivered as personalised for this particular patient. I classified this type of talk as 'specific non-personalised' linking.

Excerpt 6.5 09-02-20

```
1  Doc:→  And these people are running a study to try
2         and en::courage people u::h a:y to >understand
3         the benefits< of being lighter,= Because it's not
4         all about- it has a (.) hu:ge impact   on a lot of
5         illnesses.
```

Excerpt 6.5 shows the GP begin a linking sequence at line 1 by re-topicalising weight. His linking turns are explicitly delivered as relevant for 'people in general' rather than personalised for this specific patient. In contrast to Excerpt 6.4, the

conditions that are linked to weight are generalised by the GP, as he mentions "a huge impact on a lot of illnesses". These linking turns are neither personalised to this particular patient, or reference a specific condition. I have classified this type of linking as 'general non-personalised linking'.

Excerpt 6.6 06-07-03

```
1  Doc:    You've (.) also had your weight done haven't you,=
2  Pat:    =Yes.
3  Doc:    And you know that your bee em ↓eye is-=
4  Pat:    =Quite [high.
5  Doc:→           [>Is high yeah<,= And that affects (0.4) you
6          know your health generally.=
7  Pat:    =Yeah.
```

The GP in Excerpt 6.6 links the patient's weight and health on lines 5-6. In the GP's turns prior to this link she talks to the patient about "your weight" (line 1) and "your bee em ↓eye" (line 3). The "your" used during the GPs linking turn - "your health generally" - is hearable in the context of these prior personal pronouns as referring to this specific patient. Conversely, the link between weight and health is an explicitly general one, rather than relating to a specific condition. I classified this type of linking as 'general personalised linking'; it was hearable as personalised but did not link to a specific condition.

Excerpt 6.7 12-02-20

```
1  Doc:    Um the:: (.) measurements the girls have
2          taken show that you a:re (.) sli:ghtly overweight,
3          (0.6)
4  Doc:→   .tch and that will have an impact on your
5          risk of becoming diabetic later.= We already
6          know your sugar's< s:lightly high.
7          (2.1)
8  Doc:    Definite health benefits. Long term protection from
9          losing weight, A:nd (1.6) the best way of doing
10         that is really to do it via a: (0.7) professional
11         weight (0.5) losing: (.) support group, Like (0.4)
12         .hh (0.9) Rosemary Connelly, O:r Slimming World.
13         (.)
14 Doc:    .hh normally, you have to pay for that.= We can
15         offer that free at the moment.
16         (0.5)
17 Doc:    That is your best way of (.) taking weight off
18         and reducing your ri:sks.
```

The final type of linking I observed in shown in Excerpt 6.7, where the GP links weight and health from lines 4-9. Rather than linking to a current condition, he links to the risks of developing future disease. In this case, diabetes. The GP talks about weight loss here both in the context of "reducing risks" (line 18) and offering "protection" (line 8). The GP emphasises the personal relevance of risk reduction and protection for this particular patient on lines 5-6, by stating that ">We already know your sugar's< s:lightly high." When talking about potential future conditions it was common for GPs to use either risk framing, or to talk about the protective nature of weight loss. In all cases this talk was hearable as personally relevant for particular patients. I have classified this action as 'personalised linking to risk of a specific future condition'.

In Chapter 3 I observed how advice giving could be designed to be hearable as more or less personally relevant to a particular patient (22-25). My initial exploration of linking weight and health presented so far in this chapter has also shown a number of delivery formats that GPs used when doing this action, that varied in the degree to which they were hearable as personally relevant for a particular patient. This analysis showed that what initially seemed to be one phenomenon- linking weight and health - is actually a series of phenomena: patient initiated linking; specific personalised linking; specific non-personalised linking; general non-personalised linking; general personalised linking; and personalised linking to risk of a specific future condition. The different ways of achieving GP-initiated linking are summarised in Table 6.1.

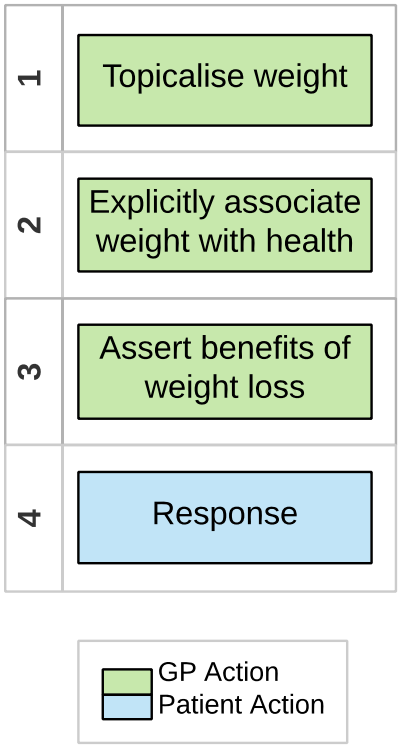
Table 6.1 How GPs in the BWeL trial linked weight with health

	Non-personalised	Personalised
General Condition	"…encourage people to understand the benefits of being lighter because it has a huge impact on a lot of illnesses…"	"…that affects you know your health generally."
Specific Condition	"Losing weight will obviously help the bones help the heart…"	"Especially with your arthritis in the shoulder."
Risk of future specific condition	-	"…reduce your risk of heart problems or diabetes when you're older."

Although the types of linking differed, the excerpts above showed that linking generally followed the same sequence. Figure 6.2 illustrates the actions within a typical GP-initiated linking sequence in the placements of focus here.

In section 6.5 of this chapter I examine statistical relationships between each delivery format for linking weight with health and patient in-consultation agreement to attend the CWMS, and subsequent CWMS attendance. I also explore relationships between linking weight and health, and patient-reported satisfaction. However, I will now take a more detailed focus on one of these phenomena 'specific personalised linking', maintaining my attention on placements 1 and 2. This type of linking was most interesting analytically, most frequent across this collection, and is the type recommended by guidelines for GPs to use. A detailed analysis of this practice offers contribution to the body of conversation analytic work on this topic (9-11, 13) and also highlights how this guideline is implemented in practice, and with what response.

Figure 6.2 Typical linking sequence



6.4.4 Specific personalised linking

I have categorised 'specific personalised linking' as instances where a GP links in a way that is hearable personalised for a particular patient's specific problem. I exemplified this practice in Excerpt 6.3. Linking in this way - to a specific condition that was hearable as personally relevant, such as 'your arthritis'- was the most common practice used by GPs. I explore this practice in detail in the subsequent seven excerpts presented in this section. Due to the placement of linking it was not possible or appropriate to directly explore the effect of linking on patient uptake displays, as these typically occurred much later in the discussion. Excerpt 6.8 for example, shows linking early in the sequence from lines 1-7, but the referral question is not done explicitly until line 22. Therefore, in the section below I explore the range of responses patients produce in their next turn following specific personalised linking. These were consistent whether or not GPs had preceded by asserting the

patient's BMI. Following each exploration, I display a wider referral sequence and use these results to explore the possible implications of specific personalised linking for patient uptake displays later in the conversation.

Excerpt 6.8 06-07-35

```
1  Doc:→  .hhhh and I know you've had a you've had a-
2         you've had a few knee problems.
3         (0.4)
4  Doc:   Um (1.0) .tch   and we know that also your
5         immunity's not quite as good, (.) If  you're
6         (0.4)um >a bigger weight< than you should
7         be. The u:m (0.4) we also know that the best
8         way to lose weight is through an intervention,
9         Where you have a twelve week (0.4) say (0.4)
10        cou:rse (0.4) of (0.4) erm somebody helping
11        you lose weight,= Giving you advi:ce (.) monitoring
12        you that kind of thing.
13        (0.3)
14 Doc:   .hhh erm if you'd be interested in doing that
15        there's um a choice available through the research
16        trial. Either exercise or (0.4) dietary.= Whichever
17        one you want.
18        (.)
19 Doc:   U:m then the researcher can >organise that<
20        for you, And you ca:n >give it a< ↑go.
21        (0.6)
22 Doc:→  How does that sound,
23 Pat:   Yeah.
24 Doc:   ↑Yeah? Sh[all we do that then?
25 Pat:           [Sounds fine.=Yeah.
26 Doc:   Oka:y. So I'll give you um this back and then
27        you go and see the re:searcher,= And she'll
28        arrange the appointment with someone for you.
29 Pat:   Okay,
```

6.4.4.1 Patient responses to specific personalised linking

6.4.4.1.1 Minimal responses

Excerpt 6.9 09-01-07

```
1  Doc:   And you know what in case (.) in your >especial<
2         case, especially with arthritis in your knees(.) it
3         would always be ↓help if you would be able to
4         lose [some weight.
5  Pat:        [Yeah.
```

In Excerpt 6.9 the GP links weight and health from lines 1-4. Her linking turn is initiated as personalised for this particular patient "in your >especial< case," and articulates an association with this patient's current medical condition "especially with arthritis in your knees" before moving to assert the benefits of weight loss. During this assertion, in the projectable completion of the GPs turn, the patient responds on line 5, with a minimal acknowledgement "yeah". As Schegloff states (26), and we have observed in chapter five, 'yeah' cannot be taken at its semantic face value of 'doing agreement'. Rather the patient's "yeah" acts as an unmarked advice receipt, occurring in response to the GPs turn which is hearable as advice giving in that it "describes, recommends, or forwards a preferred course of action" (27); in this case, weight loss to help with arthritis. This acts to receive the GPs linking turn, but avoids displaying a stance as to its acceptance, or establishing an undertaking to follow this advice (27). This type of minimal unmarked acknowledgement was the most frequent response following specific personalised linking.

As I have previously stated, linking was not placed closely to the referral question. A number of actions could occur between linking and patient acceptance or rejection of the referral. Whilst it is not possible to observe the direct implications of linking and uptake or rejection, the excerpt below highlights where linking is placed in the wider referral sequence, and I also exemplify the usual pattern of patient response following a minimal response after specific personalised linking. The referral sequence shown in Excerpt 6.9 is continued in Excerpt 6.10, illustrating the typical pattern of patient response following linking throughout the referral sequence.

Excerpt 6.10 09-01-07

```
1  Doc:    And you know what in case (.) in your >especial<
2          case, especially with arthritis in your knees(.) it
3          would always be ↓help if you would be able to
4          lose [some weight.
5  Pat:         [Yeah.
6  Doc:    .hhh there are two option- two arms of that
7          study.= One is >kind of< I do a short intervention?
8          (0.6)
9  Doc:    And you haven't fallen into °that one°.
10         (0.6)
11 Doc:    You're in the other s- °u::h° other arm of
```

```
12          the stu:dy, Which means that I can offer you (0.4)
13          to take part (.) i:n (.) in one of these f:ree
14 Doc:     weight management classes,
15 Pat:     °Hm mm°.
16 Doc:     hhh and there's <kind of> the Weight Watcher classes
17          and one of them is kind of actually in Placebury?
18          (0.4)
19 Doc:     And we can give you a free voucher for this. So
20          you could freely take part in this.
21          (0.3)
22 Doc:→    Would you be interested in this?
23 Pat:     N::o. °No. ° I've been on these things and (0.6) I
24          can do it myself, You know just-
25 Doc:     Mm,
26 Pat:     You know #I've come down a bit no::w#,
27          (0.6)
28          Y- (0.6) it's like I said >if I< (0.4)I've got
29          the pains in the knee:s and everything, I can
30          get rid of tha:t.=
31 Doc:     =Mm.
32 Pat:     You know I can do more exercise you know,
```

When explicitly asked about the referral at line 22 the patient displays actual rejection (28), followed by an account "I can do it myself". During this rejection sequence (lines 23-32) the patient explicitly mentions the GP's prior link between weight and his knees. He then asserts "I can get rid of that" and presents exercise (rather than the CWMS referral) as the solution.

Minimal responses following linking were generally followed by further minimal responses or rejection of the offer. Stivers (29) indicates that minimal responses can work to display resistance, and the trajectory between minimal response and rejection in this excerpt indicates the patient's initial responses may have been doing some passive resistance work. Minimal responses following linking were rarely associated with displays of positive reception to the referral question, further evidencing their resistance work. Whilst these responses potentially display some passive resistance, through not explicitly receiving advice, a second pattern of response seemed to do passive resistance more explicitly, and I now discuss this.

6.4.4.1.2 Passive resistance

Excerpt 6.11 09-02-20

```
1  Doc:    Ri:ght (.)  so:: (.) when they put you on
2          the sca:les (0.3)  your height weight rati:o,=
3  Pat:    =Mmm.
4  Doc:    Gave you a figure of thirty two::. Now that
5          technically it's not good for you, Being over
6          thirty.
7          (.)
8  Doc:    And these people are running a study to try
9          and en::courage people u::h a:y to >understand
10         the benefits< of being lighter,= Because it's not
11         all about- it has a (.) hu:ge impact   on a lot of
12         illnesses.
13         (.)
14 Doc:    including some of the ones that are relevant
15         to yo:u.
16         (0.3)
17 Doc:    Particularly your blood pressure.
18         (0.6)
19 Doc:    Even possibly your gout.
20         (1.3)
21 Doc:    U:m (0.6) So weight loss (.)controlled weight
22         loss on a healthy diet (.) can be very
23         beneficial to you.
24         (1.6)
```

Another common pattern of response following linking sequences is exemplified in Excerpt 6.11. Interestingly, linking weight and health sometimes followed an assertion of the patient's BMI as problematic. The term BMI to describe weight acts explicitly to medicalise weight (30), and often started a bad news delivery, as I discussed in chapter four. This action could be followed by minimal responses or no responses, which continued after linking. It seems asserting a problematic BMI could initiate a resistance trajectory, that was not overcome by linking weight with health.

Following asserting the patient's BMI the GP initiates linking at line 8, and it becomes hearable as personally relevant on lines 14-15 with the GP s turn "including some of the ones that are relevant to yo:u.". Following this turn delivered with turn final intonation and hearable as completing an informing, it was potentially relevant for the patient to respond. However, they do not so and, after a gap, the GP provides clarification on his prior turn "particularly your blood pressure." Again, this turn has falling intonation, signalling the GP has completed their turn, and has remedied any potential misunderstanding about what conditions are 'relevant' for this patient,

which could account for their withheld response at line 16. The patient does not respond to the further information delivery at line 17, and there is a further gap in talk. The GP then links to a second condition, potentially pursuing a response to this linking sequence, and once again the patient passes their opportunity to respond. The patient here is presented with a series of relevant points to respond to the GP's informing turns (lines 13, 16, 18, 20, and 24), and at each point a response in withheld. This explicitly avoids acknowledging the prior talk has been informative. In avoiding response, the patient is neither affiliating with GPs stance (asserting the impact of weight on health) nor aligning with the ongoing activity of the referral sequence. In avoiding engaging in the co-creation of this ongoing sequence we can view these responses as resistance displays. Following Stivers (29) and Heritage and Sefi (27, 29) I have called this pattern of response 'passive resistance', as these responses resist acknowledging links between weight and health by avoiding responding. In this excerpt, passive resistance occurred in a resistance implicative environment as the GP had linked following asserting the patients' BMI as problematic. However, responses were similar when BMI had not previously been asserted. I now explore how these passive resistance displays are situated within the wider referral sequence and the pattern of response which was common after passive resistance to specific personalised linking.

Excerpt 6.12 06-07-35

```
1  Doc:    .hhhh and I know you've had a you've had a-
2          you've had a few knee problems.
3          (0.4)
4  Doc:    Um (1.0) .tch   and we know that also your
5          immunity's not quite as good, (.) If  you're
6          (0.4)um >a bigger weight< than you should
7          be.
8          (.)
9          The u:m (0.4) we also know that the best
10         way to lose weight is through an intervention,
11         Where you have a twelve week (0.4) say (0.4)
12         cou:rse (0.4) of (0.4) erm somebody helping
13         you lose weight,= Giving you advi:ce (.) monitoring
14         you that kind of thing.
15         (0.3)
16 Doc:    .hhh erm if you'd be interested in doing that
17         there's um a choice available through the research
18         trial. Either exercise or (0.4) dietary.=Whichever
19         one you want.
20         (.)
21 Doc:    U:m then the researcher can >organise that<
```

```
22          for you, And you ca:n >give it a< ↑go.
23          (0.6)
24 Doc:     How does that sound,
25 Pat:     Yeah.
26 Doc:     ↑Yeah? Sh[all we do that then?
27 Pat:              [Sounds fine.=Yeah.
28 Doc:     Oka:y. So I'll give you um this back and then
29          you go and see the re:searcher,= And she'll
30          arrange the appointment with someone for you.
31 Pat:     Okay,
```

The GP in Excerpt 6.12 links the patient's weight with their current knee problems, and with their immunity. The patient withholds response at line 3 and line 8 where an acknowledgement may be expected, and then continues to withhold responses up until line 23. When there is no response to either the hearable completion of the referral question (lines 16-19) and elaboration of referral (lines 21-22) the GP produces an interrogative turn, which makes a response relevant at line 24, "How does that sound,". Rather than producing a preferred response (e.g. good, fine, or okay) or a dispreferred response (e.g. not so good) the patient produces a minimal acknowledgement in this placement "yeah". Then GP orients to this as potentially problematic through her pursuit of a response on line 26. The patient then elaborates with her response "Sounds fine.= Yeah." which is produced with flat intonation, avoiding displaying enthusiasm or positivity in her hearable uptake of the referral. The GP next provides further details, and the patient once again produces minimal responses in her remaining turns. Although the action of specific personalised linking does not occur in the proximity of patient response to the referral question, I observed a pattern where patients who displayed passive resistance to linking would often withdraw engagement from the ongoing co-creation of the referral sequence, passively resisting through the rest of the sequence, or produce minimal responses rather than enthusiastic displays of positive reception.

6.4.4.1.3 Explicit resistance

Whilst the two response types observed so far seem to both passively resist (either implicitly with a minimal response, or explicitly by withholding a response), a third response type actively resisted GP initiated linking, and I exemplify this in the subsequent excerpt.

Excerpt 6.13 51-04-16

```
1  Doc:    h hhh h um and this has been proven (0.4)
2          to be helpful.
3          (0.6)
4  Doc:    In weight loss especially if (.) if there's
5          obviously issues with mobility::,
6          (1.2)
7  Doc:    U::m (0.6) the:n,=
8  Pat:    =CAN I ask u:h just (0.4) cut to the chase,
9  Doc:    Yup.
```

In Excerpt 6.13 the GP initiates linking in her turn at line 4, making an explicit link between weight loss and mobility. It is hearable as personally relevant for this patient through the use of "obviously" indicting that issues of mobility should be seen, known, or understood by both parties in the interaction. The GP's intonation at the end of her turn at line 5 "if there's obviously issues with mobility::," indicates she may be seeking a response, as her extended elongated vowel sound and rising intonation somewhat indicate a wait for acknowledgement. However, the patient does not respond to this link between his weight and health and there is a 1.2 second gap in talk. The GP takes a further turn following this gap, initiated with a hesitation marker "U::m" and then a pause. She restarts her turn following this, but is abruptly interrupted by the patient. His turn is initiated as an interrogative, but after a pause he says an abrupt, staccato "cut to the chase". This disrupts the flow of the referral sequence; the patient takes the floor, and forcefully questions the GP in a clear move away from the usual dynamic I have observed in the BWeL referral sequence (or the typical progression of clinical talk in general). His emphasised consonant sounds throughout this forceful delivery, making this turn hearable as a clear display of resistance.

Excerpt 6.14 shows how this sequence progresses. Following his resistance display to linking, the patient asks the GP what format the referral takes, she replies "you go to meetings", and the patient then rejects the referral. He provides two accounts for this rejection, firstly at line 17 "I'm not that sort of person" and secondly at line 19 "travelling is a nightmare for me". Following the second account the patient enquires about the exact location of the referral. The GP directs him to the researcher. There is second display of marked resistance at line 26 when the patient forcefully says "listen" followed by an acknowledgement that his weight is "a problem". He then

goes on to state that "all this" (hearable as referring to weight loss, or weight management classes), is "alien" to his nature. In stating his "nature", and the type of person he is, the patient evokes a membership category, rather than an external excuse – such as continuing to discuss travel difficulties – which acts to resist referral further and makes pursuit on behalf of the GP difficult. He follows this statement with a "#yeah#" tag, forcefully requesting agreement from the GP, which is not forthcoming. The discussion then moves away from discussing referral to an extended conversation about this patient's diabetes treatment. In summary, this example illustrates a sequence of linking, resistance, and sustained resistance throughout the sequence.

Excerpt 6.14 51-04-16 cont.

```
10 Pat:    <WHAT FORMAT> (.) IS that (.) does it >you
11         know< #there's ho:w?#
12 Doc:    <You go to mee:tings.>
13 Pat:    O:h I dun it. >I'm not gonna< do that.
14 Doc:    Y- you've done meetings.
15         (0.8)
16 Doc:    You're not keen,
17 Pat:→   Uh (0.6) I'm- I'm not that sort of person.
18 Doc:    No?
19 Pat:→   Travelling is a nightmare for me.
20         (0.6)
21 Pat:    Where is it? Where would you go:?
22 Doc:    .tch (1.0) that's something that the chap (0.4)
23         next door would organise, (0.4) For you, (0.4)Um
24         to [find your most local one,
25 Pat:       [I've been- (.) um- at- it would be stupid (.)
26     →   listen weight is a problem for me.
27 Doc:    Yep.
28         (1.0)
29 Pat:    And I've already told the young man (2.0) all this
30         is like alien to my nature (0.6) #>YEAH<#?
31         (1.2)
```

Displays of explicit (rather than passive) resistance were rare across this corpus. We have seen in chapters four and five that resistance displays were not unique to linking sequences. However, linking weight with health could generate marked displays of explicit resistance, as illustrated above. I collected two examples of such displays following linking in this placement.

I have shown so far in this chapter that linking weight and health most frequently received minimal acknowledgement. I have also demonstrated that it often received passive resistance which started in the proximity of a linking sequence and was often maintained throughout the subsequent conversation. This action did not regularly generate explicit resistance, but when this did occur it was marked. Furthermore, the strongest display of resistance in the BWeL corpus (Excerpt 6.13) occurs following a specific personalised link between weight and health. My analysis of linking in other placements is not presented here, but linking following resistance displays or displays of equivocation about the offer (placement 3, Figure 6.1) generated further marked resistance from patients. An example of this was shown in the previous chapter. Excerpt 5.21 showed the GP do what we can now call 'specific personalised linking' following actual rejection from a patient and how this led to an extended and marked resistance display.

Linking is recommended by guidelines to personalise weight management referrals for patients. However, my analysis of patient responses demonstrates that what is clearly absent following specific personalised linking is a display of uptake from patients, or any indication that linking has been oriented to as a useful or helpful action to initiate during the referral process. I have demonstrated that rather than encouraging positive responses from patients, as may be expected from this widely recommended practice, specific personalised linking most frequently generated only minimal acknowledgments or passive resistance, and was rarely followed by patient agreement to attend. I will now consider what about linking weight and health could account for these responses from patients.

6.4.4.2 Linking as a display of epistemic primacy

A common theme across the examples in this collection, in that the link between weight and health was delivered *from* the GP *to* the patient as something one party knows and the other apparently does not. Revisiting Excerpt 6.11 the GP's talk asserts a knowledge asymmetry through an informing turn "now technically it's not good for you," (lines 4-5). In declaring this 'fact' the GP is asserting that it is his right to do so, and a claim to knowledge that the patient does not have. Such

assertions of a "relative right to tell, inform, assert or assess something" p.13 (31) claim epistemic primacy over the second speaker. Knowledge asymmetry, including displays of epistemic primacy, are of course usual in primary care as 'doctor' and 'patient' fulfil different institutional roles, where doctors typically display and assert medical expertise.

However, in typical medical consultations the patient attends the GP to seek advice for a particular problem. Therefore, these displays of epistemic primacy are both expected and invited. Heritage refers to this as *epistemic congruence* as both speakers agree who has greater authority to tell, inform, assert, or assess (32). Conversely, in the BWeL corpus, the GP is opportunistically talking about weight management with their patient, and links to a medical condition to assert weight as an existing or potential medical problem. These assertions of rights to knowledge and associated advice/information delivery are therefore given unsolicited.

The GP asserts epistemic primacy by claiming access to knowledge, and rights to inform the patient of this. The examples shown so far, which typify this collection, illustrate how weight and heath are linked through assertions, and information or advice delivery. The GP's turn from lines 9-10 in Excerpt 6.11 asserts that the aim of the trial is to "en::<u>cou</u>rage people u::h a:<u>y</u> to >understand the benefits< of being lighter,". In doing so, this indicates the relationship between weight loss and heath is not currently understood by "people", including this patient. Linking is generally initiated though an assertion of 'fact' such as in Excerpt 6.11; explicitly from a personal footing "*I* know you've had a- you've had a few knee problems" (Excerpt 6.12, lines 1-2). GPs in the BWeL corpus rarely employed epistemic mitigators such as 'I think' or 'maybe', when linking weight with health which can downgrade their claim to epistemic primacy (33). In taking this position, GPs assert the right to inform a patient of their own condition, but this right was not always accepted by patients. Patients could combat this display of epistemic primacy by asserting their own knowledge of the association between weight and health (Excerpt 6.15):

Excerpt 6.15 23-05-20

```
1 Doc:    There's lots of evidence that losing weight rea:lly
2         helps with you:r ↓general health,
3 Pat:    Well of ↑course it does, >I know it does<.
```

Heritage has observed that these assertions of independent access in a responsive position can combat the initial claim to epistemic primacy (34). These can suggest that either a more symmetrical orientation could be taken or that this speaker, in fact, holds primacy (31). The patient's response at line 3 challenges the GP's asserted primacy. This acts as a display of explicit resistance to linking, as it treats the information delivered on lines 1-2 as redundant. This excerpt highlights how disagreement over epistemic rights can result in an epistemically incongruent situation.

The GP's claim to epistemic primacy holds moral implications. In asserting their right to inform, GPs position the patient as uninformed. They also imply that a patient's health behaviours have caused their linked condition. As well as explicit resistance in the form of outright challenges to epistemic orientation, as in the previous excerpt, patients could also produce moral turns doing 'being a good patient' in response. These turns highlighted that the patient was doing 'good' health behaviours and resisted implications to the contrary.

Excerpt 6.16 53-02-20

```
1  Doc:   Obviously with all the problems you've got (.)
2         losing a bit of weight would a- (.) would help.
3  Pat:   °Ye[ah°.
4  Doc:      [It would reduce the need for insulin
5          °potentially°,
6  Pat:   Mmm.
7  Doc:   It'll improve your heart (0.4) pro[file things like
8         that.
9  Pat:                                     [I try to watch
10        my  diet you see. Keep- try and keep [it down.=
11 Doc:                                       [Good.
12 Pat:   =Cos I 'ave lost a lot since (0.6) back last
13        November. When I had the ope[ra:tion.
14 Doc:                               [No indeed, Indeed.
```

In Excerpt 6.16 the GP links weight and health, and the patient responds with a series of moral statements. “I’m watching my diet” “try and keep it down” and “I have lost”. Whilst the GP claims knowledge of the relationship between weight and health, the patient claims a different type of knowledge; that of this own behaviours. In doing so he asserts a claim that it is not this behaviours that contribute to his obesity, and challenges the implicit assumption that this is the case. Webb’s examination of obesity discussions asserts that there are “simultaneous institutional and moral agendas existing in obesity-related consultations” (20). These are evident in these discussions as epistemics and morality are negotiated.

I have shown that through linking weight and health clinicians assert an epistemic primacy which implies their patient is unknowledgeable about their own condition, and that the GP has rights to inform a patient about this. This resulted in epistemic incongruence, and therefore epistemic tensions. I revisit this concept in section 6.4.4.4, as I demonstrate that linking weight with health through asserting the patient as holding claims to epistemic primacy greatly mitigates the resistance displays I have highlighted so far.

Later in this chapter (section 6.5) I explore statistical relationships between specific personalised linking and patient in-consultation agreement to attend the CWMS, subsequent attendance, and patient reported satisfaction. Whist the majority of patients avoided responding, or displayed minimal responses, to ‘specific personalised linking’, there were two patterns with this group which differed. These were responses following ‘linking to multiple concerns’ and ‘linking by paraphrasing a patient’s prior talk.’ The only examples of patient uptake displays following linking are in response to these two practices. I will now discuss each of these in detail.

6.4.4.3 Linking to multiple concerns:

In the following section I illustrate how GPs linked to multiple specific conditions or concerns, and how this provided opportunity for patients to orient to one which was salient for them.

Excerpt 6.17 09-02-15

```
1  Doc:    So >basically< you've just had your height and
2          weight measured?
3          (0.4)
4  Pat:    (h)Ye(h)s,
5          (0.5)
6  Doc:    And the-=
7  Pat:    = I'm shrinking.=
8  Doc:    = NO you're no:t.=
9  Pat:    =And expanding the (h)other wa(h)y hh hhh hhh
10 Doc:    Your height weight ratio is over thirty so
11         that's why you've been put into the study.
12 Pat:    Mm
13 Doc:    hh it's really to draw to your intention that
14         (0.7) once the height weight ratio goes over
15         thirty (.).hh it means that you clinically
16         obese. And it's not so much that- that >you know<
17         (.) say (.) ↓yeah you're too heavy.
18         (.)
19 Doc:    It's a question of making you awa:re that it has an
20         impact on your circulation.
21 Pat:    °Yeah°
22 Doc:    It has an impact on your meta:bolism.
23         (0.3)
24 Doc:    It has an impact on your joints.
25         (.)
26 Doc:    There are not many systems within the body
27         that aren't adversely affected [once-
28 Pat:                                   [Yeah.= Specially
29         the joints now the arthritis has kicked in. °Yeah.°
```

Excerpt 6.17 shows a preannouncement of news in the BWeL trial. During this preannouncement sequence the GP links the patient's weight with health, starting at line 16. He links through evoking the "impact" of weight on a series of specific bodily systems. He initially links through stating the "impact" of weight on the patient's circulation. The use of 'your circulation' (line 20) makes this statement hearable as a specific and personal link. This receives a quiet minimal acknowledgement from the patient ("yeah") at line 21. The GP then links a second time to the patient's metabolism, which receives no response. The GP then makes a third link with the patient's joints. This completes a three part list (35), making this point therefore the projectable completion of the GPs linking action (36). Indeed, when the patient does not respond here, rather than continue with his 'list of links' the GP initiates another action. This is a broader linking action to "bodily systems", rather than linking specifically as in his previous turns. The patient interrupts the GP

during this turn at line 28, with an acknowledgement "yeah" and says "specially the joints now the arthritis has kicked in". The GP has linked to circulation; metabolism; joints; and wider bodily systems. The patient's turn acts to foregrounded one of these linked items – her joints- as a salient concern, as she has developed arthritis. Through linking to a series of different bodily systems the GP provides opportunity for the patient to foreground one of these as salient-for-her. I exemplify a similar pattern in Excerpt 6.18:

Excerpt 6.18 11-03-04

```
1  Doc:    So (0.6) what we've found is that you're (0.4)
2          a little bit overweight, Oka:y, And that's uh not
3          really that good for your health. In [terms of=
4  Pat:                                         [No.
5  Doc:    =(0.4) you know your joints, Heart disease.
6          (.)
7  Doc:    Diabe:tes, >You know< later on in life (.) pretty
8          much >(I know)< realise it at twenty fou:r you seem
9          invincible, .hhhhh but you're a bit >sort of<
10         (.) on the (0.4) chunky side shall we say,
11 Pat:    Well I found out (.) my u:h (.) my uncle (0.3)
12         hhh has heart disease.
13         (0.5)
14 Pat:    And my granddad (.) has it as well.=
15 Doc:    =Ye:ah so I think it's important we try and get
16         (.) uh your weight down,
17         (0.2)
18 Doc:    .hhh and one of the ways that we fo:und (.)
19         is that if you have a structured e:r >sort of< uh
20         (.) programme to help you lose weight hhh um then
21         (0.4) uh that is much more successful.
```

In Excerpt 6.18 the GP starts linking during the preannouncement sequence from lines 2-9. He initially links to the patient's general health "that's not good for your health", before listing specific bodily systems and diseases that are associated with obesity. As in Excerpt 6.17 this GP also employs a rhetorical three-part list (as do most GPs in this collection). The conditions the GP links to are joints; heart disease; and diabetes that could occur later in life. On lines 9-10, the GP strongly emphasises the patient's high weight saying "but you're a bit sort of (.) on the (0.4) chunky side shall we say,". The turn initial conjunction "but" acts to connect and contrast the idea of being 'young and invincible' with the patient's high weight and risk of developing future disease. The patient responds at line 12, by foregrounding one condition in the GPs three-part list - heart disease - and states that two family

members do have this condition. In doing so the patient highlights the personal salience of this particular condition.

Both Excerpt 6.17 and Excerpt 6.18 illustrate how GPs presented links between a series of concerns and weight, and patients may have oriented to one of these as salient. However, these responses from patients did not always occur following linking to multiple concerns or conditions, as exemplified in Excerpt 6.19.

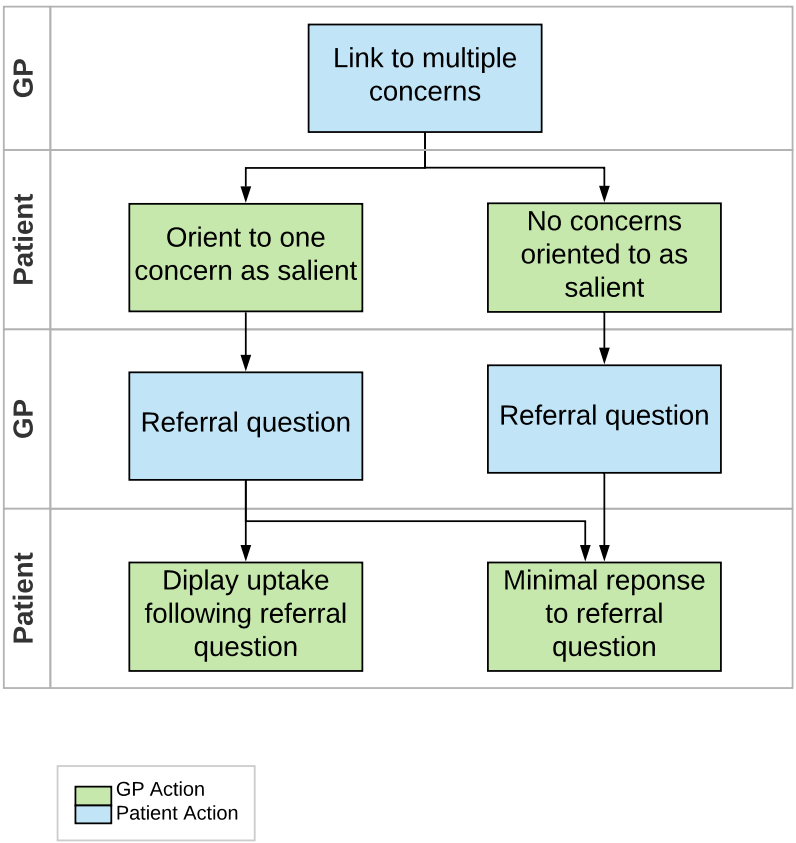
Excerpt 6.19 09-01-18

```
1  Doc:    And as you know (0.4) and generally kind of losing
2          weight will obviously help the bo:nes, Help the
3          hea:rt,
4  Pat:    Yeah.
5  Doc:    Prevent strokes, (.)And and uh (0.4) um (0.4)
6          especially with your arthritis in the shoulder,=
7          =You probably have it in the knees and the hips
8          as well,=
9  Pat:    =Yeah.=
10 Doc:    =Losing weight (.) will (0.6) be very (0.4)
11         you know (.) beneficial (0.4) in the future
12         for your general health.
13         (.)
14 Pat:    Yeah.
```

In Excerpt 6.19 the GP initially initiates generalised linking (from lines 2-5). The use of "the" rather than "your" in these turns means that these links are not directly hearable as relevant for this patient. On line 6 "especially with your arthritis" she employs the possessive pronoun "your" to make this link hearable as personally relevant for this patient. She then says "you probably have it in your hips and your knees as well", continuing the specific personalised linking as she completes her three-part list. This receives only a minimal acknowledgement "yeah" from the patient. The GP then links again to benefit for the patient's general health in the future, which received another minimal "yeah" acknowledgment at line 14. The GP has linked to a number of conditions, and benefits to a number of bodily systems, however none of these have been foregrounded by the patient as salient-for-them, and this linking sequence has received the minimal acknowledgment that I have previously shown was produced frequently following linking sequences. The wider patterns of patient response trajectories throughout these sequences were minimal or passively resistive, as shown in Excerpt 6.9 and Excerpt 6.11.

These extracts illustrate that when GPs linked they sometimes listed a series of health conditions. This provided opportunity for patients to foreground one which was salient for them. However, listing a series of conditions did not guarantee that one of these would be highlighted by the patient. This process is similar to chaining of hypothetical situations as outlined in Sliverman's study of sexual health clinics (23, 25). Clinicians would list a series of hypothetical situations and a patient had the opportunity to identify one of these as aligning with their own practices. Similarly here, through listing a series of health conditions, patients may foreground one as relevant. However, there was no assurance that, when multiple conditions were presented, one would be highlighted as salient. Furthermore, orienting to a link as salient one did not guarantee that patients would display positive reception to the offer of CWMS referral. This process is illustrated in Figure 6.3. Additionally, GPs rarely took further steps to orient to the relevance of a patient's salient condition. The GP in Excerpt 6.18 for example, continues the consultation without acknowledging the patient's identification of a salient concern, or tailoring subsequent discussion accordingly.

Figure 6.3 Patient responses following specific personalised linking to multiple concerns



6.4.4.4 Linking by paraphrasing a patient's prior talk

So far in this chapter I have presented an overview of where linking occurs within the BWeL referral sequence and explored the different ways through which the action of 'linking weight and health' could be achieved. I have focussed on specific personalised linking in two key placements: in the pre-sequence, before delivering the news of a free referral; and immediately following the news of a free referral. I have demonstrated that patients most frequently produce a minimal response or display passive resistance following specific personalised linking in these placements. I showed how, through linking to a series of concerns, GP provided patients with an opportunity to orient to one of these as salient-for-them. However, this response was not guaranteed. Furthermore, foregrounding a condition as salient was not consistently followed by displays of uptake of the referral.

In nine out of the 52 consultations where GPs initiated specific personalised linking the GP crafted the link in a clearly different way; through paraphrasing a patient's prior talk, as demonstrated in Excerpt 6.20, below. This type of linking received a clearly different type of response from patients in their next turn. I will now present a detailed analysis of how paraphrasing was achieved in the BWeL trial, and how patients typically responded to this practice.

Excerpt 6.20 46-01-62

```
1  Doc:     So (0.8) as you- (.) >we were saying  < (0.4)
2           the problem with the- the weight being hi:gh
3           is the fact that (.) u:m the diabetes is not so
4       →   well controlled.= As you were saying.=.hh and-
5           and then you have more insulin, More tablets,
6           And more problems.
7  Pat:→    That's right.
8  Doc:     So the question really is what is the best way
9           to lose weight,
```

In this excerpt the GP establishes the patient is overweight and forms a clear association between weight and an existing condition – diabetes. The sequence here is the same as I have observed in previous examples of linking (and illustrated in Figure 6.2); the GP topicalises weight (lines 1-2), raises a prior concern and associates this with weight (lines 3-4), asserts the problems of obeisty (lines 4-6) and moves into trial procedures. However, rather than the claims of epistemic primacy (37) we saw in many of the previous examples (*I'm* sure the problems you've had are all relate to your weight) the GP is linking by apparently paraphrasing the patient's own words.

In the GP's turn at line 1 "as you-" he does what is hearable as initiating paraphrasing. However, he then initiates a self-repair (38) for a collaborative turn ">we were saying<". This acts to both assert that prior talk had been a collaborative venture and to topicalise the patient's weight. The GP then goes on to associate "high" weight with a lack of control over the patient's diabetes. Following this, at line 4, the GP says "as you were saying". This explicitly marks the GP's previous turn as a paraphrase, so that it is hearable to the patient as being a paraphrase of his own prior talk. Such paraphrases are "inevitably selective" (39); they act to

foreground a particular aspect of prior talk and in doing so background the rest. Whilst we do not know the time, place, or details of the prior talk that is being evoked we can infer that this paraphrase is not a word-for-word recount of the patients talk, and it has undergone "local editing" (39) by the GP to foreground the aspect of relevance to the current conversation.

From lines 5-6 the GP employs a three-part list (35, 36) which I have shown is frequently used as a rhetorical device in these linking sequences to both assert the problems linked to being overweight and project action completion. Following the three-part list "and then you'll have more insulin, More tablets, And more problems" the patient displays a response which is different from all of those observed so far to specific personalised linking. He responds not minimally, but with "That's right". This response can be seen as a marked confirmation (40-42), not just acknowledging prior talk has occurred, but indexing agreement with this association between weight and health. The production of "That's right" could also be seen to acknowledge this prior talk as a paraphrase, as this utterance has also been associated with doing 'remembering'(43, 44). Although the actions of 'remembering' and 'agreeing' may seem initially different, Barnes (45) and Clift (46) identify common ground between the two. Both actions are associated with claims to a-priori knowledge and, at line 7, the patient's 'that's right" affirms something already known by the recipient (46). This contrasts with the epistemic incongruence observed in section 6.4.4.2 of this chapter. Rather than claiming epistemic primacy, which I have observed could subsequently be challenged by patients, the GP here mitigates epistemic claims through apparently paraphrasing the patient's prior talk. "As you were saying" acts to present the link between weight and health not as 'something *I* only know' which I observed could generate orientations to epistemic incongruence, but as either 'something *you* know' or 'something *we both* know', creating a more symmetrical epistemic orientation (31). As well as avoiding epistemic tensions, paraphrasing also differs in the action being achieved. Rather than linking occurring in 1st position, to initiate discussion, the GP changes their action to a *responsive one* to the patient's prior topicalisation at another time. Through reframing their action as a responsive one, the patient is shown to have already made this association themselves, and uptake becomes more relevant: I observed in chapter 3 of this thesis that patient-initiated health behaviour change talk was unlikely to be resisted; and I also

observed earlier in this chapter that patients who linked weight and health themselves often displayed subsequent uptake of the CWMS referral. Stokoe and Edwards (47) and Simpson (48) have explored how evoking prior talk can serve to invoke a version of the original teller's point of view. In foregrounding this prior view and seemingly quoting what the patient has said, subsequent talk is framed not as unsolicited advice or information giving, which Heritage and Sefi state is potentially problematic (27), but as collaboratively building on a prior *patient-initiated* action. In the BWeL corpus this claim of 'saying the same thing' has the ability to transform subsequent talk, as shown in the example below:

Excerpt 6.21 10-01-04

```
1  Doc:    Sorry >just to start again<, Ha- ha- t- have
2          you ever th- (0.4) thought about getting
3          any help for losing weight.
4  Pat:    Not rea:lly.
5  Doc:    No.
6          (0.6)
7  Doc:    Oka:y,
8          (0.6)
9  Doc:→   .hh and you mentioned earlier about (0.8)
10         you being on steroids for a long whi:le,
11 Pat:    Yes.
12 Doc:    U::m (.) and then (.) you've now developed
13         diabetes, And- and the high blood pressure,
14         (0.8)
15         .hhh so all those things will helped wi-
16         with weight reduc[tion really,
17 Pat:                     [Absolutely.
18 Doc:    As y- you're probably well awa:re.
```

The GP in Excerpt 6.21 initially asks the patient if they have "thought about getting any help for losing weight". The patient responds with a clipped "Not rea:lly.". The production of this dispreferred response is seemingly resistive and avoids inviting further discussion of weight loss or positively respond to the topicalisation of weight. The GP acknowledges this response from lines 5-7 then initiates paraphrasing on line 9: "and you mentioned earlier" and then directly references a number of concerns - long term steroid prescription, diabetes and high blood pressure. Whilst steroid use is specifically identified as a paraphrase, from lines 12-13 when talking about diabetes and high blood pressure, it is unclear whether the GP is paraphrasing or not. On line 15 the GP clearly moves back into his own words with a "so" discourse marker indicating that what is coming next is separate

but indicates an "inferential or causal connections" p.974 (49) between the previous turn and the forthcoming one. In this turn the GP then explicitly links concerns expressed by the patient with her weight and asserts weight loss as a solution. This receives a marked "absolutely" from the patient in overlap with the GP's talk, indicating affiliation with the articulated relationship between weight loss and health improvement. In this case the GP has not paraphrased a patient's prior link between weight and health, as in Excerpt 6.20. Rather paraphrasing has been used to craft a link by paraphrasing the patient's own words to evoke a relevant health condition they have spoken about, and then moving to link these with weight to receive marked acknowledgement. Prior to paraphrasing the patient produces a seemingly resistive response. However, evoking the patient's own previous words allowed a link between weight and health to be safely crafted without generating further resistance and producing marked agreement. Couper Kuhlen states that "claims of saying the same thing' p.557 (50) transform subsequent talk to a 'joint venture'. Here the act of paraphrasing has transformed subsequent talk to a collaborative effort. Through paraphrasing, the GP has co-implicated the recipient in the subsequent linking sequence. This co-implication explains why even if a patient hasn't articulated a link previously, moving from paraphrasing to linking still received marked agreement.

So far I have called these claims of saying the same thing *paraphrasing*, but these could also be called *formulations* (51). However, most studies of formulations display access to the prior turns which the speaker is formulating (47). In the BWeL corpus no instances of "saying the same thing" formulate talk to which I have direct access, and so these do not wholly align with may be usually called a formulation. However, Pino et al. observed a similar practice and described this as "You said"-prefaced *paraphrases* p.6 (52). The "You said" explicitly marks this as a local editing of something the patient has said – even if this is not talk to which there is access. Therefore, following Pino et al., I have also described this phenomenon as *paraphrasing* throughout this thesis. Additionally, in line with my applied focus, this term is perhaps more understandable to clinicians than *formulations*.

I have shown so far paraphrasing can foreground a patient's previous association between weight and health, or evoke a relevant health condition they have spoken

about, and then moving to link these with weight. A third way paraphrasing was done occurred in one consultation and is presented below:

Excerpt 6.22 46-01-77

```
1  Doc:    So (0.8) we've obviously had you wei:ghed. A:nd
2          we know your weight is one hundred and
3          tweny two:,= Which has got - (.) we call your
4          body mass index (.) which is fort[y six.
5  Pat:                                     [Yeah.
6  Doc:→   But as you would say (.) you know it's up,
7          T[hat's the root of all your problems.=
8  Pat:     [hh hh
9  Pat:→   =£Tha:t's ri:ght.£= Yeah.
```

In Excerpt 6.22 the GP topicalises weight and informs the patient of their BMI from lines 1-4, receiving a minimal response. He then does what is hearable as what I have called a *speculative* paraphrase, not evoking what the patient has *said*, but what they *would say* at line 6 ("but as you would say") before associating high BMI and health problems at line 7. Rather than evoking a specific conversation 'as you said' this paraphrase may be evoking a number of previous conversations about this topic, with "would" evoking something this patient has done a number of times in the past and this GP is projecting he would say again. This speculative paraphrase is followed by affiliative laughter from the patient, and the subsequent association with health received marked agreement in smiley voice from the patient "£ Tha:t's ri:ght. £ = yeah.". Although the GP has not paraphrased a specific aspect of a prior conversation, he has seemingly used his prior knowledge of this patient to speculate a potential current response, and it has received clear uptake. The work this does in seemingly evoking patient's own words is similar to the other instances of paraphrasing, and generated a similar response.

I have demonstrated in Excerpt 6.11 that specific-personalised linking in this position without paraphrasing is likely to generate minimal responses or resistance. Conversely, every time the GP paraphrases in this position whether the patient had previously associated weight with health, or whether the GP makes this association themselves following paraphrasing, it results in a marked acknowledgement from the patient. I have shown so far in this chapter that conversations were the GP uses specific personalised linking often result in minimal uptake displays when the

referral question is done explicitly. However, the response trajectory following paraphrasing was different, and I explore this in the two excerpts presented below.

6.4.4.4.1 Patient response trajectory following paraphrasing

Excerpt 6.23 25-06-29

```
1  Doc:    So what we're do- >what this is all< about (.)
2          (.) is (.) to (.) see (.) if (.) supporting you
3          with weight loss (0.4) >gives better results than<
4          letting you do it alone.= So what we're doing is
5          offering u::m slimming club membership. For free.
6          For twelve weeks. And the:n (.) seeing how you get
7          on compared to people that >we're not offering
8       →  it to<.= So(.) >like you've said< you've already
9          said (.) °a couple of times in this consultation°
10         (.) hh tha:t losing weight would help,
11         (.)
12 Doc:    And it probably wou:ld help.
13 Pat:    [°Mm°
14 Doc:    [With your hips, And your back.
15         (1.3)
16 Pat:    And me legs.
17 Doc:    £And [your legs£.
18 Pat:         [h hh h h h
19 Doc:    Would you be interested in doing it?
20 Pat:    V:ERY interested [°(in) doing it.°=
21 Doc:                     [Okay,
22 Doc:    =Brilliant.
```

The GP initiates paraphrasing at line 8 explicitly marking her forthcoming turn as a paraphrase of the patient's own words "So(.) >like you've said< you've already said" and then paraphrases the patient's prior talk "losing weight would help". The GP then seems to go back to her own words at line 12 doing an agreement with the turn she paraphrased "and it probably wou:ld help." The emphasis on *would* highlights that the GP is agreeing with the patient's paraphrased turn, and she moves from this agreement to an elaboration on the specific areas weight loss would help with – the patients hips and her back. Following this the patient offers a third area weight loss would help with, that seems salient for her "and me legs.". In offering another link between weight and health this patient is affiliating with the GPs action of doing linking, and her first turn following this 'paraphrase + link' sequence is an

affiliative one. The GP confirms the link between weight loss and helping the patient's legs with a partial repeat at line 17 "£and your legs£.". The patient affiliates with laughter (53) during this turn, displaying a second affiliative response to linking. Following the explicit referral question at line 19, the patient repeats the second part of the GP's question, and upgrades her answer with the addition of an emphasised 'very' - "V:ERY interested °(in) doing it.°". This repeat and upgrade format displays strong uptake of the referral, and is oriented to as such by the GP who assesses this response as "Brilliant". This is the only example of a move to closing in the proximity of linking by paraphrasing. This excerpt shows how an affiliative response following paraphrasing continued throughout the rest of the referral sequence and was followed by a display of strong uptake.

It was more usual pattern following paraphrasing for a longer discussion to take place with many patient-initiated questions. Therefore, displays of patient uptake could not be observed as directly related to the GPs paraphrasing turn. I return below to the patient from Excerpt 6.22, who displayed marked agreement following paraphrasing, and explore the trajectory of the conversation following this turn:

Excerpt 6.24 46-01-77 cont.

```
1  Doc:    So (0.8) we've obviously had you wei:ghed. A:nd
2          we know your weight is one hundred and
3          tweny two:,= Which has got - (.) we call your
4          body mass index (.) which is fort[y six.
5  Pat:                                     [Yeah.
6  Doc:→   But as you would say (.) you know it's up,
7          T[hat's the root of all your problems.=
8  Pat:     [hh hh
9  Pat:→   =£Tha:t's ri:ght.£= Yeah.
10 Doc:    So (.) the question really is (.) what is-
11         (.) what is the best way to lose weight?
12 Pat:    Mmm,
13 Doc:    And the evidence that we've got now (.)
14         building up from what we call resea:rch(.)
15         is that the best way >↑potentially< for you
16         to lose some weight would be to try going to one
17         of these commercial slimming pro:grammes.
18         (.)
19 Doc:    Hhh have you ever heard of them?
20 Pat:    Well e- I- (.) obviously - I've got to say yeah,
21         (.)
22 Pat:    But whether it comes down to this actual
```

```
23          business (.) but- u:m I know there is all this
24          thing - frightens me to death >some of em< (.)
25          (.) but (.) I've hea:rd, Yeah.
26 Doc:     Oka:y. So the sort of things I'm talking about are
27          things like Slimming World? And u:h there's one
28          called Rosemary Conle:y, There are a number of
29          them which (have) a:l[l-
30 Pat:                          [Oh yeah,= ↑Slimming World.=
My
31          sister's in that.
32 Doc:     Yeah. And that's been shown to be very very
33          effective.
34          (.)
35 Doc:     You said that it >frightens you to death<. What
36          sort of thing were you ta:lking about when you
37          were meaning <frightens you to> death? Were you
38          thinking of-=
39 Pat:     =Hypo.
40 Doc:     Yeah. O:kay. Well (.) I think the u:::m- I mean
41          the way that the sugars are at the moment(.)
42          °if we just quickly: have a look on there°.#The::
43          (5.9)- yeah. So (.) I mean (.)(.) >obviously< it
44          may be that if you truly can get some wei:ght do:wn
45          (.) that u::m we could (.) get your insulin down.
46 Pat:     Well, Yeah.= It's a double edged sword innit.=
47          =[Yes.
48 Doc:       [Which would be fant(h)ast(h)ic.=
49 Pat:     =Yeah.=Y[eah.
50 Doc:             [Because if we got - if you lost some
51          weight you get your insulin ↓dose down. If you get
52          your insulin dose do:wn (0.3) you'll lose some
53          more weight.
54 Pat:     Yeah.
55 Doc:     So if we can start breaking that cycle (.) that
56          would be brilliant.
57 Pat:     Yeah, I'm all for tha:t.= Yeah.
```

This conversation is longer than many I have shown in this thesis, and this was common across my paraphrasing collection. This conversation continues for another 121 seconds after the fragment shown here. I have demonstrated that, in 'typical' conversations where GPs initiated specific personalised linking, a patient's subsequent responses were minimal (for example Excerpt 6.9 and Excerpt 6.10). Conversely, we can observe that this patient produces more than minimal responses in most of his turns. These act to simultaneously affiliate with the ongoing referral sequence and also to elaborate on initial responses, aligning with the GPs stance. For example, in the linking sequence from lines 43-45 the GP asserts the benefits of weight management for insulin dose, and the patient responds with "well, yeah."

followed by an elaboration "it's a double edged sword innit". This displays his understanding of the relationship between insulin reduction and weight reduction. Each time a response to referral is made relevant in this discussion the patient responds positively, for example "Yeah, I'm all for tha:t.= Yeah" on line 57. Furthermore, the discussion beyond this fragment ends with the patient's response "There's no one would be more keen than me to do that" which displays clear uptake of the referral.

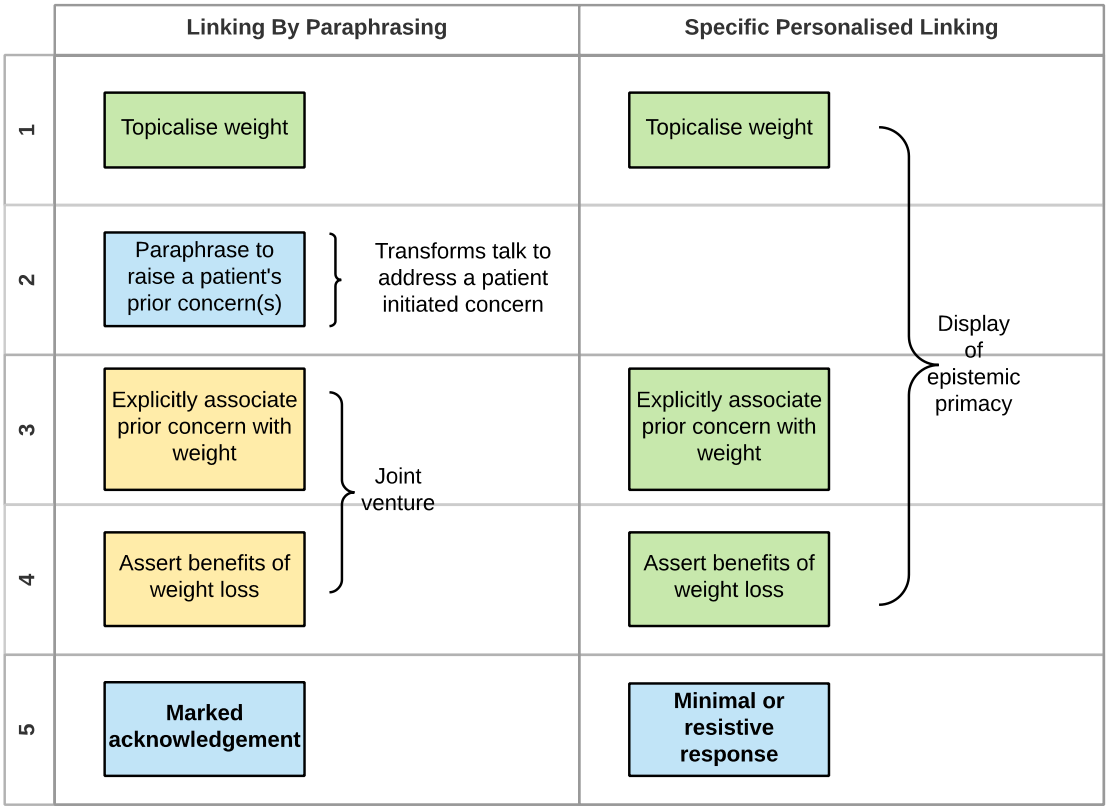
This excerpt exemplifies those in this collection. Whilst many turns occur between paraphrasing and uptake displays, it was usual for a paraphrasing turn to be followed by affiliative turns and positive responses to the referral through the rest of the brief intervention discussion. It was also common for patients to elaborate on their responses. I have already stated that paraphrasing a patient's prior talk acts both to mitigate epistemic incongruence and create a collaborative environment for subsequent talk. Exploration of the wider sequence, as presented in Excerpt 6.24, further evidences this, as patients take more frequent and longer turns, potentially due to the collaborative environment asserted through paraphrasing. These discussions appear lengthier than discussions where weight and health were not linked. Later in this chapter I quantitively explore the length of consultations where a GP linked, or did not link, weight and health, and I specifically explore the length of conversations where the GP used paraphrasing.

6.4.4.4.2 Specific personalised linking and paraphrasing – clinical dominance and collaboration

I have shown that GPs use paraphrasing to do a number of actions. Firstly, to formulate patient's prior talk to evoke a prior shared understanding of the relationship between an existing condition and the patient's weight. Secondly to use paraphrasing to craft a shared understanding by framing advice giving as patient initiated rather than unsolicited, and finally by hypothesising what a patient *would* say. Patient responses contrasted strongly with specific personalised linking without paraphrasing, as the responses received were consistently positive. Having explored both displays of epistemic primacy, and the role of paraphrasing in building

collaborative discussions in this chapter, patient responses can be better understood when framed in these environments of clinical dominance or collaboration. Figure 6.4 illustrates the effect of displays of epistemic primary and collaboration on patient responses, and the subsequent conversation in these collections.

Figure 6.4 The effect of linking by paraphrasing on subsequent talk



I have shown in this chapter that there are a number of ways GPs can link a patient's weight with their health. I have focused on the phenomenon of specific personalised linking in two placements before patients respond to the referral question.

Figure 6.5 illustrates the different types of specific personalised linking I have explored and patient responses following these. I have shown that this practice can result in minimal responses, passive resistance and, in rare cases, explicit resistance displays. If specific personalised linking is done through listing concerns, patients may respond minimally, but they may orient to one of these concerns as salient for

them. If they do so this may be associated with later enthusiastic uptake of referral, but may also be associated with a minimal response. I explored how specific personalised linking could be initiated through paraphrasing something a patient had previously said (or hypothesising what they 'would say'). This practice resulted in marked receipts from patients in their next turn and often in displays of enthusiastic uptake when the referral question was delivered. In the next section I statistically explore the the 'linking' phenomena I observed during conversation analysis.

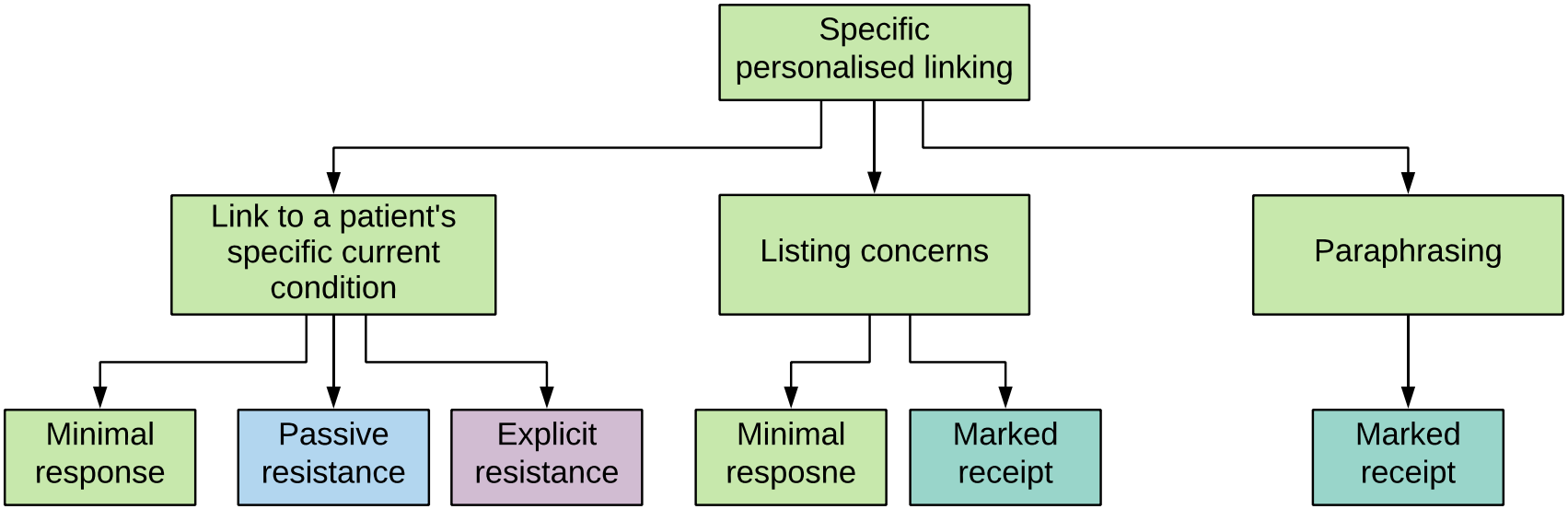


Figure 6.5 Patient responses following specific personalised linking

6.5 Linking weight with health and outcome measures

6.5.1 Quantification point and methods of statistical analyses

I examined the association between linking and the outcomes consultation length, post-consultation satisfaction reports, agreement-to-attend, and initial attendance at the weight management programme, as outlined in Chapter 2. I first coded all consultations for the presence or absence of the GP-initiated action 'linking weight and health'. I identified four placements where linking was initiated by GPs. I chose placements 1 and 2 (in the preannouncement or announcement) as my point of quantification. This is because these occur before patients respond to the offer of referral. Therefore, linking in these positions may generate agreement, or non agreement-to-attend. As evidence from conversation analysis showed the work that linking achieved in placement 1 and 2 was similar, I combined these placements in my statistical analyses to increase power to detect differences.

I conducted univariable logistic regression analyses to compare the likelihoods of patient agreement to attend, and then attendance at the CWMS in each group, calculating odds ratios (ORs) and 95% confidence intervals (CI), relative to consultations where a GP did not initiate a link between weight and health. I then conducted a linear regression analysis to explore relationships between linking weight and health and continuous variables patient satisfaction, and consultation length. I next conducted multivariate regression logistic and linear regression analyses incorporating participant age and gender as confounding variables.

Conversation analysis showed that some ways of 'linking weight and health' appeared more effective than others. I coded the 'linking weight and health' group into a series of codes: type 1- 'specific personalised'; type 2- 'general personalised'; type 3- 'specific non-personalised'; type 4- 'general non-personalised'; and type 5- 'personalised linking to risk of a specific future condition'. If there were multiple links to weight and health that incorporated different strategies I coded the first one used. I repeated all regression analyses, comparing type of linking with consultations where a GP did not link. Conversation analysis also showed that one

type of linking 'specific personalised' could be delivered in different ways. I conducted further univariable an multivariable regression analyses examining relationships between two sub-categories 'paraphrasing a patient's prior talk' and 'specific personalised linking without paraphrasing', and consultations where a GP did not initiate a link between weight and health.

6.5.2 Results of statistical analyses

Combined analyses of all types of GP-initiated linking in placements 1 and 2 showed that linking weight with health was no more likely to result in agreement-to-attend than not doing so (77% vs 76% agreed-to-attend; Univariable OR=1.02 (95% CI=0.48-2.19), p=0.98; Multivariable OR=1.06 (95% CI=0.56-1.99), p=0.85) (Table 6.2). Sub-group analyses by type of linking showed that 3 types were no more likely to result in agreement-to-attend than not linking: Specific personalised linking (77% vs 76% agreed-to-attend; Univariable, OR= 1.05 (95% CI=0.49-2.24), p=0.95; Multivariable OR=1.11 (95% CI=0.52-2.40), p=0.78); generalised personalised linking (78% vs 76% agreed-to-attend; Univariable OR=1.08 (95% CI=0.33-3.50) , p=0.90; Multivariable OR=1.14 (95% CI=0.35-3.77) , p=0.83); and personalised linking to risk of a specific future condition (89% vs 76% agreed-to-attend; Univariable OR=2.46 (95% CI= 0.54-11.28) , p=0.25; Multivariable OR=2.24 (95% CI=0.48-10.45) , p=0.31). One type of linking – general non-personalised linking - was more likely to result in a lack of agreement-to-attend when compared to not linking (20% vs 76% agreed-to-attend; Univariable OR=0.077 (95% CI=0.008-0.71), p=0.024; Multivariable OR=0.092 (95% CI=0.0092-0.87), p=0.038). Although my analysis of this final practice is not presented in this chapter, my work indicated that general non-personalised approach generates less of a preference for agreement as it was not hearable as personally relevant for patients. However, the small sample size meant that conclusions from statistical analysis as to the effectiveness of this practice are not possible.

In this chapter I showed that specific personalised linking could be achieved through paraphrasing a patient's prior talk, or not. I conducted further analyses examining these sub-types of specific personalised linking. Specific personalised linking

without paraphrasing was no more likely to result in agreement-to-attend than not linking (72% vs 76% agreed to attend; Univariable OR=0.79 (95% CI=0.36-1.73), p=0.56; Multivariable 95% OR=0.90 (CI=0.41-1.99), p=0.80). In line with results from conversation analysis all nine patients whose GP used paraphrasing agreed-to-attend (100% vs 76% agreed-to-attend; Univariable OR=1 (95% CI= n/c), p=n/c; Multivariable OR=1 (95% CI= n/c), p=n/c). Table 6.2 shows the relationship between linking and patient agreement-to-attend their free referral.

Combined analyses of all types of GP-initiated linking in placements 1 and 2 showed showed that linking weight with health was no more likely to result in attendance than not doing so (43% 46% attended; Univariable OR=0.96 (95% CI=0.57-1.64), p=0.89; Multivariable OR=1.03 (95% CI=0.60-1.77), p=0.91). Sub-group analyses by type of linking showed that no types of linking were more likely to result in attendance than not linking: Specific personalised linking (40% vs 46% attended; Univariable OR=0.81 (95% CI=0.42-1.55), p=0.52; Multivariable OR=0.82 (95% CI=0.42-1.60) , p=0.56); Generalised personalised linking (45% vs 46% attended; Univariable OR=0.95 (95% CI=0.36-2.57), p=0.93; Multivariable 95% CI=0.39-3.03, OR=1.09, p=0.87); General non-personalised linking (20% vs 46% attended; Univariable OR=0.30 (95% CI=0.033-3.74), p=0.29; Multivariable OR=0.37 (95% CI=0.039-3.46), p=0.38); and personalised linking to risk of a specific future condition (67% vs 46% attended; Univariable OR=2.39 (95% CI=0.85-6.73), p=0.10; Multivariable OR=2.78 (95% CI=0.95-8.20), p=0.063), (Table 6.3).

I conducted further analyses examining sub-types of specific personalised linking (paraphrasing, or not paraphrasing). Specific personalised linking without paraphrasing no more likely to result in attendance than not linking (30% vs 46% attended; Univariable OR=0.52 (95% CI=0.25-1.08), p=0.078; Multivariable OR=0.55 (95% CI=0.26-1.19), p=0.13). In line with results from conversation analysis, univariable analyses showed that paraphrasing was significantly more likely to be associated with attendance than not linking (89% vs 46% attended; Univariable OR=9.55 (95% CI=1.16-78.45), p=0.036). Multivariable analysis did not show a significant relationship (Multivariable OR=7.46 (95% CI=0.89-62.46), p=0.064). However, due to the large odds ratio it is reasonable to assume that this small sample size (N=9) provided insufficient power to detect significance in this

multivariable analysis. Table 6.3 shows the relationship between linking and patient attendance their free referral.

Analysis of the relationship between linking and patient post-consultation satisfaction scores showed no differences between linking of any type and patient-reported satisfaction (Table 6.4).

On average, conversations including any type of linking took 43 seconds longer than not linking (117 seconds vs 74seconds; Univariable difference in means=42.86 (95% CI=25.94-59.77), p<0.001; Multivariable difference in means= 42.48 (95% CI=25.83-59.13), p<0.001). Two sub-types of linking took significantly longer than not linking: specific personalised linking (124s vs 74s; Univariable difference in means=49.30 (95% CI=28.74-69.85), p<0.001; Multivariable difference in means=46.29 (95% CI=25.94-66.64), p<0.001), and general personalised linking (131s vs 74s; Univariable difference in means=56.84 (95% CI=25.57-88.12), p<0.001; Multivariable difference in means=57.56 (95% CI=26.67-88.46), p<0.001). Neither general non-personalised linking, or personalised linking to risk of a specific future condition took significantly longer than not linking: general non-personalised linking (92s vs 74s; Univariable difference in means=17.11 (95% CI=-39.62-73.84), p=0.55; Multivariable difference in means=12.34 (95% CI=-43.83-68.50), p=0.67); personalised linking to risk of a specific future condition (92s vs 74s; Univariable difference in means=17.12 (95% CI=-14.16- 48.40), p=0.28; Multivariable difference in means=24.36 (95% CI=-6.82-55.55), p=0.13.).

Analyses examining sub-types of specific personalised linking (paraphrasing, or not paraphrasing) showed significant differences in consultation time, when compared to not linking. Specific personalised linking by not paraphrasing took an average of 51 seconds longer that not linking (125 s vs 74s; Univariable difference in means=50.58 (95% CI=28.59-72.61), p<0.001; Multivariable difference in means=47.27 (95% CI=25.94-66.64), p<0.001). In line with result from conversation analysis, univariable analyses showed that consultations where the GP used paraphrasing took an average of 43 seconds longer than not linking (118s vs 74s; Univariable difference in means=43.29 (95% CI=0.55-86.03), p=0.047). Multivariable analysis

did not show a significant relationship (Multivariable difference in means=40.22 (95% CI=-2.04-82.49), p=0.062). However, it is possible that the small sample size (N=9) provided insufficient power to detect significance in this multivariable analysis. Table 6.5 shows the relationship between linking weight with health and consultation time.

Whilst this chapter focussed in detail on linking early in the consultation, appendix 8 shows results from statistical analyses of linking as an overall consultation strategy. These results show that linking as a general strategy was also no more effective than not linking, but did significantly increase consultation length.

To summarise, these results show that, although linking as a general strategy is recommended by guidelines, it is not more effective than not linking. Patients are not more likely to report greater satisfaction with linking, and these consultations took significantly longer than those where a GP did not link weight and health.

Table 6.2 Relationship between linking weight with health and agreement-to-attend

				Univariable Analysis		**Multivariable Analysis***	
Linking Placement	Linking type	Number of consultations	Agree-to-attend	Odds ratio (95% Confidence interval)	P-value	Odds ratio (95% Confidence interval)	P-value
Placements 1 and 2							
	No linking**	136	104 (76%)	-	-	-	-
	Any linking	94	72 (77%)	1.02 (0.48-2.19)	0.98	1.06 (0.56-1.99)	0.85
	Specific personalised	52	40 (77%)	1.05 (0.49- 2.24)	0.95	1.11 (0.52-2.40)	0.78
	i. No paraphrasing	43	31 (72%)	0.79 (0.36-1.73)	0.56	0.90 (0.41-1.99)	0.80
	ii. Paraphrasing	9	9 (100%)	1 (n/c)	(n/c)	1 (n/c)	(n/c)
	Specific non-personalised	1	1 (100%)	1	(n/c)	1	(n/c)
	General personalised	18	14 (78%)	1.08 (0.33-3.50)	0.90	1.14 (0.35-3.77)	0.83
	General non-personalised	5	1 (20%)	0.077 (0.008-0.71)	0.024	0.092 (0.009-0.87)	0.038
	Risk of future disease	18	16 (89%)	2.46 (0.54-11.28)	0.25	2.24 (0.48-10.45)	0.31
	*Age and gender were adjusted for in these analyses **Comparator						

Table 6.3 Relationship between linking weight with health and attendance

				Univariable Analysis		**Multivariable Analysis***	
Linking placement	Linking type	Number of consultations	Attend	Odds ratio (95% Confidence interval)	P-value	Odds ratio (95% Confidence interval)	P-value
Placements 1 and 2							
	No linking**	136	62 (46%)	-	-	-	-
	All	94	42 (43%)	0.96 (0.57-1.64)	0.89	1.03 (0.60-1.77)	0.91
	Specific personlaised	52	21 (40%)	0.81 (0.42-1.55)	0.52	0.82 (0.42-1.60)	0.56
	i. No paraphrasing	43	13 (30%)	0.52 (0.25-1.08)	0.078	0.55 (0.26-1.19)	0.13
	ii. Paraphrasing	9	8 (89%)	9.55 (1.16-78.45)	0.036	7.46 (0.89-62.46)	0.064
	Specific non-personalised	1	0 (0%)	1	(n/c)	1	(n/c)
	General personalised	18	8 (45%)	0.95 (0.36-2.57)	0.93	1.09 (0.39-3.03)	0.87
	General non-personalised	5	1 (20%)	0.30 (0.033-3.74)	0.29	0.37 (0.039-3.46)	0.38
	Risk of future disease	18	12 (67%)	2.39 (0.85-6.73)	0.10	2.78 (0.95-8.20)	0.063
	*Age and gender were adjusted for in these analyses **Comparator						

Table 6.4 Relationship between linking weight with health and post-consultation satisfaction reports

				Univariable Analysis		**Multivariable Analysis***	
Linking placement	Linking type	Number of consultations[⊥]	Mean satisfaction (SD)	Difference in means (95% Confidence interval)	P-value	Difference in means (95% Confidence interval)	P-value
Placements 1 and 2							
	No linking**	132	4.37 (0.61)	-	-	-	-
	All	92	4.41 (0.62)	0.045 (-0.12-0.21)	0.60	0.051 (-0.12-0.21)	0.56
	Specific personalised	51	4.35 (0.90)	0.21 (-0.12-0.56)	0.23	0.23 (-0.12-0.57)	0.20
	i. No paraphrasing	41	4.24 (0.96)	0 .11 (-0.27-0.49)	0.57	0.13 (-0.26-0.52)	0.51
	ii. Paraphrasing	9	4.83 (0.25)	0.70 (-0.04-1.43)	0.062	0.69 (-0.051-1.43)	0.068
	Specific non-personalised	1	5 (n/c)	0.86 (-1.21-2.94)	0.41	0.86 (-1.22-2.95)	0.41
	General personalised	17	4.24 (0.59)	0.10 (-0.43-0.63)	0.71	0.10 (-0.44-0.63)	0.73
	General non-personalised	4	3.40 (1.98)	-0.74 (-1.67-0.20)	0.12	-0.71 (-1.65-0.24)	0.14
	Risk of future disease	18	4.50 (0.57)	0.36 (-0.15-0.88)	0.17	0.33 (-0.19-0.86)	0.21

*Age and gender were adjusted for in these analyses
**Comparator
[⊥]Total consultation number differs from those in previous tables as not all patients reported satisfaction post consultation

Table 6.5 Relationship between linking weight with health and consultation length

				Univariable Analysis		**Multivariable Analysis***	
Linking placement	Linking type	Number of consultations	Mean consultation length (SD)	Difference in means (95% Confidence interval)	P-value	Difference in means (95% Confidence interval)	P-value
Placements 1 and 2							
	No linking**	136	74 (54.42)	-	-	-	-
	All	94	117 (74.64)	42.86 (25.94-59.77)	<0.001	42.48 (25.83-59.13)	<0.001
	Specific personalised	52	124 (81.15)	49.30 (28.74-69.85)	<0.001	46.29 (25.94-66.64)	<0.001
	i. No paraphrasing	43	125 (83.53)	50.58 (28.59-72.61)	<0.001	47.27 (25.48- 69.06)	<0.001
	ii. Paraphrasing	9	118 (73.11)	43.29 (0.55-86.03)	0.047	40.22 (-2.04-82.49)	0.062
	Specific non-personalised	1	129 (n/c)	54.51 (-70.78-179.80)	0.39	53.22 (-70.55-176.99)	0.40
	General personalised	18	131 (80.20)	56.84 (25.57-88.12)	<0.001	57.56 (26.67-88.46)	<0.001
	General non-personalised	5	92 (25.87)	17.11 (-39.62-73.84)	0.55	12.34 (-43.83-68.50)	0.67
	Risk of future disease	18	92 (54.37)	17.12 (-14.16- 48.40)	0.28	24.36 (-6.82-55.55)	0.13
	*Age and gender were adjusted for in these analyses **Comparator						

6.6 Discussion

6.6.1 Summary of findings in the context of current literature

Guidelines recommend that clinicians link weight and health when offering a brief intervention for weight loss. However, there has been no detailed examination of how this practice is achieved or responded to in practice. Clinicians in the BWeL trial frequently articulated a link between a patient's weight and their health during the referral sequence. The presence of this practice in the BWeL corpus provided opportunity for in-depth exploration. I demonstrated that linking weight and health was largely a GP-initiated action which could occur in four placements in the consultation: (1) in the pre-sequence, before delivering the news of a free referral; (2) following the news of a free referral; (3) following the patient's initial response; (4) during closings in consultations where a patient has agreed to referral. I focused analysis on placements one and two and explored how linking weight and health was achieved. Existing work has largely explored this practice as one phenomenon. An exception to this is Pilnick and Coleman (11), who identified three sub-types of linking in primary care smoking cessation discussions. I found that, rather than one practice, linking in these primary care weight management discussions was a series of closely linked phenomena, each differing in the degree to which they were hearable as being specific or personalised. I identified five ways that GPs could initiate a link between a patient's weight and health in the BWeL trial. These were (1) specific personalised linking (2) specific non-personalised linking (3) general non-personalised linking (4) general personalised linking (5) personalised linking to risk of a specific future condition. I then focused analysis on the first and most prevalent of these practices, specific personalised linking.

Patients did not produce marked acknowledgement following specific personalised linking. Rather, they frequently displayed minimal responses or passive resistance. In rare cases patients displayed active resistance following GP initiated specific personalised linking. This initial resistance frequently initiated a wider resistance trajectory that ended with rejection, or displays of minimal uptake of the referral. My findings contrast with current clinical guidelines which recommend this practice as it makes weight loss hearable as personally relevant for a patient. This also contrasts

with reports from GPs where they have stated that they believed people are more likely to receive discussions positively if they talk about weight loss in the context of an existing or future condition (7).

Although specific personalised linking most frequently generated minimal responses and passive resistance displays, I identified two ways this action could be done which had potential to result in marked acknowledgement from patients. The first of these was 'linking to multiple concerns'. When a GP linked to multiple conditions, often through use of a three-part list, patients had the opportunity to foreground one condition which was salient for them. If GPs subsequently acknowledged the salience of this concerns for patients and moved forwards with referral discussions usually resulted in agreement to attend, however they did not always do so. Similarly, GPs could craft multiple links and not receive a marked response from patients. Pilnick and Coleman's examination of linking in the context of smoking cessation in primary care found that there needed to be shared understanding of the relationship between smoking and a particular health condition for a link to be acknowledged, rather than resisted (11). Just as one patient (Excerpt 6.18) oriented to heart disease as salient because his uncle has developed this condition, other patients may orient to certain links as salient as they have a prior understanding of these relationships, however these data provided no evidence of these prior understandings. The second pattern I observed that received uptake in next turn was 'paraphrasing a patient's prior talk'. These 'you were saying' or 'you said' prefaced paraphrases frequently resulted in displays of agreement to attend from patients. They presented advice giving as solicited, rather than unsolicited, evoked a collaborative environment, and linked weight loss with something a patient had previously foregrounded as salient-for-them.

Whilst previous work explored 'linking weight and health' as one practice, this work has demonstrated that there are a series of practices for doing the same action in the context of brief interventions for weight loss. Previous work which explores in-consultation weight-management interactions has identified this as a practice which has strong potential to generate resistance displays (13), but some evidence conflicts with this, indicating this is a strategy unlikely to generate resistance (10, 19). Gray et al's interactional analysis of primary care consultations in New Zealand, for

example, showed that GPs mention health to "clinically 'warrant' raising the potentially sensitive and personal topic of weight and weight management" p.155(19). The authors note that this was most 'notable way of achieving a constructive dialogue'. However, the authors acknowledge that these can be interactionally delicate and challenging. My work presented in this chapter has potentially identified the reason for this reported variability – that, in line with Pilnick and Coleman's study of linking *smoking status* and health (11) linking *weight* with health is a series of practices, and these vary in the responses they receive from patients. Both the work presented in this chapter, and Pilnick and Coleman's study, provide evidence that links can be designed as hearably relevant for either 'patients in general' or 'this specific patient'.

I examined the associations between linking and: patient acceptance of their referral; patient post-consultation satisfaction scores; patient post-consultation attendance; and consultation length. Linking as a general strategy was no more effective in generating agreement-to-attend or attendance than not linking. Results from statistical analyses showed that conversations where linking was used were significantly longer than consultations where GPs did not do so. Evidence from the conversations showed that this difference in length may be due to attempts to address resistance displays following linking, resulting in further elaboration of the news of free referral, and longer discussions. Therefore, although this is a guideline recommended strategy, evidence from this corpus shows linking weight with health may not fit the remit of a brief intervention. Linking, therefore, does not seem to be effective in practice, and has great potential to generate resistance displays.

Further analysis of types of linking found that specific personalised linking, the type of linking I focussed on in this chapter, was no more effective in terms of patient agreement or attendance than not linking. I explored specific personalised linking qualitatively in the context of morality and epistemic primacy. This showed elements of the consultation which generated resistance, and could explain why patients were not more likely to agree to attend, or attend following these discussions. I hypothesised that one reason to account for the displays of resistance, or minimal responses, from patients following linking was that GPs were offering advice which was unsolicited. Heritage and Sefi state that advice is best received by a prepared

party (27), and the unpreparedness and lack of solicitation of advice could account for the resistive responses observed following linking in the BWeL corpus. Furthermore, in delivering unsolicited referrals to a behavioural programme, GPs were implicitly making assumptions about a patient's health behaviours as causing their linked condition. I observed that these moral statements from GPs were frequently delivered as a fact-based assertion; implying that this is an area which the GP is an expert (and able to assert epistemic primacy) and the patient is not. In the case of their own health behaviours, in contrast to perhaps typical medical conditions for which one would visit the GP, the patient has significantly more knowledge than the GP. Patients here have lived experience of their own behaviours. The GP does not have epistemic access to these, therefore resistance displays or minimal responses following these displays of unsolicited epistemic primacy from GPs are understandable, as the patient's role as expert in their own behaviours is overlooked.

In contrast to this, I identified paraphrasing prior talk as a phenomenon that was likely to promote a collaborative environment for subsequent talk, which frequently resulted in both agreements to attend CWMS, and subsequent attendance. Guidelines in intervention delivery encourage GPs to 'work collaboratively' (recommendation 15 (54)) with their patients, but provide no specifics on how to do so. The practice of paraphrasing here demonstrates how to initiate weight loss discussions in a way which enables subsequent talk to be collaboratively built. Situating a paraphrase early in a discussion shapes the production of subsequent talk. This action avoids claims to epistemic primacy, which we have seen throughout this thesis as problematic in the context of health behaviours. Parry et al (55) also explored these overt links with what a patient has previously said in the context of end of life discussions. They found that, through presenting a topic as one a patient had previously initiated, it was harder for a patient to avoid engaging with this topic. They also found that paraphrasing constructed an 'atmosphere of agreement' and conveyed that the patient had the 'lead responsibility' when making plans. These results complement those presented by Parry et al, by showing paraphrasing serves a similar function in a different context – brief interventions for weight loss in primary care – where they similarly encourage patients to engage in potentially sensitive discussions. Evidence from everyday conversations has shown that evoking shared knowledge can be a means of pursuing agreement (56). Evidence here also shows

that evoking shared knowledge can elicit initial agreement, so that it does not need to be pursued. My results additionally offer new comment on this practice, by identifying the transformational qualities of a paraphrase. I demonstrated that this transformed subsequent talk into a joint venture and that patients were more likely to engage in conversation with the GP following GP initiated paraphrasing.

I also uniquely identified associations between paraphrasing and patient next action. Results from univariable analysis indicate that, through using paraphrasing to create a collaborative in-consultation discussion, patients are more likely to attend their referral, than if the GP had linked without paraphrasing. To initiate paraphrasing however, a patient must have raised a concern associated with weight (whether or not that association is acknowledged or articulated) in this or a prior consultation. Therefore, this resource is not accessible to all GPs who may wish to deliver brief interventions for weight loss. Additionally, the collaborative environment that was built resulted in longer accounts and more frequent turn taking from patients. This was associated with significantly longer referral sequences where paraphrasing was used, meaning this may not be a useful strategy during tightly time limited consultations.

In this chapter I identified and addressed a number of knowledge gaps. I explored how linking weight with health is achieved and received in the context of brief interventions for weight loss, and the implications linking had for the length of a brief intervention. I also, uniquely examined associations between use of this practice and patient next action. The evidence I have identified here perhaps most importantly, offers comment on the effectiveness of this strategy which is frequently recommended despite a current lack of evidence. In the subsequent section I draw out recommendations for clinical practice from these results.

6.6.1 Implications for practice

I showed in Chapter 1 that the training resources provided for BWeL GPs did not recommend linking weight and health. Qualitative interviews with GPs who took part in BWeL trial have shown that GPs stated that they believed this practice to be more effective (Wheat 2018 personal communication), and this aligns with reports

from a range of primary care clinicians (7). I considered carefully how results from this chapter, which contrast both with current guidelines and clinician's perspectives, could translate to a brief resource for training GPs. This practice does not result in more attendance than not doing so, but is associated with consultations which are significantly longer. This practice frequently generated passive resistance or minimal responses in a patient's next turn, and was rarely associated with displays of enthusiastic uptake of the referral. Two ways of linking had initial potential to be 'trainables': 'linking to a salient concern' and 'paraphrasing'. However, my results showed that GPs cannot presume what is salient for a patient. I demonstrated that GPs linked to known conditions that patients had developed but these were only rarely oriented to by patients as salient-for-them. Therefore, I would not recommend this strategy. I considered if paraphrasing could be a recommended practice. This resulted in uptake displays and collaboratively built conversations. However, these conversations ranged in length from 53-285 seconds with a mean of 118 seconds. The collaborative environment facilitated by paraphrasing arguably expanded discussions and meant these rarely fitted the remit of a 'brief' intervention. This strategy therefore did not meet the objectives of this thesis to identify conversational phenomena that are well received, result in attendance, and do not unduly lengthen conversations.

Therefore, in the information resource for GPs I explicitly recommend not to link a patient's weight and their health. The complexities and riskiness of this method could not be appropriately conveyed within the time constraints of this resource, and not-linking offers an alternative that is as effective in terms of patient attendance and satisfaction scores, but takes less time. Whilst engaging with stakeholders members of the public who did not have obesity stated they were surprised that the information resource advised clinicians not to link a patient's health concerns and their weight. They stated that they "imagine" it would be effective. People with obesity (PWO), however, responded differently. In general, PWO stated they had negative thoughts when their weight and health to be linked, one saying "I really appreciated the point about not linking the referral to health conditions.". As well as being received positively by people with obesity, not linking fits better within the tightly limited time constraint of the primary consultation. Formulating a referral

using the ‘good news’ delivery outlined in chapter four offers an alternative to the riskiness of linking weight with health.

6.7 Summary

I have shown that linking weight with health, a commonly recommended practice, was not effective. It was no more likely to result in agreement-to-attend or attendance at the commercial weight management service, and these consultations took significantly longer than these where linking was not done. This chapter shows that the empirical study of interaction is critical in identifying an evidence base of effective practice, and using this to provide communication skills guidance. The current reliance on post-hoc reporting and expert opinion to develop guidelines can lead to encouraging clinicians to engage in potentially risky communication strategies, and generate resistance that could otherwise be avoided.

6.8 Reflections on chapter six

When engaging with stakeholders, primary care clinicians, and people who did not have obesity were surprised by this result. However, people with obesity said they really welcomed this. As I have stated results from this chapter translated into the resource for training GPs as ‘do not link weigh and health’, so the details of paraphrasing etc were not presented. One patient with obesity however, independently mentioned paraphrasing in our discussion, saying “It needs to be put to the patient as their idea…”. I was interested to see that this patient who had experience with this type of referral had independently highlighted this as helpful for her in the past, and that this phenomenon rang true as valuable and important.

This chapter emphasised for me the importance of detailed conversation analysis before statistical analysis. Being guided by what I found analytically interesting allowed me to explore how linking worked, and discover paraphrasing as a way of doing linking. Paraphrases were initially ‘deviant cases’ – cases where patients responded very differently to the rest of my linking collection – and emerged from deviant case analysis as an effective way to link weight and health. If I was guided only by collections which provided opportunity for quantification I would have

potentially missed the intricacies of how paraphrasing was achieved and responded to.

6.9 References

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Chapter 7

Discussion

7.1 Chapter overview

Here I summarise the key findings across all four results chapters, and how these relate to one another. I discuss the offerings of these findings to our current understanding of weight management discussions. I then show the completed training resource to which each chapter contributed (section 7.4), and discuss the process of stakeholder involvement which contributed to its development. Following this, in section 7.5, I present the strengths and limitations of this thesis, and I discuss the contributions this thesis offers. In section 7.7 I then make recommendations for further research to build upon the evidence base I have identified, and draw out the implications for policy and practice resulting from this thesis (section 7.8). I finally present my conclusions from this thesis.

7.2 Summary of findings

In this thesis I aimed to understand what conversational strategies used by clinicians are likely to result in patient agreement to attend and actual attendance at a weight management referral, and to develop an information resource to support delivery.

In chapter three I addressed my first objective, to identify and synthesise evidence from conversation and discourse analytic studies regarding how health care professionals communicate with their patients about health behaviour change, and how patients respond. I also aimed to map the extent of current literature and identify evidence gaps. I reviewed the current evidence on health behaviour change talk. My key findings from this chapter are outlined below:

- There is a paucity of literature on health behaviour change talk in English-speaking clinical settings, and just five studies which explored weight management discussions. Weight management was the main focus in only one of these five studies.
- All studies used patient responses to health behaviour change talk to measure the effectiveness of conversational strategies and not patient action on their health behaviours, highlighting a clear evidence gap.
- Evidence indicated that conversational practices used across studies were similar, despite different clinical settings, countries, and ages of studies.
- Evidence showed which specific conversational practices are likely to be well or poorly received by patients. I enumerated the clinical strategies that look likely to be most effective based on this existing evidence.
- In general, the results support the advice in guidelines about how to discuss behaviour change. However, one guideline-recommended strategy – linking weight with health - was shown to be potentially risky. This highlighted the importance of examining evidence from clinical interactions before making recommendations for practice.

In the subsequent three chapters I used conversation analysis and statistical methods to address the evidence gap identified in chapter three. In these chapters I used data from the BWeL trial to address the second and third objectives of this thesis: To determine the conversational strategies used by GPs in the BWeL trial which were particularly effective or ineffective in producing in-consultation displays of agreement, patient reported satisfaction, and post-consultation attendance at CWMS and post-consultation attendance at CWMS; and to identify whether brief interventions for weight loss in primary care could be shortened.

In chapter four I explored the referral sequence in the BWL trial. I mapped the actions done during the referral, and identified components of the referral sequence which contributed to a smooth discussion. I then explored how GPs could deliver a referral sequence in ways which were displayed as well received

by patients in-consultation, associated with patient reported satisfaction scores post-consultation, and patient attendance at their weight management referral. My key findings were:

- Across the 250 referral sequences thirteen broad actions were done, across eight sequential positions.
- The referral was delivered as 'news' by clinicians. These news delivery sequences followed established sequences in current literature, and prefaced a subsequent 'referral question'.
- I identified key words, and their sequential placement, that were likely to smooth the referral sequence and avoid lengthy responses, or questions about the details of the referral. These were to say commercial weight management *service* or *programme*; follow this with an exemplification "like" Weight Watchers or Slimming World; explicitly say it is both *free* and *local*; and use a 'would' prefaced referral question, such as "Would you be interested in going to one of those?".
- I explored how news was valenced and identified three patterns: good news, negative news, and neutral news. I showed that valence was achieved through lexical and non-lexical features of news delivery. It was most evident in the pre-announcement and concretised during news elaboration.
- Patients could accept or resist the valence asserted by GPs. However, even if it was resisted, most GPs maintained their initial valence throughout the referral sequence. Patient responses indicated that 'good' news delivery sequences were oriented to as well received in most cases. Good news valence was strongly associated with both acceptance of the offer and subsequent attendance at a weight management programme, but no difference in post-consultation satisfaction reports.
- I found that neutral news deliveries were shorter than good and bad news deliveries; the least effective strategy also took the least time.

Chapter four showed, for the first time, what news delivery patterns are likely to be well received and associated with patient attendance at a referral a commercial

weight management service. These results address many concerns outlined by clinicians in the existing literature, and the evidence gap highlighted by my systematic review. However, the most effective strategy took longer than other ways of offering referral. Therefore, in chapter five, I took a tight focus on patient responses to examine if these offered clues to shorten interventions. I examined patterns of patient responses that constituted displays of positive reception, or rejection. I also examined how clinicians oriented to these in ways which truncated the referral sequence, offering clues on how best to deliver *brief* interventions. Key findings showed that:

- Following patient responses to the news of the free referral GPs often engaged in an 'elaboration of news', providing further details, or displaying attempts to persuade a patient to attend.
- When patients displayed a marked positive stance or an 'oh'-prefaced response as their first response following the completion of the announcement of the news of a referral, they were displaying that the referral had been positively received. Patients were likely to maintain or upgrade this stance throughout the referral sequence. Both these utterances were associated with patient post-consultation referral attendance.
- When patients displayed an actual rejection as their first response following the completion of the announcement of the news of a referral, they displayed that referral has not been positively received. Further attempts to convince or persuade patients to agree were unsuccessful. Patients were likely to maintain or upgrade this negative stance throughout the referral sequence. These displays of actual rejection were significantly associated with non-attendance at the referral.
- Following both displays of positive reception and actual rejection GPs often elaborated the news. Patients who had displayed positive reception frequently oriented to this as unnecessary, and patients who produced actual rejection could respond with displays of marked resistance. Clinicians who moved to close following patient production of these responses, truncated the referral sequence. Moving to close did not affect patient attendance at the referral, but did significantly shorten the intervention length.

In my final results chapter (chapter six) I focussed on a prevalent practice in the BWeL corpus, 'linking weight and health'. Chapter 3 showed that this practice, which is recommended by clinical guidelines, may cause interactional difficulties and negative responses in patients. However, before this study there was limited evidence on the practice of 'linking' in the context of weight, and there was no evidence on whether it affected subsequent health behaviour. To address this gap, in Chapter 6 I focussed on 'linking' in two key placements: in the pre-sequence, before delivering the news of a free referral; and following the news of a free referral. My key findings were:

- Linking weight and health was common, occurring in 44% of consultations even though GPs were trained explicitly not to do this.
- Rather than emerging as one phenomenon I identified 'linking weight and health' as a series of phenomena, varying in the degree to which they were hearable as personally relevant to the patient. These linking actions were GP-initiated in most cases, and I classified them as: specific personalised linking; specific non-personalised; general non-personalised; general personalised; and linking to a potential future condition.
- My analysis focussed on specific personalised linking. I identified several ways this could be achieved and the responses each elicited. Specific personalised linking usually received minimal or passive resistive responses from patients, and I showed evidence that minimal responses did some resistance work. Linking appeared to have implications for the wider sequence as patients could follow these initial displays of resistance to this action with further resistance, or moral work. These sequences often ended in a minimal response token when a response to the offer of referral was made relevant. I hypothesised these resistance displays occurred in response to the epistemic primacy asserted by GPs in their linking turns where the GP displayed a "relative right to tell, inform, assert or assess something" p.13 (1) that patients had not solicited and, potentially, did not view as a doctorable problem. Although specific personalised linking appeared to generate resistance in many cases, there was no difference in patient reported satisfaction scores when compared to consultations where a GP did not link weight and health.

- Some GPs linked to multiple concerns, and patients could orient to one of these concerns as potentially salient for them. Some patients oriented to none of these concerns. If they identified one as salient, patients could display uptake, or only a minimal response following the referral question. The range of responses showed this was a risky strategy to use.
- GPs could initiate specific personalised linking by paraphrasing a patient's prior talk. Paraphrasing was typically followed by patient displays of agreement in next turn, and a wider trajectory towards uptake of the referral. I hypothesised that paraphrasing a patient's prior talk acted to transform subsequent talk into a joint venture, avoiding the epistemic primacy commonly displayed during linking.
- There was no evidence of an association between most types of linking and patient attendance at their referral. However, there was evidence that paraphrasing a patient's prior talk was associated with patient attendance when compared with not linking, as 89% of patients went on to attend.
- Consultations where a GP linked weight with health were significantly longer than those where they did not do so. This aligns with results from my systematic review which indicated that tailored conversations were longer than those which were not.

My final objective in this thesis was to work with key stakeholders to formulate successful conversational strategies into a video-based information resource using the conversation analytic role play method (CARM). The first step was to translate the evidence base I identified through conversation and statistical analyses into useable pragmatic recommendations for practice, or 'trainables' for clinicians. In each chapter, I discussed how results were translated into trainables, and I presented these trainables in each individual chapter. In the section below, I have collated all trainables resulting from this thesis. I then discuss how stakeholders were involved in resource development.

7.3 Overview of key trainables resulting from this thesis:

Table 7.1 Trainables identified in each chapter of this thesis

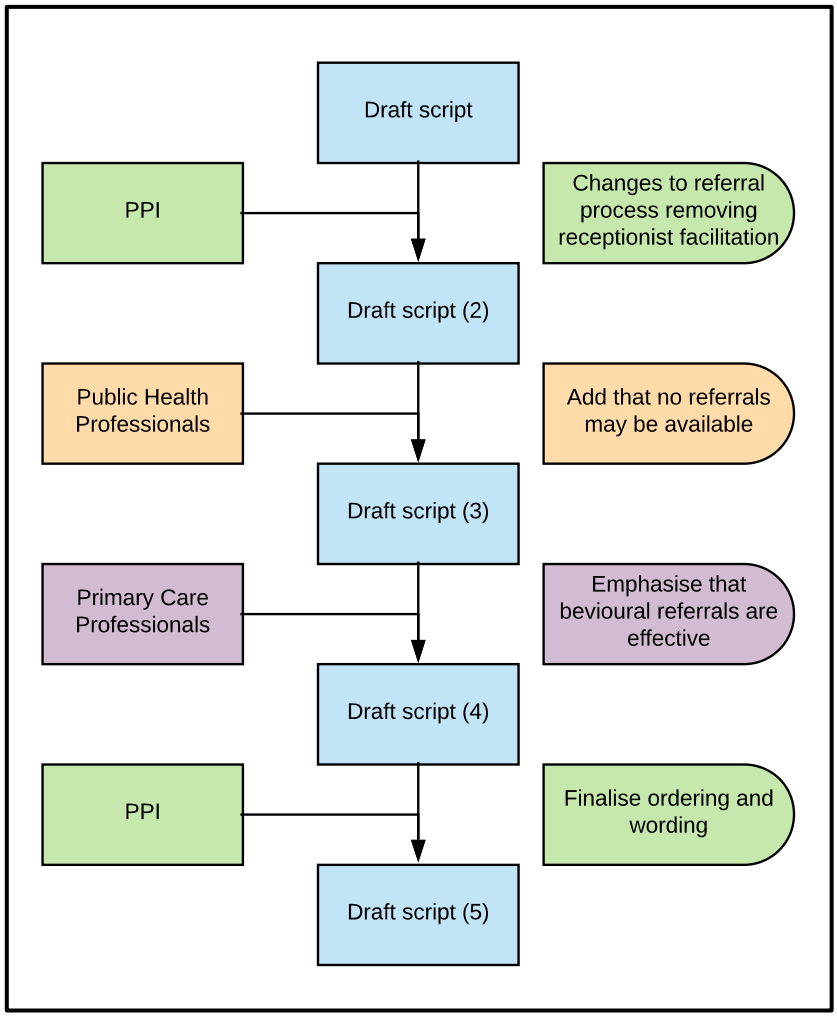
	Recommendation	Details	Chapter
1.	Sound confident	If you sound reluctant or nervous, patients are unlikely to want to attend. But if you sound confident it is likely patients will receive referral positively.	4
2.	Establish referrals are effective before offering these to patients	If you don't do this, patients are unlikely to agree, as they may not know referrals are effective	4
3.	Offer an **opportunity**; that provides **support** and is **local**	Saying the words 'offer' 'opportunity' 'support' and 'local', are well received and address questions patients may otherwise ask later.	4
4.	Say the word **free**	It is important that you say the referral is free before asking if patients would like to attend. Otherwise there can be misunderstandings and patients may decline because they think they have to pay.	4
5.	When you ask the question start with **would,** eg 'Would you be interested in that?'	Ask the question starting with 'would'. Do not use 'if' or 'or' as this is likely to open discussion further and take a longer time.	4
6.	Do not link a patient's weight and their health, as this is potentially risky and may cause offence	This can make patients upset or defensive, so this strategy is best avoided.	3 and 6
7.	Listen to patient responses. 'Yes' and 'yeah' may require more information whilst enthusiastic responses like 'yes definitely' or 'oh' at the start of a response shows these have been received well.	If your patient says 'yes' or 'yeah' try telling them a little more about what you are offering. However, a positive response like 'yes definitely' or 'oh right' indicates enthusiastic receipt of the offer. If your patient responds this way be positive too and move to next steps.	3 and 5
8.	No means no, do not try and convince or persuade	Trying to convince or persuade people that had declined an offer doesn't work. It is likely to make people frustrated and could sound like you aren't listening to them. If your patient does say "no", acknowledge their decision but remind them you're there to talk if they ever want to discuss their weight again.	3 and 5

I used these trainables in an animated resource for training clinicians, which aimed to address many of their reported barriers to delivery. In the section below, I outline how key stakeholders were involved in reviewing this resource.

7.4 Resource development.

I formulated the trainables presented in section 7.3 of this chapter into an animated information resource for clinicians. I did this through working with key stakeholders in brief interventions for weight loss in primary care – members of the primary care team, patients, and public health policy makers. These were: 42 patients, 7 GPs, 4 nurses (one of whom was a specialist diabetes nurse), one practice manager, the head of Public Health England's Obesity and Healthy Weight team, and a member of Public Health England's Obesity and Healthy Weight team who is responsible for communicating delivery of brief interventions for weight loss to clinicians. The methods of this stakeholder engagement are described in Chapter 2. Patient and public involvement is recognised as 'an essential component'(2) of clinical resource development (3, 4). There is also recognition it is important to meaningfully involve not just patients, but clinicians and other healthcare stakeholders in this development process (5-7). This multiple stakeholder engagement supporting translation of findings is important in ensuring their usefulness (7). Figure 7.1 illustrates the process of iteration that occurred during stakeholder engagement and feedback.

Figure 7.1 Input on information resource and resulting changes at each stage



42 patients and members of the public commented on the initial version of the training script. Quotes are reproduced here, with permission, to illustrate the feedback I received from these patients. Whilst members of the public who did not have obesity stated they were surprised that the information resource advised doctors not to link a patient's health concerns and their weight, as they "imagine" it would be effective, those with obesity response differently. In general, people with obesity (PWO) stated they had negative thoughts when their weight and health to be linked: "*I really appreciated the point about not linking the referral to health conditions*.". This highlighted the value of conducting detailed patient involvement from people with obesity, and ensuring they found the trainables presented acceptable. Responders with obesity also strongly agreed with the 'good news' delivery: "*I also very much agree with the idea that the doctor needs to be very positive about the success of these sessions*". As a result, in the second iteration of the script, I further

emphasised the need for clinicians to sound positive. In general responses from PWO said that they thought this training could really support their GPs to have effective conversations, and could address a lot of the "difficult times" currently experienced in these discussions: "*I think doctors and practice nurses could find it very helpful and as a patient what you are saying rings true in so many ways of what is helpful and not helpful for the dr to say*".

Whilst feedback on the trainables was consistently positive and resulted in no changes, many comments focussed on the referral process itself. In the initial script (appendix 2) the GP offered referral and the patient was then asked to see the receptionist for details. However, PWO who commented identified this as a clear barrier to attendance, stating "*...some patients might want to accept the offer but be uncomfortable going and seeing the receptionist as this is often in front of the entire waiting room*." and "*..many patients would be embarrassed to ask at reception and / or might change their mind by the time they get there*.". Most PWO suggested that instead the referral could be facilitated by the doctors in the consultation: "*My one suggestion would be for the GP to be able to give the patient details themselves then and there*". Although I had not planned to alter the mechanism of referral presented I felt it was important to do so having received these comments. I therefore, changed the mechanism of referral shown in this information resource. The iterated resource instructs clinicians to action the referral, and illustrates how they could do this, by stating that the patient will receive a call from the weight management service:

"*Excellent, I'll make a referral and you'll get a call from the weight management service"*

Following the first round of PPI, I sent the revised information resource to members of the Obesity and Healthy Weight team at Public Health England. They agreed with the changes in referral processes, and also suggested that I add a short sentence mentioning that no referral may be available, as not all areas have referral processes in place. The script in this section had previously stated: "These [CWMS] are available on the NHS, although the exact type might be different in your area." And was updated to state "In many areas, these [CWMS] are available on the NHS,

although no weight management service, or other services, might be available where you work."

I revised the script a second time, and then consulted with primary care professionals to seek their feedback on the acceptability of this resource. I aimed to get a range of perspectives from different members of the primary care team, and so I ran a focus group with 7 GPs, 4 nurses (one of whom was a specialist diabetes nurse), and one practice manager in a practice with a high prevalence of obesity.

When inviting feedback from medical professionals I was interested in both feedback on the content, and in what 'take home points' these professionals drew from this script, that had not already known. During the focus group all participants had a copy of the script, and viewed pictures of the proposed animation style for the video. Feedback on the trainables and training format was consistently positive. The brief timing of the planned resource (5 minutes), and the easy online accessibility were highlighted as particularly well received by the group. Aspects of the training that were foregrounded as particularly useful were (1) to not pursue a response if a patient declines a referral, and (2) to make the referral sound like 'good news'. At the end of the focus group I asked each participant to report a 'take-home point'. Twelve primary care clinicians reported one take home point, and three reported two. These were: do not associate weight and health (N=5) that weight management referrals are actually effective (N=5); be confident (N=3); 'yes' and 'yeah' require more information (N=3); 'oh' indicates positive reception not negative reception (N=2). I next fed-back these take home points and the key aspects of the focus group discussion, to the animation team so that they could allocate more time for these specific points. This is because clinicians had highlighted this as information of which they had previously been unaware, and more time meant that this new information could be explained more clearly. Following this feedback, I then sent the final revised script back to PPI contributors for final thoughts and comments. These comments were positive from all PPI responders. I finally sent this to the animators to start work on the information resource.

To summarise this process, initial PPI on the draft script was positive, and few changes were suggested. At this stage, many PPI responses emphasised the

importance of a good news delivery and highlighted concerns about talking about weight in front of a receptionist. As a result I added further emphasis on the good news delivery element, and changed the referral mechanism presented so that it was GP-facilitated (rather than actioned by a receptionist). The updated resource was then sent to the Obesity and Healthy Weight team at Public Health England who commented that clinicians should be aware that in some areas referrals are not available. I then added a sentence to the script reflect this. This revised script was then reviewed by a focus group of primary care professionals. They also responded positively, and stated this would be a helpful resource. They provided 'take home points' - things they had not known before, or thought were particularly useful. I communicated these to the animators in order to allocate more training time to these points. PPI responders reviewed this final resource, responded positively and did not suggest further changes. The updated script was then sent to the animation team. This process, and the key changes made following feedback from each group, is illustrated in Figure 7.1.

I felt that this process ensured feedback from all stakeholders in referral process, and was helpful in producing a resource to which clinicians and patients had both contributed . This is important because patients, who often report negative experiences abut discussing weight management, found the conversations suggested in the final script acceptable and helpful. It is also important because doctors report a number of barriers to delivery, and their involvement in resource development meant that it could be appropriately tailored to address these barriers in line with their feedback. Also, as Public Health England had agreed to support dissemination of this resource, it ensured that the format and content was acceptable to them, and that it was appropriate for the types of dissemination which they had planned.

This animated resource for training was developed from an evidence base of effective practice identified through this thesis. The storyboard for this resource for training is available in (appendix 9). It was collaboratively designed with feedback from people with obesity, members of the public, health policy makers, and clinicians. It provides brief tips to support clinicians to deliver brief interventions for

weight loss. It will be freely available through the Public Health England website to complement their guidelines on brief intervention delivery.

7.5 Strengths and limitations

7.5.1 Strengths

The key strength of this thesis was analysis of naturalistic recorded conversations of GPs offering referral to patients as part of a randomised controlled trial. This allowed me to examine how referrals are done and responded to in practice, rather than post-hoc accounts of what was done or what was well received, which have been shown to be contradictory, and may be subject to recall and social desirability biases (8, 9). A further strength was that all recordings contained these offers of referrals, which occur rarely in usual practice and have not been captured in other corpora. Additionally, these data were collected from 86 GPs and 250 patients. This amount of data allowed for a rich description and depth of analysis of interactional practices.

In this thesis I used audio recorded data and also data on whether or not patients accepted and attended their referral, patient reported satisfaction, and consultation timing. This is the first work, to my knowledge, to use conversation analysis to explore associations between in-consultation conversational patterns and post-consultation measures of both satisfaction and a subsequent behaviour. This was a strength as phenomena displayed to be well received in consultation, post consultation, and associated patient action could be identified, rather than hypothesising what patient responses were likely to result in action. In chapter 3 I identified a lack of data on patient post-consultation behaviours as a limitation of current studies, which I was able to address throughout this thesis. Incorporating patient-reported satisfaction meant that all strategies I chose to recommend were both identified as positively received in-consultation, and post-consultation. This added robustness to these findings, as fear of causing offence is commonly reported by clinicians.

A strength of my analytic approach in this thesis was my initial unmotivated looking approach. This meant that, rather than looking for patterns which I already believed to be effective or ineffective from existing literature, I examined the data and collected instances I found analytically interesting, and looked for what practices may have resulted in, or from, these phenomena. This meant, for example, that rather than looking for 'linking weight and health' and finding it ineffective, it arose through unmotivated looking as a series of phenomena varying in efficacy which was an important finding of my thesis. Blinding to patient satisfaction and attendance data during conversation analysis was also a strength. This meant that results were grounded firmly in the actualities of an interaction rather than being affected by knowledge of what actions patients took following their consultation. The co-occurrence of the systematic review (chapter 3) and conversation analysis (chapters 4, 5, and 6) meant that research was an iterative process, and each analysis was informed by the other. This strengthened the conversation analysis through constant grounding in the existing literature. Emerging results and evidence gaps from the review also informed my decision-making on which initial collections to place detailed focus. Systematically reviewing data alongside conversation analysis also strengthened this study as it illuminated practices used in the wider context of health behaviour change. My conversation analysis results complemented my systematic review results, so it may be likely the practices identified here are also effective both outside of a trial setting and in the context of other health behaviour referrals, such as to smoking cessation services.

A further strength of this analysis was its applied focus. Choosing which collections to refine and focus on following unmotivated looking was strongly informed by the barriers GPs have reported to discussing weight and offering referral to patients, as well as the evidence gaps identified in the systematic review. Therefore, I am confident that the resulting training is targeted to addressing many of these barriers, namely: lack of time; lack of confidence in treatments offered; lack of confidence in patient action on their behaviours; and lack of support from existing evidence about how to have these conversations. Furthermore, in my systematic review I highlighted how useable recommendations for practice are not often explicitly foregrounded in conversation analytic studies. With this in mind I used aspects of the

CARM approach (10) to identify key 'trainable elements' from my results. This was a strength as it ensured potentially complex patterns of conversation were presented as clear, concise recommendations for practice. A further important strength of this training development was its review by key stakeholders through a process of member checking, feedback, and iteration. This meant it was both based on conversation analytic evidence, but also has been shown to be acceptable to policy makers, clinicians, and people with obesity.

7.5.2 Limitations

A limitation of this thesis is that these data were recorded from a clinical trial where GPs were encouraged to offer referrals to patients. Although this was a relatively real-world trial, it is possible that delivery of referrals in usual care could differ. However, as primary care clinicians very rarely intervene on obesity (11), these data represent the best currently available. Another limitation was that, in the BWeL trial, patients were approached by a researcher who asked if the GP could talk to them about their weight. They therefore were aware some mention of weight was forthcoming. Whilst in usual care patients are increasingly encouraged to weigh themselves in the waiting room, and take a BMI readout from the scales to their GP, and similarly may be prepared to discuss weight, this practice is still very rare. Therefore, it is possible referrals with unprepared patients may differ. However, it is likely this is not a major limitation as results from my systematic review suggest the patterns of interaction in natural conversations are very similar, and showed many of the practices also identified in the BWeL corpus.

Another limitation was that these recordings were audio only, which meant that embodied communication could not be studied. Additionally, the audio recordings started just before the referral was delivered. It may be possible that a patient was displaying dissatisfaction or satisfaction with the main business of the consultation and this was also displayed when the referral was offered. However, I did not have access to these prior discussions, so could not analyse these sequences. A further limitation of these data was that topic initiation frequently mentioned 'the trial', and there was limited data on how best to initiate the topic of weight before offering

referral. As a result, I was unable to identify and recommend ways of smoothly initiating the topic of weight, but these data did allow me to identify ways of initiating the topic of weight that may be best avoided.

I did not have access to GP or patient reports of the doctor-patient relationship, and this was a limitation. Current evidence on the role of this relationship in weight management discussions is contradictory. On one hand clinicians have reported that they are reluctant to deliver referrals which they fear will damage their existing relationship (12), and on the other they have said they are more likely to discuss referrals if they know the patient well (13). Data on this relationship could have complemented my research, particularly as the previous relationship was oriented to in the talk in some cases. Paraphrasing for example, which was shown to be associated with agreement to attend, may have been successful because of a prior relationship evoked through formulating prior talk, but I was unable to analyse this.

Another potential limitation was that I did not have access to the GPs' own BMI. Prior work suggests GPs may be reluctant to deliver weight management advice due to being overweight or obese themselves (12). However, only one GP oriented to his own body weight in the BWeL corpus, so it seems unlikely these data would have offered additional insights when using conversation analysis. For statistical analyses, however, this was a potential confounder that could not be controlled for, as patients may reject or accept advice based on the GP's own body size.

GPs were trained to deliver brief interventions for weight loss, incorporating CWMS referral. Therefore, it is likely that problems occurring in real life, where GPs are not trained, may be underrepresented. This is a limitation, as the range of interactional troubles which may occur when referrals are delivered from untrained clinicians, or potential ways to mitigate or negotiate these, may not have been present in these data. However, the fact that these referrals are delivered so rarely means this range of deliveries is also unlikely to have been captured in a purely usual practice dataset.

In chapter two, I discussed the limitations of quantifying sequence organisation. When exploring particular phenomena, I chose a quantification point. For example,

when analysing 'linking weight with health', I coded the first type of linking clinicians used. When coding news delivery format, I coded the valence asserted in the pre-announcement. Similarly, when coding patent responses to news, I coded the first responses to the first news delivery. Sequences where news was delivered, receipted, then clarification was provided and news delivered a second time were not quantitively captured. However, these offered important insights that are discussed in the qualitative data analysis sections of chapter four. This limitation to quantifying sequence was mitigated by using results from conversation analysis to inform my choice of quantification point. For example, in chapter four I describe how valance was both initially and most strongly asserted in the pre-announcement, and was typically maintained subsequently. Stivers states that the analyst must ground their identification of a phenomenon, and its transformation into a variable, firmly in the interlocutors' reality. I followed Stiver's approach here as I felt it mitigated some of the sequential limitations of quantification. For example, in the BWeL corpus the GP may have done a number of actions which were only minimally responded to, followed by another action which received a marked response. This locally foregrounded action, would be the one I collected, examined further, and used as a variable in my statistical analysis.

7.6 Contributions of this thesis:

7.6.1 Addressing GP-reported barriers

In the first chapter of this thesis, I outlined that guidelines recommend that GPs intervene on weight, but GPs are reluctant to do so (14). I discussed a series of barriers to delivery that GPs have identified. These were:

- A perceived lack of time to discuss weight-management (12, 13, 15)
- Concern that raising the topic of weight management opportunistically would offend patients(16)

- Concern about damaging the doctor-patient relationship (12, 16)
- Beliefs derived from anecdotal observations that weight loss interventions are unsuccessful (17)
- A lack of confidence when talking about weight (18)

However, I also outlined that, should they deliver such interventions, GPs report a preference for offering programmes that encouraged lifestyle change (19). During this thesis I explored how GPs could best deliver this preferred method. Most specifically how they can best offer an opportunistic referral to a behaviourally informed weight management service such as a commercial weight management service (CWMS). Results of these analyses offer comment on many of these existing GP-reported barriers. I now discuss these.

Firstly, the BWeL corpus comprises discussions designed to be brief. Training showed that GPs could deliver referrals in around 30 seconds. However, the variability on discussion length (range: 8-458 seconds, average: 95 seconds) highlights the potential difficulty in maintaining this brevity. Whilst this may seem to align with GP reports about 'opening a can of worms', my conversation analysis in this thesis highlighted that brief discussions were possible. I also showed it was often GP initiated actions which acted to lengthen consultations, rather than patient-initiated actions. In chapter four I showed that conditionally presenting the referral as contingent on the patient's decision (through use of an if-preface to enquiry) was designed to prefer a longer response, and account for this response from patients. These longer answers could be often avoided through using a 'would' preface instead. Another way GPs acted to lengthen consultations in these data was often engaging in unnecessary news elaborations. In chapter five I showed that when patients produce a marked positive stance, oh-prefaced response, or actual rejection there is opportunity for the GP to truncate discussions in their next turn. However, there was considerable variability in GP responses with some orienting to this truncation potential and some engaging in unnecessary elaboration. Therefore, potential to shorten conversations was often missed. Patients also acted to lengthen consultations by asking questions about the referral, like 'is it free' or 'is it local',

which initiated further discussion. However, in chapter four I showed this could be avoided in any cases if doctors mentioned this key information in the news announcement, before the patient's response. This work has shown that, whilst lack of time is a very real concern in primary care, there are ways that conversations can be designed which are likely to ensure they remain brief.

As well as lack of time, GPs also report concern that discussing weight management opportunistically would offend patients (16). In line with these reports I observed that patients could display resistance to GPs topicalisation, and subsequent problematisation, of weight. These resistance displays were most marked following associations between weight and health, which I discussed in chapter 6. Resistance also occurred during a news delivery which had a negative valence, which I examined in chapter 4. These results align with both GP reports and existing interactional analyses which show that these discussions can indeed be sensitive (20, 21). My results offer comment on how these resistance displays were likely generated, and how they could be avoided. Resistance seemed to be most likely to occur when referral was presented as a necessary solution to a medical problem. I showed that this evoked issues around morality, doctorability, and the patient's role of 'good patient'. Results showed that, in many cases, resistance to discussing weight can be avoided. When GPs delivered 'good news' about a referral, it was very rare for patients to display offence. Similarly, if a GP paraphrased a patient's prior talk, patients were likely to positively receive referral. This was because talk was built collaboratively, and discussion of weight was framed as a patient-initiated action. This aligns with results from my systematic review in chapter three, which showed health behaviour change talk is likely to be well received if it is patient-initiated. I have shown in this thesis that, just like lack of time, GP's concern about causing offence is a very legitimate one. However, I also showed ways GPs can offer a referral in ways which are very likely to be well received. The most prevalent of these was a '*good* news delivery'.

The results presented above also offer comment GPs' reported concern about damaging the doctor-patient relationship (12, 16). Although I have no pre, or post-

consultation measures of patient or doctor perspectives of their relationship, some inferences can be drawn from these results. It is reasonable to infer that generating displays of resistance to discussing weight may be more likely to damage the doctor-patient relationship than not doing so. In general, patients who displayed that discussions were well received in-consultation also reported positive post-consultation satisfaction measures. Although no conclusions can be made, I think it is likely that the same strategies that avoid generating resistance, are also likely to avoid significantly damaging the doctor-patient relationship.

A further reason GPs report for not discussing weight is that they believe it will be ineffective. While the BWeL trial itself showed this belief to be wrong, my analysis of the consultations showed key elements that enhance effectiveness, or decrease effectiveness, such as good news delivery. The trial recruited the large majority of 'all-comers', suggesting that intrinsic motivation was not the key, but my CA work showed that it was the nature of the consultation that made the difference.

Results showed that some ways of offering referral that address one barrier could also contribute to another. For example, paraphrasing a patient's prior talk was likely to be both well received and was also associated with patient attendance at their referral. However, discussions that included paraphrasing were likely to take significantly longer than those which did not, aligning with GPs barrier of a lack of time. Conversely, some ways of offering referral addressed multiple barriers. When patients did an actual rejection (for example 'no'), GPs either elaborated in apparent attempts to convince or persuade patients to agree, or they closed the conversation. Elaborating frequently caused resistance displays from patients, and always took additional consultation time. If the resistance was particularly marked, consultations often took even longer, as GPs displayed attempts to address this resistance. Moving to close, however, shortened the consultation and did not create resistance from patients. This addresses both clinicians' concerns about causing offence and time constraints.

GPs report a lack of confidence when discussing weight, and have stated a need for more specific training and resources to support them. The results in this thesis have been formulated into a resource for training specifically to address this barrier. I

demonstrate in section 7.4 of this chapter how this resource was designed with input from key stakeholders in the delivery and reception of weight management referrals. This means that primary care clinicians worked to ensure that this resource provides those specificities that are lacking from current resources. Of course, discussions about weight are just a part of a wider socio-cultural milieu where obesity occupies a complex space (this is discussed further in section 7.6.3 of this chapter). However, it is reasonable to assume that the evidence base built through this thesis, and the resource for training clinicians, could play a part in addressing their lack of confidence, through provision of clear strategies which show these conversations can be helpful, brief, effective, and well received.

7.6.2 Contributions to primary care research

I have shown how brief interventions which incorporate the offer of referral to a CWMS can be carried out in ways which are likely to be well received; associated with patient action; and keep interventions appropriately brief. Existing literature which examines obesity discussions in primary care has largely explored GP and patient *views* and recollections of discussing weight. This work has explored what words or phrases patients report receiving well, and which they report may be motivational or demotivational for weight loss (22). However, this literature has largely been limited to post-hoc reporting which, as I discussed in chapter two, provides a rich understanding of the interlocutors' reported thoughts and feelings about these discussions, but can be subject to considerable recall and social desirability biases (8, 9). Conversely, the approach I have taken here allows researchers to more robustly answer questions about how weight is discussed. I have shown that the actualities of a consultation can conflict with these posts hoc reports. Linking weight and health, for example, is consistently reported as preferred by clinicians. However, this work has shown that it is actually likely to generate resistance in many cases. These results highlight the importance of analysing recorded consultations in order to interactional practices explicit.

This thesis also contributes a broader understanding of approaches to behaviour change in primary care. The behaviour change taxonomy (BCT) has been frequently

used in primary care to describe the components of behaviour change interventions, and to identify active ingredients likely to result in patient action on behaviours such as excessive alcohol consumption (23) or smoking cessation (24). However, emerging evidence indicates that for very brief interventions, such as those explored in this thesis, the behaviour change components are relatively consistent (25, 26). I have shown in this thesis that conversation analysis highlights that it is the way these intervention components are delivered, including their sequential placement and prosody, that affects patient action, in a way that analysis using behaviour change techniques is not designed to identify. The approach I have taken here offers a new way to explore the aspects of very brief interventions in primary care which could contribute to their effectiveness. This is important because there are a growing number of weight management interventions that have been shown to be effective in primary care (27). However, if GPs do not know how to deliver these effectively in ways which are likely associated with patient action, these may not be as effective as they could be. Furthermore, if GPs do not know how to avoid inadvertently causing offence, they may cease to deliver interventions that could be effective out of legitimate concern for their ongoing relationship.

The results from this thesis also show the wider potential of data collected as part of clinical trials in primary care. It is not uncommon for interventions to be recorded in order to conduct basic fidelity assessments. This thesis highlights that these recordings also can reveal the intricacies of how these conversations are constructed, and generate learning that could improve both clinical practice and patient experiences. Although conversation analysis has been incorporated into a number of clinical trials, at varying stages of the development (28), recruitment (29, 30), implementation (31) or analysis process, its use is still rare. Here, I have contributed to a growing body of work highlighting the great potential of routinely collected trial recordings for detailed interactional analysis. This approach also acts to reduce research waste and expand the types of questions primary care researchers can answer.

7.6.3 Obesity and liminality - Findings in the context of anthropological understanding of obesity in western biomedicine

Lupton has argued that, in western society, obesity contrasts with the prevailing preference for thinness (32). She states that, whilst thin now represents affluence, health, and desirability, society frames 'fat' as an uncontrolled body, excessive consumption, and laziness (32, 33). Increasingly 'fatness' has been moved under the medical gaze (34), and it has been named as a medical condition. In their studies of the medicalisation of obesity Harjunen and Lupton both state that this medicalisation is an attempt to control and change defiantly obese bodies and move them in line with social norms (32, 33). Central to much debate on obesity is whose responsibility it is to address. Many arguments focus on intersections between the food industry; the government; medical professionals; or the obese person themselves to solve the issue (35). Others argue that obesity is not an issue to be addressed or solved (36). This thesis shows a snapshot of this debate. Results showed GPs take some responsibility to address the issue, and arising tensions between GPs and patients as they negotiate issues of morality and responsibility.

As I was analysing data in this thesis I began to frame obesity in healthcare in the context of liminality. Latent within the discussions in the BWeL corpus, and existing literature exploring GP and patient perspectives, were clear tensions in how to medicalise a state of being that is neither healthy nor diseased. Liminality was conceptualised by Van Gennep (37), and later built upon by Turner (38), then Douglas (39). In his Rites of Passage Van Gennep shows how transitional or liminal times are marked through rites of passage which include temporary removal from society, as a socio-cultural approach to dealing with in 'between-nes'. As Turner states, "Liminal identities are neither here nor there they are betwixt and between the positions assigned and arrayed by law, custom, convention and ceremonial" p.95 (40). The liminality explored by Van Gennep and Turner was *transient* betweenness, but liminality can also be permanent. Chronically ill and disabled bodies, as well as obese bodies, have been conceptualised as embodying a permanent liminal state (41). Douglas (39) explores this permanent 'matter out of place'. She shows how liminal objects that do not fit within society's existing norms are viewed as

anomalous and, resultingly, are often stigmatised. Following Jackson (42), I view Turner and Van Gennep's 'betwixt and between' and Douglas' 'matter out of place' as inseparable concepts constructing how objects become liminal and are treated as such by society. An obese body occupies a liminal space "between normal and abnormal, health and disease, acceptable and unacceptable" p.1 (43). As is usual for liminal objects, the obese body is treated with "derision and even repulsion" p.3 (32) in Western society. The position obesity occupies between health and disease became clearly evident through my analysis of the BWeL corpus, as tensions arose over the medicalisation of obesity. This is most evident in chapter 6, where I demonstrated that patients resisted explicit links between their weight and their health. From my work in this thesis I hypothesise obesity, or an obese body, occupies two liminal spaces in these consultations, both a liminal doctorable domain, and a liminal epistemic domain, these concepts are closely related, and I now discuss each briefly.

As I have already stated, an obese body deviates both from traditional models of a 'healthy' body, but also from traditional notions of 'sick', occupying a liminal state in between (41, 43). I observed orientations to this liminality in both the existing literature, and in the BWeL corpus. Clinicians in interview and focus group studies consistently express reluctance to discuss obesity. This is because they state they feel these conversations may be awkward, disruptive, and they have little expectation that conversations will lead to patient action on their weight (12, 13, 44). Existing literature demonstrates contradictory positions are expressed on the role of the medical professional in addressing obesity. Many state that they perceive it not to be their role, despite training and guidelines to the contrary (12). Whilst a sick body is eligible for medicalisation, tensions here are evident about the status of an obese body in the healthcare context. I observed in this thesis that GPs displayed difficulty talking about obesity, and often repaired or omitted the word 'obese': "what we do with people who a- are (.) is- is to". This aligns with the discomfort often reported in the literature (12, 13). Routinely defined conditions such as infectious diseases, chronic diseases, and injuries, are generally accepted conditions which show disorder of bodily functioning. They have easily applied biomedical definitions and treatments (41) , and so fall entirely within existing notions of 'sick' (and therefore doctorable). Doctors displayed reluctance to discuss obesity becomes more

understandable as obesity's liminal position makes it neither doctorable nor undoctorable. A way many doctors in the BWeL corpus dealt with this was to frame obesity in the context of an existing or potential concern. This showed an effort on behalf of the GPs to shift obesity from a liminal domain into a clear medicalisable category; frame it as a medical problem, and justify subsequent advice giving as part of the clinicians' medical role. Whilst I observed these doctorable transformations enacted at the individual level in the BWeL corpus, Lupton observes this pattern at the societal level (32). She shows that as biomedicine attempts to move 'obesity' into the medical sphere, by creating medical definitions and medical treatment, this is resisted by other areas of society (32, 36). This further concretises obesity's liminal positioning.

In chapter five I commented on the production of actual rejection ("No") of the offer of referral, and the surprising lack of accounts, delays, hedges, or palliatives to mitigate these rejections. I hypothesise that the liminal positioning of obesity, as outside the medical domain, allows permission for this outright rejection, as clinicians have stepped outside of their designated role, into a domain where they are neither an expert, nor permitted to give unsolicited advice.

A second, closely related, liminal space occupied by the obese body is a liminal epistemic domain, which I discussed in chapter six. In these data clinicians implicitly or explicitly claimed knowledge of a patient's health behaviours though stating their BMI, and then offering a behavioural intervention (on diet and physical activity) as a solution. Outward appearance was used as a proxy measure to hypothesise as to health behaviours and, resultingly, direct access to knowledge of unhealthy behavioural practices was claimed by clinicians. Clinicians asserted medical authority, knowledge, and power in these discussions. However, this claim to epistemic access of the patient's health behaviours was resisted by patients. Evident in the BWeL corpus was moral work undertaken by patients to assert 'good' health behaviours related to diet and exercise in response to these assumptions. This moral work evoked an epistemic tension; a challenge to the GP's assumption of knowledge primacy. I showed that one patient said that the GP had used his BMI to make assumptions about these behaviours. Here again liminality became relevant as epistemic access belong neither wholly to the doctor (demonstrated through the

frequent challenges from patients), nor wholly to the patient (demonstrated by the fact the doctor did not seek details of health behaviour but claimed access to these though medicalised measurements). Interventions on obesity in primary care are often compared with those on smoking cessation. However, what emerged from this analysis is that smoking is a health behaviour, and being obese is not. Asking "how much do you smoke", for example provides a measure of the frequency of the health behaviour, and provides the doctor with knowledge of this behaviour, for which they are then able to give advice and support. However, measure of BMI does not do the same function. This provides the doctor with knowledge of how much a patient weighs, not of their diet and activity. Perhaps uniquely in the context of obesity both clinicians and patients have access to claims of epistemic primacy – clinicians asserting knowledge through evoking biomedical measures of BMI, and patient's knowledge through lived experience - setting obesity apart from many other 'health behaviours' to which it is often compared.

Issues around liminality, and doctorablity, have been discussed only briefly to maintain my applied goal of useable recommendations for practice, to improve these conversations for both clinicians and patients. However, a broad understanding of the space that the obese body occupies can account for the resistance to weight loss observed in a number of these conversations. The tensions observed in these conversations mirror wider social tensions around the categorisation and treatment of obesity. Framing obesity in terms of the liminal spaces occupied by the obese body provides an underlying hypothesis for the patient's 'deviant' behaviours in the medical setting; claiming epistemic primacy, and rejecting medical advice. I have demonstrated that it can be difficult to address obesity, potentially because this condition carries sociocultural tensions that reach beyond the consultations analysed here. However, I have also demonstrated in this thesis that there are some helpful ways to do so. Bringing obesity into the medical domain in many instances enhanced tension, potentially foregrounding the liminal state of obesity both epistemically and medically. However, a brief non-judgemental offer of help that did not attempt to medicalise obesity, nor assert the clinician as an expert, could be well received.

7.6.4 How this fits in with conversation analytic research on health behaviours

There has been limited conversation analytic exploration of conversations about weight management in primary care. Those that have explored this topic often do so with a specific focus on people with diabetes, rather than a broader population of people with obesity (20, 21, 46). This thesis offers for the first time an understanding of how brief referrals to commercial weight management services are offered and received in practice. I outlined in chapter three how existing studies used patient responses as a proxy measure of the effectiveness of clinician talk. This thesis builds upon this work by not only focussing in detail on both clinician talk and patient responses, but also exploring associations between this talk and patient next action. Whereas previous analyses have hypothesised which conversational practices result in behaviour change, I have been able to explore associations between practices and outcomes. I have also built upon wider conversational analytic work on health behaviour change, which I reviewed systematically in chapter 3. In this section I discuss how my work fits in with these existing studies.

Freeman (47) has previously shown the potential for health behaviour change talk to occur opportunistically at the end of a consultation. She identified two ways this could be done. Firstly, though conversational bracketing (changes in tone indicating the conversation is 'off the record') and, secondly, mixed into usual closing talk. My work showed that, in the context of a brief CWMS referral, conversations were neither bracketed, nor mixed into closings. Rather they were framed as their own referral sequences, with preannouncements and closings. Therefore, identifying a third way that opportunistic health behaviour change talk at the end of a consultation can be delivered. The methods identified by Freeman were reported to somewhat mitigate the delicacy of these discussions. Conversely, the method of entering into a news delivery sequence, identified in this thesis, was shown to have great variability in generating displays of uptake or resistance depending on the sequential components and their delivery.

Conversation analytic work has shown that personalising behaviour change advice through question-answer sequences (48, 49) (50, 51) is likely to result in uptake displays, and likely indicates receptivity to health behaviour change advice. Question-answer sequences in the BWeL corpus did occur, rarely, in the form of a perspective display series. They did not provide opportunities to tailor advice, as patients generally responded negatively to the prospect of weight management services early in these sequences, and GPs had no tailored alternative to offer following these responses. Although I had few examples of personalising behaviour change talk through question-answer sequences, the instances that were available for analysis indicate this method is not best used in this setting.

Another way of personalising health behaviour change talk is to collaborate with patients (50, 52, 53). Existing studies have shown that this approach facilitates patient participation in decision making, and encourages patients to both comment on, and agree with health behaviour change. In this thesis I demonstrated that GPs built referrals collaboratively with patients though paraphrasing their prior talk. In line with existing studies, this collaborative environment facilitated patient comment on the acceptability referral, and often in displays of enthusiastic uptake. My work on this practice offers a key addition. Whilst previous studies hypothesise that agreement-to-change generated by collaborating may result in actual behaviour change, I was able to show that this is indeed the case in the context of brief interventions for weight loss which incorporate the offer of CWMS referral. Personalising behaviour change talk has been shown to have potential for effectiveness. However, Silverman indicates that this practice may result in longer consultations than non-personalised discussions. I was able to quantify consultation time in this work. Talk that was explicitly tailored to a specific patient, through evoking existing or potential health concerns, was significantly longer than talk that was not designed in this way. Although this did not incorporate all ways of tailoring talk, the results for this specific type of tailoring aligns with Silverman's observations regarding additional consultation length.

One study of weight management in dietary counselling (52) explored the concept of positioning the patient positively or negatively with regard to efforts to change behaviours. Thille et al showed that a patient could be positioned as a 'failure' for

not changing their behaviours. This negative positioning was likely to generate resistance displays. Whilst Thille et al explored appointments to review previously agreed upon dietary change, their findings align closely with my results on negative news delivery. Presenting referral in a negative way, as a necessary solution to a medical problem also generated resistance displays in many cases. Thille et al had limited evidence on positive positioning. Conversely, many GPs in the BWeL corpus presented referral positively. I found that this was likely to result in both agreement-to-attend the referral, and subsequent referral attendance.

Existing conversation analytic research shows that patient-initiated heath behaviour change talk is likely to be well received by patients. My work builds upon this, showing that when GPs framed a discussion as patient initiated (for example "you were saying…") it was also likely to be both well received and, additionally, significantly associated with patient CWMS attendance.

In Chapter 3 I reviewed ways of addressing resistance to heath behaviour change talk. These were: pursuing health behaviour change talk (48, 49, 51), through (a) evoking worst case scenarios (51), (b) varying recommendations (48), (c) linking to a salient concern (51, 54), and (d) long pauses and repeat questions (22); or initiating a change in topic (47, 51). Results from my analysis of the BWeL corpus offer additional insights on these previously identified practices. Many GPs pursued health behaviour change talk through linking to salient concerns could avoid further resistance displays. However, I showed that, in line with Pilnick and Coleman's work (51, 54), many clinicians asserted potentially salient concerns which were not oriented to as such by patients. Therefore, this was a risky strategy. GPs in the BWeL trial also used repeat questions to peruse a response, a method to address resistance identified by Silverman. Whilst Silverman argues this method could encourage behaviour change, I observed that it did not. In the BWeL corpus, if a patient had rejected the referral initially, repeat questions resulted in escalating resistance displays. Another way to deal with resistance is to change the topic to less delicate matters (47, 51). In the BWeL trial, GPs could orient to resistance displays and move to close, and as demonstrated in this existing work, this enabled health behaviour change talk to be discontinued successfully.

Research on health behaviour change talk has not so far focussed on single utterance analyses. Instead, existing studies of health behaviour change conversations typically explore wider practices of action, such as advice giving. In analysing single utterances in great detail (for example, 'oh' and 'no') I have shown that these analyses can reveal results that have direct relevance for practice.

I examined the relation of these findings to clinical guidelines in chapter six. Webb's work also explored discussions about weight in an obesity clinic and related her findings to clinical guidelines. Webb showed that clinical guidelines did not consider the sequential or interactional complexities of these discussions. These recommended praising obese patients at every opportunity, which Webb showed was not always interactionally appropriate. My results here aligned with Webb's in many cases, showing that two practices recommended by guidelines - linking weight with health, and emphasising patient effort - were risky and potentially resistance generating in practice. Webb concluded that guidelines on praising obese patients, should be followed cautiously. Conversely, I have concluded that guidelines encouraging clinicians to associate weight and health, and emphasise effort, are best not followed. My thesis aligns with Webb's work in highlighting the importance of careful attention to recorded conversation before making recommendations for practice, and offering comment on how guidelines are best followed (or not).

7.7 Recommendations for future research

In this thesis I identified ways of offering referral which seem both well received by patients and can be associated with future action. I have used results to develop a resource for clinicians, to support training in these practices. Further research could test this to explore the effectiveness of this training, and to build upon the evidence base I have identified.

One way to test this in further research would be to conduct a RCT, following the Quintet (29) process. Following training in the evidence-base identified in this thesis, clinicians could be video-recorded opportunistically offering referrals, and data on post-consultation satisfaction and attendance collected. Further analysis could then

be conducted focusing on the delivery and reception of the training components in practice. This would allow identification of any difficulties in implementing the training; commonly omitted elements; or elements that were not performing in line with the results developed from this thesis. It would also facilitate a second round of analysis to identify any additional strategies including those identified as limitations of this study, such as the role of embodied action. These results could facilitate an iteration of the initial training package, with further engagement from key stakeholders which reflects the learning generated from this further research.

One limitation (discussed in section 7.5 of this chapter) which was highlighted by all three stakeholder groups who were involved in design of the information resource was that the current data provided no evidence on effective topic initiation. Either clinicians mentioned 'the trial' which would not be the case in a routine practice setting; they linked weight and health, which I have shown to be a risky strategy; or they topicalised weight by mentioning the patient's BMI, which was also potentially risky. Further research is needed to examine how topic of weight can be raised smoothly to initiate a brief intervention.

Further work could also add richness to this study by exploring these results in the context of GP and patient opinions of the BWeL referrals. Although many studies have conducted interviews and focus group analyses, these have not been combined with complementary naturalistic data. An approach grounded in action-implicative discourse analysis (55) could add new depth to the field. During this approach, conversations are recorded, analysed, and also supplemented with clinician interviews and reflections on the recorded data. This theoretical–methodological approach is "used to reconstruct institutional members' communication problems, challenges, and dilemmas; the communicative strategies they use to manage multiple, and contradictory, inter-personal and institutional goals; and participants' situated ideals about how to act." P.137 (56). I believe that through integrating a series of approaches to data collection, and encouraging clinician reflection on their behaviours, new insights could be gleaned about how to overcome clinician-reported barriers to supporting patients to change their behaviour. For example, clinicians could reflect on what specific aspects of a conversation were particularly

challenging; or what wider processes could have been in place to make things easier or smoother at specific points.

7.8 Implications for policy and practice:

At the start of this thesis I outlined a lack of evidence underpinning current policy on weight management discussions which incorporate the offer of referral to a behaviourally informed weight management service, such as a CWMS. I also discussed how clinicians state they are reluctant to have these discussions. A leading reason for this is because current policy and training provide no specific advice on how best to have these conversations. Clinicians stated a need for more specific advice to support practice. Throughout this thesis I have built an evidence base to address this knowledge gap. However, to implement this evidence routinely, practice, training, and policy level changes are needed. I discuss these below.

Research from this thesis has informed Public Health England (PHE) guidelines for clinicians in brief intervention delivery (57, 58). These are the first guidelines to my knowledge that advise GPs to avoid articulating an association between weight and health when discussing weight. These also advise GPs to present referrals positively, in line with my results which showed good news was more likely to be well received. These guidelines demonstrate specificities of how to have these conversations, rather than the general advice which clinicians have stated is problematic. Whilst results from this thesis have made a direct contribution to PHE guidelines, these contradict NICE guidelines in many cases. For example, two specific strategies which I have shown to generate resistance: linking weight with health and emphasising the need for patient effort and commitment, are discouraged by PHE guidelines but encouraged by NICE. I have already discussed that these results may seem counterintuitive to clinicians. Therefore, it is likely that, when faced with contradictory advice, clinicians may follow those from NICE which are already used frequently, and better align with their current practice. To increase uptake and use of the results generated from this thesis, key clinical guidelines, such as NICE, need to align with the best-available evidence presented here.

Changes to guidelines alone, however, may not be enough to support the wider use of this evidence in everyday practice. Whilst I have shown that referrals to effective behavioural services can be successful, and fit within the time constraints of the primary care environment, emerging evidence shows that primary care clinicians do not consider weight management a priority. GPs report that they lack knowledge and understanding of obesity (59, 60). This may be because "curricula addressing obesity are underrepresented in clinical medical education" p.176 (60). Brief resources for training, such as the one presented here are likely effective in communicating the specificities of delivering a very brief intervention incorporating a referral. However, if clinicians do not have an existing basic understanding of the complexities of obesity and its causes, then they may lack motivation to follow PHE guidelines. This is because GPs often report anecdotal, rather than evidence-based beliefs about obesity. GPs in the literature, for example, report believing that high weight is the patient's responsibility and that it is the patient's responsibility to lose weight (14). I experience this perspective regularly when training experienced clinicians to deliver very brief interventions incorporating referral. Prioritising obesity in medical education could also motivate clinicians to see obesity treatment as an important preventative intervention that addresses social inequalities in health.

As well as increases to medical education, policy changes could also encourage prioritisation of these discussions. Implementing financial incentives for offering referrals could be one way to increase this prioritisation. Public Health England has suggested, for example, that GP practices could score QOF points as an incentive to recommend effective behavioural services (61).

Small changes to the primary care environment could also better support GPs to offer referral to effective behavioural services. The way patients are weighed in general practice, for example, could be adjusted to facilitate intervention. As I have already stated in this chapter, routine BMI calculation in general practice is increasing, but is still relatively rare. Weight data are commonly missing from electronic health records, and patients are not routinely weighed (62). GPs normally have access to scales which measure body weight only, meaning access to a measure of BMI is not available to all GPs. There is no routine access to a measure of a patient's body fat. Therefore, even if GPs did feel prepared to intervene, they have

no way of knowing if patients have a BMI of ≥30 and a raised body fat and are, therefore, eligible for referral. Implementing routine weighing using body composition scales (which measure weight, body fat, and calculate BMI) would give GPs access to patient BMI information; informing them of eligibility and facilitating the offer of referral.

Although referral was commonly available at the time of writing this thesis, few patients are aware that these are free from their GP. I showed in chapter four of this thesis that the perception of cost is a common barrier to attendance. Therefore, public health campaigns informing patents of this free service could support many people to initiate discussions with their clinicians and request referral.

Increasing GP skill in offering referrals, particularly in the ways identified here which are likely to result in attendance, likely means increasing demand for limited places at effective behavioural referrals. Increasing capacity to refer could mean that all patients offered referral are able to take these up. A recent promise of increased governmental funding with a focus on prevention (63) could be targeted at increasing capacity for patients who are referred.

The renewed government focus on prevention could support these wider changes necessary to make referrals to effective behavioural services a part of routine practice (64). The evidence presented here could be used to inform change as policy shifts to focus on prevention (63). Addressing obesity is complex. However, this work has shown that conversations likely to be associated with positive reception and referral attendance can be had effectively within the existing time and organisational constraints of primary care. These is no need for significant extra time, resources, or cost to offer referral in this way. There is a need however, for policy level changes to better support GPs to deliver these effective referrals through implementing small but important changes to current guidelines, training, and the general practice environment.

7.9 Conclusions

Clinical guidelines encourage healthcare professionals to offer referral to effective behavioural programmes to patients with obesity. However, the difficulties in engaging in these often-sensitive discussions are well documented, and there has been no evidence on how best to do so. In this thesis I have used conversation analysis (CA) to explore the delivery and reception of a brief intervention for weight loss which incorporated referral to a commercial weight management service. I took a systematic approach to identifying conversational patterns, and exploring relationships between word choice, grammatical structure, sequential positioning, and patient response. I demonstrated that conversation analysis can be combined with quantitative approaches to examine associations between particular conversational sequences, or phrases, with both how patients respond and actions they take on their behaviours. The main contribution of this thesis is an evidence base of effective practice. Results demonstrated that what is 'effective' in a consultation is often counter-intuitive to GPs, and foreground the importance of detailed attention to conversational patterns before making recommendations for practice. The evidence base developed here addressed a series of barriers clinicians have expressed to delivering these conversations. GPs report lack of time, lack of confidence that patients will change their behaviours, concerns that they will offend their patients, and lack of knowledge about what to say when discussing weight. Conversely, I have shown that offering referral to an effective behavioural service does not need to be difficult, time consuming, or resistance generating. Furthermore, I have made the strategies available for clinicians to access. The evidence identified here should reassure clinicians that there are several ways of offering referral that are brief, that patients respond to well, and that are associated with attendance. These can easily fit within the time and resource constraints of general practice.

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Appendix 1 Jeffersonian transcription conventions

=	Equal signs indicate latching talk
[	Square brackets indicate the start of overlapping talk
→	Draws the reader's attention to a particular line of the transcript
oka:y	Pitch slides from down to up during the word
lo:se	Pitch slides from up to down during the word
(0.3)	Numbers in parentheses indicate pauses in talk, measured in tenths of a second
(.)	A full-stop in parentheses indicates a hearable pause of less than 0.3 seconds
Commercial	Indicates stress via pitch or volume
Wo::rld	Colons indicate elongation of the immediately-prior sound. The number of colons show the length of elongation
LOOK	Capitals (except at the beginnings of TCUs), indicate talk is markedly louder than the surrounding talk.
.hhhh	A dot followed by a row of 'h's indicates an inbreath. The number of 'h's indicates the length of the inbreath.
hhhh	'H's without a dot Indicates aspiration, such as outbreaths of laughter particles
-	A hyphen shows that a word or part of a word has been cutoff
Y(h)e(h)s	'H's in brackets within a word indicates laughter during speech
°management°	Degrees signs either side of a word or TCU shows that the enclosed talk was markedly quiet or soft.
>you know<	"Greater than" and "less than" signs in this order either side of a word or TCU shows that the enclosed talk was hearably faster than the surrounding talk
<Slimming World>	"Greater than" and "less than" signs in this order either side of a word or TCU shows that the enclosed talk was hearably slower than the surrounding talk.
↓ or ↑	Up and down arrows mark notable and/or sharp rises or falls in pitch.
Ye**p**. **F**ine.	Boldfaced consonants indicate that consonants were delivered with unusually hardened sounds.

#I've come down a bit no::w#	Hashtags either side of a word or TCU shows that the enclosed talk was delivered with a creaky voice
£Tha:t's ri:ght.£	Pound-signs either side of a word or TCU shows that the enclosed talk was delivered with 'smiley voice', and indicates the speaker was smiling.
It's Weight Watchers.	A full stop marks falling intonation, giving some sense of completion
lifestyle change,	A comma marks gently rising tone, giving a sense of speaker continuation
How do you feel about that?	A question mark indicates a rising tone
YA:H!	An exclamation mark indicates a TCU final utterance that conveys animated delivery (over and above turn final intonation contours)
(have)	Words in brackets mark a lack of certainty as to the exact word that was said.

Appendix 2 Draft script for resource for training

Section 1:

Guidelines say we should be opportunistically intervening on our patients' weight. One way to do this is to offer patients with a BMI of 30 or over a free referral to a commercial weight management service, like Weight Watchers or Slimming World.

Evidence shows these are more effective than other ways of losing weight and are cost effective. These are available on the NHS, although the exact type might be different in your area.

We've analysed hundreds of recorded consultations between GPs and patients, where the GP opportunistically offers referral to commercial weight management services, like Slimming World or Weight Watchers.

We found these conversations can easily fit at the end of a typical consultation, and that if you are positive about them, your patient is likely to be too.

We identified what you can say that will be well received by your patients and is also likely to lead to attendance at weight management services.

We've found you can have positive helpful conversations in around 30 seconds.

Section 2:

Offering a referral doesn't need to be complicated. Simply

1) Establish services are effective
2) Offer a free referral
3) Acknowledge the patient's response
4) Outline next actions

Let's look at an example:

The evidence about the best way to lose weight shows that commercially run slimming organisations have the best results.

I can actually offer you the opportunity for a free referral to a local one today, for twelve weeks.

Would you be interested into going along to one of those?

Yes, I would

Brilliant, I would very much encourage to take up the opportunity.

Go and see reception on your way out, they will give you details of that, and they can book you in to sessions.

Section 3:

Here are some techniques you can use at each of these four stages that will support you to have effective, brief, and well received conversations.

1) Establish CWMS are effective

Before offering a referral, it's important to first say that commercial weight management services are the best way to lose weight.

"Did you know commercial weight management services are the best way to lose weight, and people do really well with that?"

If you don't do this, patients are unlikely to accept as they may not know they are effective.

2) Offer a free referral

1) Be confident

Firstly, confidence is key. Remember, you're offering something that normally costs a lot of money for free, it's extremely unlikely your patient will be upset or offended by this. but if you sound reluctant or nervous, they are unlikely to want to attended.

3) Don't talk about other conditions

It may seem like a good idea to talk about the benefits of weight loss for a patient's exiting condition, like their diabetes or asthma. However, our research has shown that this is one thing that can make patients upset or defensive, so this strategy is best avoided.

4) Offer an opportunity

Simply say:

*"I can **offer** you the **opportunity** to have a **free** referral for twelve weeks at a commercial weight management service, like Weight Watchers or Slimming World. These are available **free locally** to **support** you to lose weight."*

Our research has shown that saying the words 'offer' 'opportunity' 'support' and 'local', are well received and address questions patients may otherwise ask later.
Saying the word 'free' is very important.

5) Would you be interested?

After you've outlined the offer ask the patient directly: would you be interested in that? The way you make the offer is important: Don't use 'if' or 'or' as this is likely to open discussion further and take a longer time.

"Would you be interested in that"?

6) Be brief

Talk simply and clearly, you don't need to use medical language, spend a long time describing the offer, or talk about the potential medical consequences if a patient doesn't lose weight.

3) Acknowledge the patient's response

Here's how to reply to patient's in ways which are likely to keep the conversation brief and motivational. Remember it is extremely unlikely your patient will be upset or offended by these conversations.

1. Your patient may say they're already losing weight. Acknowledge and congratulate these current or past efforts. If they're already losing weight it doesn't mean they can't also attend commercial weight management services, and this could be really helpful to help them keep up the good work.

   "That's brilliant"

2. If patients are unsure, or on the off chance they are upset, saying "*I think* this will be a really good thing", can support them in making their decision, It's unusual to be offered these referrals at the doctors' and patients may be unsure about accepting, but knowing that their doctors thought this was good and helpful, really supports patients in making their decisions.

   "I think this will be a really good thing"

3. Surprisingly, we found that when a patient said 'yes' or 'yeah' in response to an offer, they weren't always agreeing, they were actually requesting more

information. If your patient says ‘yes’ or ‘yeah’ try telling them a little more about what you are offering. However, our research showed that a positive response like ‘yes definitely’ ‘or ‘that sounds good’ indicated enthusiastic receipt of the offer. If your patient responds this way be positive too and move to next steps.

4. Listen for the word ‘oh’- this shows an offer is well received and you can stop the referral right away.

“I can actually refer you for free today.
***Oh right**.”*

5. Some people don’t want to accept the referral, and that’s okay. Trying to convince or persuade people that had declined an offer doesn’t work and is likely to make people frustrated if you don’t listen to them. If your patient does say “no”, acknowledge their decision but remind them you’re there to talk if they ever want to discuss their weight again.

Would you be interested in doing something like that?
No, not really. No.
Okay. That’s fair enough.
What I would suggest to you, maybe come back if you want to talk more at any time.

4) Next steps:

Signpost the patient to the person in your practice who can tell them more:

“That’s brilliant, go and see the receptionist on you way out, and they’ll give you more details about this.”

And ask them to come back inn a month to see how they’re getting on:

“And book in to see me in a month to chat about how you’re getting on”

Remember, even if you don't follow all of our advice, it's very unlikely you will cause offence, as long as you sound positive and confident.

By offering a referral you are giving your patient the best opportunity for a supportive effective way to lose weight.

If you have more questions check out the Public Health England guidelines 'Let's talk about Weight'.

Appendix 3 Systematic review search terms:

The following databases were searched: MEDLINE; Embase; Web of Science; AMED; CINAHL; PsycINFO; Scopus; Sociological Abstracts CSA, and restrictions were applied to specify human subjects and English language. Where the database permitted use of MeSH terms, these were included. We searched peer-reviewed journals and published book chapters from 1945-2018

Each database was searched twice, using two different search strategies. The first search strategy was designed to identify literature which focusses on a specific health behaviour (such as weight loss, or smoking cessation), and the second was designed to identify literature which may focus on a behaviourally-related action (such as adherence or motivation), rather than specific behaviours.

Search Strategy 1:

1. (medic* OR treatment* OR care* OR healthcare* OR health* OR patient* OR doctor* OR clinic* OR physician* OR primary care* OR consult* OR general practi* OR family practi*)

2. ("conversation analysis" OR "conversational analysis" OR "conversation analyses" OR "conversational analyses" OR "conversation analytic" OR "conversational analytic" OR "discourse analysis" OR "discourse analytic" OR "discourse psychology" OR "sequential-analysis" OR "conversation-

analysis" "conversational-analysis" OR "conversation-analyses" OR "conversational-analyses" OR "conversation-analytic" OR "conversational-analytic" OR "talk in interaction" OR "talk-in-interaction" OR linguistic*)

3. ("weight loss" OR smok* OR alcohol* OR lifestyle* OR intervention* OR diet* OR exercise* OR "phyiscal activity" OR activ* OR "blood pressure" OR diabetes OR "tobacco use" OR "physical inactivity" OR "body weight" OR cholesterol OR "stress management" OR "sexual health" OR "organ donation" OR "life support" OR vaccinat* OR weigh*)

4. (audio OR video)

5. 1 AND 2 AND 3 AND 4

MeSH Headings: (Physician-Patient Relations OR Health Communication OR Patient Compliance OR Medication Adherence OR Patient Satisfaction OR Treatment Refusal OR Negotiating OR health behaviour OR decision making OR motivation OR health behavior)

Search Strategy 2:

1. (medic* OR treatment* OR care* OR healthcare* OR health* OR patient* OR doctor* OR clinic* OR physician* OR primary care* OR consult* OR general practi* OR family practi*)

2. ("conversation analysis" OR "conversational analysis" OR "conversation analyses" OR "conversational analyses" OR "conversation analytic" OR "conversational analytic" OR "discourse analysis" OR "discourse analytic" OR "discourse psychology" OR "sequential-analysis" OR "conversation-analysis" "conversational-analysis" OR "conversation-analyses" OR "conversational-analyses" OR "conversation-analytic" OR "conversational-analytic" OR "talk in interaction" OR "talk-in-interaction" OR linguistic*)

3. (motivat* OR coerc* OR recommend* OR interven* OR resist* OR incentiv* OR encourage* OR accept* OR "descision making" OR ahere* OR cooperat* OR empower* OR instigat* OR initiat* OR "behaviour change" OR "behavior change" OR "behavioural change" OR "behavioral change" OR "behavioural changes" OR "behavioral changes" OR persuad* OR choice* OR uptake* OR nudge* OR convinc* OR concord* OR communicat* OR agen* OR pressur* OR negotiat* OR comply OR compliance OR enable* OR co-operat* OR facilitat* OR barrier* OR disincentiv* OR refusal)

4. (audio OR video)

5. 1 AND 2 AND 3 AND 4

MeSH Headings: (Physician-Patient Relations OR Health Communication OR Patient Compliance OR Medication Adherence OR Patient Satisfaction OR Treatment Refusal OR Negotiating OR health behaviour OR decision making OR motivation OR health behavior)

Appendix 4 Template for data extraction (adapted from Parry & Land, 2014):

Sections in red were added to adapt the existing data extraction tool (1) for the purposes of this review.

Review details		**Notes**
Name of reviewer		
Date of data extraction		

Publication details		Notes
Title		
Author(s)		
Year of publication		
Source of publication		
Synopsis		

Data		
Research question/aims		
Recording – audio visual or audio only?		
Co-present participants or non co-present?		
Interactions are one-to-one, multiparty or both?		
Country in which data was collected		
Institutional setting(s)		
Type of health behavior discussed		
Participant roles		
Total corpus size		
Multiple settings /sites		
If multiple settings/ sites how many episodes at each setting		
Other features of data mentioned		
Number of episodes in collection(s) used for paper – state number at each location if a multi-setting study		

Number of excerpts from the collection that appear in the publication		

Method		**Notes**
Methodological approach (as described by author(s))		
Reviewer's comment on methodological approach (if relevant)		

Summary of Findings		**Notes**
Phenomenon (in brief) and outcome if reported		
Phenomenon one in author's own words		
Second phenomenon (in brief) and outcome if reported		
Second phenomenon in authors own words		
Third phenomenon (in brief) and outcome if reported		
Third phenomenon in authors own words		
Implications for practice		
Links to other references from bibliography sampling		

Appendix 5 Asserting valence in news elaboration

Appendix 5.1 News elaboration negative news

Excerpt 1 09-02-20 b

```
1  Doc:   So it's it's totally up to you. It's important
2         that you understand the significance of
3         having this ratio over thirty, That's (.)
4         not good for you. Has implication on a
5         wide range of health issues. Getting it
6         under thirty (.) is rea:lly a good thing
7         for you. In general health °and in
8  Doc:   specific disease terms°. In your case (.)
9         °hypertension°. U:m it's very much a question
10        of whether or not you want to go down
11        this line.
12        (.)
13  Doc:  If you are interested (0.3) you need
14        to just pop back and talk to that lady
15        and she'll sort- (0.3) sort of out
16        tendancies for you. All locally.
17        If you want to do that, It's open to yo:u,=
18        =And it's free of cha:rge.
19  Pat:  Ah hm.
```

The GP in Excerpt 1 delivers a longer news elaboration than was typical of a 'negative news' valence. He utters a series of statement-based informings that are not designed to explicitly request a response form the patient, and indeed do not receive one. This act as a strong display of epistemic primacy, asserting 'something I know' and 'something you do not know'. Initially at line 1the GP seems to be presenting the referral as the patient's choice. However, he follows this statement "it's totally up to you" with a series of statements "It's important that you understand" at lines 1-2; "That's not good for you" at line 4. The GP uses long word "significance" "tendencies" "implication" which further contribute to this epistemic imbalance. As I have previously stated, Maynard refers to this type of delivery pattern as an 'information dump' delivering more information than can be 'understood or absorbed in the immediate circumstances' (2). Whilst we do not know what this particular patient can understand or absorb we can observe a series of statement-based informings delivered one after the other with no patient response or invitation for a patient to do so. Although the GP does not use first

person reference to endorse the referral throughout this information dump, his list of the problems of not accepting act to present acceptance as a preferred course of action.

This excerpt illustrates that some features more common in a good news delivery sequence could also be present as part of a negative news sequence. Here the GP, at line 45, states “is a really good thing for you”. However, this positive assessment is of weight loss, not of the referral itself. This assessment also takes place as part of a wider ‘information dump’ which evokes epistemic incongruence between doctor and patient.

Whilst some areas are delivered at a faster pace (for example lines 25-26 and 27-28) the GP’s turns are otherwise consistently slow throughout this sequence. It is hearable here as doing ‘being serious,’ and acting to delay the news delivery conveying some level of reluctance or trouble in formulating its telling. Freese and Maynard also observed this slow pace as a characteristic of bad news delivery (3). This GP also uses creaky voice at a lines 9 and 39 during this sequence which is consentient with a bad news delivery.

Excerpt 2 illustrates another feature of the elaboration of negative news. I showed in section 4.6.1.2 that patient activity burden was emphasised in preannouncement of negative news. It is similarly emphasised in the elaboration of negative news. Whilst the GP states that attending CWMS is not a “lifelong” commitment, he emphases that the patient will be given an “education package” (lines 3-4). This indicates patient activity burden during referral, as “education” in particular is hearable as communication of a serious, intensive, effort. The GP then states that the patient should take on this education package indefinitely. This conveys post-referral activity burden, suggesting the patient will need to change her behaviours indefinitely beyond attending the CWMS. This is emphasised in the GP’s subsequent turn at line 9, when he states “it’s a lifestyle change that you need”. The GP asserts his right to tell or inform, and therefore his epistemic primacy from lines 9-10. “it is a lifestyle change that you need”.

Excerpt 2 09-02-24

```
1  Doc:   It does not mean that you are committed
2         lifelong to going to a slimming club. It's
3         a question >you know< of utilising
4         the education package that they can give you.
5  Pat:   Right.
6  Doc:   And then taking that on on a (0.5) in- in
7         >°indefinite basis°<.
8  Pat:   Yes.
9  Doc:   Because (.) it is a lifestyle change that
10        you need and they seem to be able to get the
11        message over better. Than you doing on your own.
12 Pat:   Mm mm.
```

Appendix 5.2 News elaboration neutral news

Where a neutral valence was asserted, news elaborations were often absent. Excerpt 3 illustrates how these were achieved when they were present.

Excerpt 3 06-01-02

```
1  Pat:   Oh right.=
2  Doc:   =Through (.) u:h basically (0.4) tried and
3         tested methods .hh (.) using um different
4         companies to provide support u:h to do that.
```

The GP briefly provided further information (Lines 7-9) which acts to provide vague details. He does not assess the referral or agreement as a preferred course of action. If elaboration was requested by a patient GPs rarely provided this information. I showed earlier in chapter 4 that GPs often responded to requests about further details by providing specific information like "it's local". However, in these neutral deliveries they deferred further information delivery to the trial team. In excerpt 4 the patient asks when the referrals will be (line 1) and the GP states that the researcher will proved these details. The trial team are framed as information providers on the specifics of the referral. Through these deferrals the GP avoids claiming to be knowledgeable about the referral, or asserting the epistemic primacy that was typical in the negative news deliveries. These features neither work to present the referral as a good thing or a bad one, nor do they exert an explicit preference for agreement.

Excerpt 4 06-01-02

```
1  Pat:   Is it going to be through the da:ytime that?
2  Doc:   Um basically what- what I'd like to do is to
3         um direct you back to um the >researcher Janet<.
4  Pat:   Right.
5  Doc:   And then she will give you the details.
6  Pat:   Ah.
```

Appendix 6 Final training script

Words in '*green'* indicate details of the animation that is playing during the voice over.
Words in 'black' show the video narration.
Words in '*blue*' show conversation examples which will appear on the screen during the video.

Section 1:

Guidelines say we should be opportunistically intervening on our patients' weight. The best outcome of these interventions is to offer patients with a BMI of 30 or over a free referral to a weight management service.

We see a medical center. Arrows appear, guiding patients to the doorway. From there they are directed along the path to a weight management service meeting

Evidence shows that commercial services, like Slimming World and Weight Watchers are more effective than trying to lose weight without support and are not only cost effective but cost saving, even if people put the weight back on. In many areas, these are available on the NHS, although no weight management service or other services might be available where you work.

The meeting is taking place, with smiling attendees who are succeeding at their goals.

We've analysed hundreds of recorded consultations between GPs and patients, where the GP opportunistically offers referral to commercial weight management services, like slimming world or weight watchers.

Conversation from the meeting is recorded on a series cassette tapes

We found these conversations can easily fit at the end of a typical consultation, and that if you are positive about them, your patient is likely to be too.

We identified what you can say that will be well received by your patients and is also likely to lead to attendance at weight management services.

The final cassette slots into place, giving a full picture of the conversation

We've found you can have positive helpful conversations in around 30 seconds.

A stopwatch counts up to thirty

Section 2:

Raising the topic.
It may feel strange to raise the topic out of the blue but it is easier than you might imagine.

'While you're here, can I just check your weight please?'

When stating the patient's weight don't say obese or BMI, but mentioned their weight is higher that you would like, and immediately mention some support is available.

"Your weight is a little higher than we'd like, and I can actually offer you some support to lose weight today"

Offering a referral doesn't need to be complicated. Simply:

A notebook appears with the four steps, each being ticked off as they are completed.

1) Establish services are effective
2) Offer a free referral
3) Acknowledge the patient's response
4) Outline next actions

Let's look at an example:

A doctor is speaking to her patient. As she uses key words, they appear highlighted green in speech bubbles. He is nodding and leaning in, responding positively to these.

The evidence about the best way to lose weight shows that commercially run weight management organisations, like Weight Watchers, have the best results.

I can actually offer you the opportunity for a free referral to a local one today, for twelve weeks.

Would you be interested into going along to one of those?

Yes, I would

Brilliant. I would really encourage that, I can make a referral today and you'll get a call from the weight management service soon

Section 3:

Here are some techniques you can use at each of these four stages that will support you to have effective, brief, and well received conversations.

1. **Establish Commercial Weight Management Services are effective**

Before offering a referral, it's important to first say that commercial weight management services "like Weight Watchers" or "like Slimming World" are the best way to lose weight.

Another doctor and patient. Again, she responds positively when the doctor uses key words.

"Did you know commercial weight management services like Slimming World are the best way to lose weight? People do really well with that – they're far more successful than trying on their own"

If you don't do this, patients are unlikely to agree, as they may not know they are effective.

2. **Offer a free referral**

There are five important features of the referral, which should be simple, short, and jargon-free.

The key words are highlighted by a confident looking doctor

a) **Be confident**

Confidence is key. Remember, you're offering something that normally costs a lot of money for free. We found no evidence that patients are upset or offended by this. But if you sound reluctant or nervous, they are unlikely to want to attend.

b) Don't talk about other conditions

A series of other conditions appear on the screen. They quickly pile up even though they are being crossed out and erased again, seeming overwhelming and confusing

It may seem like a good idea to talk about the benefits of weight loss for a patient's existing condition, like diabetes or asthma. However, our research has shown that this is one thing that can make patients upset or defensive, so this strategy is best avoided.

c) Offer an opportunity

Simply say:

*I can **offer** you the **opportunity** to have a **free** referral for twelve weeks at a commercial weight management service, like Weight Watchers or Slimming World. These are available **free locally** to **support** you to lose weight.*

*"I can **offer** you the **opportunity** of a **free** twelve week referral at a service like weight watchers or slimming world. These are available free, locally, and will **support** you to lose weight*

Our research has shown that saying the words 'offer' 'opportunity' 'support' and 'local', are well received and address questions patients may otherwise ask later. Saying the word 'free' is very important.

A hand offers the schedule for the weight management meeting. Patient's hand takes it.

d) Would you be interested?

After you've outlined the offer ask the patient directly: would you be interested in that?

The way you make the offer is important: Don't use 'if' or 'or' as this is likely to open discussion further and take a longer time.

These words appear as they are spoken, but are quickly crossed out

"Would you be interested in that?"

3. Acknowledge the patient's response

Here's how to reply to patients in ways which are likely to keep the conversation brief and motivational. Remember it is very unlikely your patient will be upset or offended by these conversations.

1) Your patient may say they're already losing weight. Acknowledge and congratulate these current or past efforts. If they're already losing weight they can still attend a weight management service, and this could be really helpful to support them to keep up the good work.

"That's brilliant"

Doctor and Patient. The patient speaks about his new exercise plan, which is shown in a bubble above him.
The doctor congratulates and encourages him to continue.

2) If patients are unsure, or on the off chance they are upset, saying "*I think* this will be a really good thing", can support them in making their decision, It's unusual to be offered these referrals at the doctors' and patients may be unsure about accepting, but knowing that their doctor thought this was good and helpful, really supports patients in making their decisions.

"I think this will be a really good thing"

3) Surprisingly, we found that when a patient said 'yes' or 'yeah' in response to an offer, they weren't always agreeing, they were actually requesting

more information. If your patient says 'yes' or 'yeah' try telling them a little more about what you are offering. However, our research showed that a positive response like 'yes definitely' 'or 'that sounds good' indicated enthusiastic receipt of the offer. If your patient responds this way be positive too and move to next steps.

Patient says "Yeah' but secretly has questions, shown by question marks around his head. The doctor responds by offering more information, shown on a document behind them

4) Listen for the word 'oh'- this shows an offer is well received and you can stop persuading and move to make the referral right away.

"I can actually refer you for free today
***Oh** right"*

5) Some people don't want to accept the referral, and trying to convince or persuade people that had declined an offer doesn't work and is likely to make people frustrated and could sound like you aren't listening to them. If your patient does say "no", acknowledge their decision but remind them you're there to talk if they ever want to discuss their weight again.

The doctor is talking a lot, but not listening to his patient. The constant stream of words and medical jargon builds a physical wall between them. The more he goes on, the higher the wall becomes.
When he respects her decision to say no at this time, bricks are removed again, re-opening the lines of communication.

Would you be interested in doing something like that?
No, not really. No.
Okay. That's fair enough.
You can come back if you want to talk more about it.

4. **Next steps:**

Let your patient know what will happen next, and how they can hear more about the referral:

"Ok, that's brilliant, I'll make a referral and you'll get a call from the weight management service"

A doctor shakes hands with his patient following a successful referral.

It may seem obvious that 'a person who is motivated enough to lose weight is motivated enough to make their own appointment' but it's simply wrong. Clinical trials show the reverse: simply taking the onus of initial contact out of the patient's hands and leaving it in your hands, as would be true of all other referrals you make, is the single most important thing you can do to facilitate engagement with the weight loss programme *and* long-term weight loss.

And ask them to come back in a month to see how they're getting on:

"And book in to see me in a month to chat about how you're getting on"

Remember, even if you don't follow all of our advice, it's very unlikely you will cause offence, as long as you sound positive and confident, and are polite and respectful of patient's responses.

By offering a referral you are giving your patient the best opportunity for a supportive, effective way to lose weight.

Back at the weight management meeting, the new patient comes through the door to attend her first meeting.

If you have more questions check out the Public Health England guidelines 'Let's talk about weight', available on the gov.uk website.

Details appear on screen.

Appendix 7 GP-delivered brief weight loss a cohort study of patient responses and subsequent actions, using conversation analysis in UK primary care (4)

Research

Charlotte Albury, Elizabeth Stokoe, Sue Ziebland, Helena Webb and Paul Aveyard

GP-delivered brief weight loss interventions:

a cohort study of patient responses and subsequent actions, using conversation analysis in UK primary care

Abstract

Background
Guidelines encourage GPs to make brief opportunistic interventions to support weight loss. However, GPs fear that starting these discussions will lead to lengthy consultations. Recognising that patients are committed to take action could allow GPs to shorten brief interventions.

Aim
To examine which patient responses indicated commitment to action, and the time saved if these had been recognised and the consultation closed sooner.

Design and setting
A mixed-method cohort study of UK primary care patients participating in a trial of opportunistic weight management interventions.

Method
Conversation analysis was applied to 226 consultation audiorecordings to identify types of responses from patients that indicated that an offer of referral to weight management was well received. Odds ratios (OR) were calculated to examine associations between response types and likelihood of weight management programme attendance.

Results
Affirmative responses, for example 'yes', displayed no conversational evidence that the referral was well received and showed no association with attendance: 'yes' (OR 1.2, 95% confidence interval [CI] = 0.37 to 3.95, $P = 0.97$). However, 'oh'-prefaced responses and marked positive responses, for example 'lovely', showed conversational evidence of enthusiasm and were associated with higher odds of commercial weight management service attendance. Recognising these could have saved doctors a mean of 31 seconds per consultation.

Conclusion
When doctors make brief opportunistic interventions that incorporate the offer of help, 'oh'-prefaced or marked positive responses indicate enthusiastic acceptance of the offer and a higher likelihood of take-up. Recognising these responses and moving swiftly to facilitate patient action would shorten the brief intervention in many cases.

Keywords
conversation analysis; health behaviours; medical communication; primary health care.

INTRODUCTION

National guidelines exhort GPs to use brief opportunistic interventions to encourage patients to improve their health behaviours.[1–3] A recent trial showed that one such intervention for weight loss was acceptable to patients and doctors, and could effectively reduce population mean weight.[4] Although brief interventions have been shown to be successful, GPs report several barriers to their frequent delivery in primary care consultations, citing limited consultation time as a key restriction.[5,6] Healthcare professionals are often unsure whether, and how best, to raise the topic of their patients' weight,[7] and there is sparse evidence about how GPs can deliver effective interventions that are acceptable to patients and yet do not take up unnecessary consultation time. In this article the authors examine patient responses during the Brief Interventions for Weight Loss (BWeL) trial, where GPs intervened with consecutively attending patients who were overweight but not consulting for help with weight loss. The brief intervention comprised endorsing, offering, and facilitating a referral to a commercial weight management service (CWMS) free of charge. Following patient response to the offer of a free referral, GPs often entered into negotiation or further explanations, which lengthened consultations.

The aim of this study was to identify patterns of patient responses to the initial announcement of the offer of referral, which displayed that the offer had been well received by the patient, and which could be associated with future action. Conversation analysis (CA) was used to systematically explore and document observable patterns of communication. A leading principle of this method is that talk is systematic and orderly, and can be broken down into a series of actions.[8] This enables identification of relationships between conversational patterns and specific outcomes.[9] CA has been used to research medical interactions since the early 1980s, and extensive focus has been placed on communication in general practice.[9–11] This approach highlights, for example, strategies that a doctor can use to avoid unnecessary prescriptions for antibiotics[12] or to encourage patients to raise additional concerns.[13] This method can be combined with statistical measures to further illustrate findings.[14,15] In this study CA was combined with outcome data regarding CWMS attendance, enabling the researchers to explore relationships between patient responses to the offer of CWMS referral and future action. Early identification of responses that indicate an offer is well received by patients — and is associated with future action — could help GPs to tailor their discussions to avoid unnecessarily lengthy negotiations.

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How this fits in

Guidelines encourage doctors to identify patients who are obese and refer them to weight management services. However, doctors fear that such conversations take a long time. In this study of consultation audiorecordings of doctors offering such referrals, it is shown that saying 'yes' to an offer does not indicate acceptance, but other responses including saying 'oh yes' do. Recognising these could allow doctors to shorten the consultation.

METHOD

Context and participants

In the BWeL trial, the researchers sought to enrol all patients attending 137 different GPs where the patient had a body mass index (BMI) ≥30 kg/m^2 (or ≥25kg/m^2 if Asian). Enrolment was from 4 June 2013 to 23 December 2014. Participating GPs received video-mediated training in intervention delivery but were not provided with a standardised script. At the end of the consultation, GPs in the intervention arm made an audiorecorded opportunistic brief intervention where they endorsed, offered, and facilitated a referral to a weight management service (either Slimming World® or Rosemary Conley). Participants were telephoned after 3 months and seen in person after 12 months, where the researchers ascertained whether participants had tried to lose weight and the means by which they had had done this. Patient attendance data was provided by the weight management services.

Participants had the option to decline audiorecording, or to request deletion after the intervention had been delivered. Of 940 participants, half were randomly selected for audiorecording. Some GPs did not record, though prompted, or did not make an offer, some participants did not consent to be recorded, and some recordings were rendered unusable for technical reasons; consequently 226 recordings were available for this analysis. The recorder was visible to the GP and participant and was started when the GP was about to deliver the brief intervention.

Data analysis

CA was conducted by one of the authors, who listened to the data and prepared specialist Jeffersonian transcripts, which highlighted information about the way talk was delivered. This included intonation, timing, and organisation of turns at talk.[16] Audio data were analysed in conjunction with transcripts to identify how participants responded to the offer of a free referral, and how GPs reacted to participant responses. In line with the aim of identifying cues that indicate interventions do not need to be pursued further, analysis focused on the initial announcement of the offer of a free referral, and how participants responded at this early stage of the discussion. During CA the authors were blinded to patient attendance data, and displays that an offer had been positively received, or 'positive reception displays' (PRDs), were identified. This was done through attention to type of utterance, how and where they were produced, and the responses that they received. Where a pattern was identified through CA, statistical analysis was used to corroborate the study's findings. The authors were interested in patient action following the intervention, so the outcome measure for this study was patient attendance at one or more CWMS session. Participant responses to the initial offer of CWMS referral were grouped into a series of utterance categories, and the authors then assessed on whether these categories were associated with attending the CWMS, calculating odds ratios (ORs) and 95% confidence intervals (CI) for the likelihood of attending relative to the most common response, which was 'yeah'. Statistical analyses were conducted using OpenEpi (version 3.01).

RESULTS

There were 19 different responses produced following the initial announcement of the offer of a free CWMS referral. Table 1 shows the breakdown of the utterance types most frequently produced in response to the GP's initial announcement of the offer of a free CWMS referral. Although there was some variation in how referrals were offered, Box 1 demonstrates a typical consultation sequence where an announcement was followed by a response from the patient, and then an explicit offer from the GP, or further negotiation. The results presented in this article focus on patient responses to these initial announcements (line 5, Box 1). In accordance with convention of CA presentation in clinical journals, the transcripts have been simplified for presentation here. In these excerpts, a full stop in brackets represents a gap in talk of <0.3 seconds and a number in brackets indicates a timed gap in talk. A full stop at the end of turn represents falling intonation; a comma indicates a slight rise in intonation; and a question mark is used when intonation strongly rises.

Table 1. Relationship between utterance and attendance across most common response types[a] (*N* = 226)

Utterance type		Example		CWMS attendance	Utterance, *n* (%)	Comparator, *n* (%)	*P*-value	Odds ratio	95% CI
1. Yeah	1 2 3 4 5 6 7 8 **9**	DOC: **PAT:**	What that means is that erm we can offer you erm erm basically a support programme to help with you losing weight. **Yeah.**	+ – 	19 23 	n/a n/a 	n/a n/a 	1 (comparator)	N/A
2. Oh-prefaced positive response	1 2 3 **4**	DOC: **PAT:**	It's free (.) with this referral **Oh right yeah I'll try anything,**	+ –	16 (84) 3 (16)	19 (45) 23 (55)	0.008	6.27	1.68 to 30.48
3. Right	1 2 3 4 5 6 7 8 9 **10**	DOC: **PAT:**	What they're offering here is for you to go and be funded to join a group weight management session, one of the commercial companies. **Right.**	+ – 	8 (67) 4 (33) 	19 (45) 23 (55) 	0.33	2.38	0.62 to 10.34
4. Yes	1 2 3 4 5 6 7 8 9 10 11 **12**	DOC: **PAT:**	We know the best way for you to lose weight is for you to go for a commercial weight management service. I can refer you now for free if you'd like. **Yes.**	+ – 	8 (50) 8 (50) 	19 (45) 23 (55) 	0.97	1.21	0.37 to 3.95
5. Okay	1 2 3 4 5 6 7 8	DOC: PAT:	So (.) as part of this study er we're able to offer you these sessions without any cost (.) [to yourself, [Okay.	+ – 	8 (40) 12 (60) 	19 (45) 23 (55) 	0.91	0.81	0.26 to 2.41
6. No	1 2 3 4 5 6 7 8 **9**	DOC: **PAT:**	And we can give you a free voucher for this so you could freely take part in this (.) would you be interested in this. **No.**	+ – 	2 (20) 16 (80) 	19 (45) 23 (55) 	0.02	0.16	0.02 to 0.69

... continued

Stand-alone affirmative responses

Negative responses to the announcement of a free referral, such as 'no' (utterance types 6 and 8, Table 1) were not identified as displays an offer had been well received, and were not associated with attendance at CWMS (20%, *n* = 2, attended versus 80%, *n* = 16, not attended, Fisher's exact test

Table 1 continued. Relationship between utterance and attendance across most common response types[a] (*N* = 226)

7. Marked positive stance	1 2 3 4 5 6 7 8 9 **11**	DOC: **PAT:**	You get given twelve free sessions at uh Weight Watchers which I think is in Citychester Is that something that you'd quite fancy doing? **Yes please.**	+ – 	26 (79) 7 (21) 	19 (45) 23 (55) 	0.006	4.40	1.59 to 13.14
8. Marked negative stance	1 2 3 4 5 6 7 8 9 10 11 **12** **13** **14** **15**	DOC: **PAT:** 	We know that the best way for you to lose weight is to go to a commercial weight management service (.) and I can refer you now for free if- if you like, **I haven't really** **erm been** **interested in it** **really.**	+ – 	1 (14) 6 (86) 	19 (45) 23 (55) 	0.26	0.21	0.008 to 1.57

CWMS = commercial weight management service. DOC = doctor. N/A = not applicable. PAT = patient. (.) indicates gap in talk of <0.3 seconds. A full stop at end of turn represents falling intonation. Comma at end of turn indicates slight rise in intonation.[indicates where talk is overlapping. [a]*Only eight of the 19 different response types are explored in this study and presented in this article.*

P = 0.02). However, analysis showed that responses that appear to be affirmative, such as 'yes' and 'yeah' were not PRDs when produced as standalone utterances following the initial offer. GPs frequently treated these responses as displays that an offer was positively received, however they were often followed by further questions from a participant, or with a negative response later in the consultation. While affirmative responses may be expected to convey agreement, these utterances typically display

Box 1. Typical BWeL consultation sequence

Line	Action	Speaker	Excerpt
1	Announcement	DOC:	We've got the option to offer you well a good opportunity
2			to offer you (0.4) erm the er chance to have fully (.) er
3			funded on the NHS (.) er twelve er er so er Slimming World
4			er (0.4) to help lose weight?
5→	Announcement response	PAT:	Oh right,
6	Explicit offer of referral	DOC:	Would you like to do that?
7	Response	PAT:	Er yeah?
8		DOC:	Yeah.
9	Confirmation check		Very good,
10	Assessment		There's lot of health benefits to losing weight.
11	News delivery		And it's er (0.6) it's free,
12	Information receipt	PAT:	Yeah.

BWeL = Brief Interventions for Weight Loss. DOC = doctor. PAT = patient. (Number) indicates gap in talk, seconds. (.) indicates gap in talk of <0.3 seconds. A full stop at end of turn represents falling intonation. Comma at end of turn indicates slight rise in intonation. ? indicates strong rise in intonation. → = line of significance.

Box 2. Display of marked positive stance

Line	Action	Speaker	Excerpt
1 2 3	Announcement	DOC:	So what this project is er offering people (.) if you'd like (.) er would be a twelve-week course through one of these commercial weight loss programmes paid for by the health service.
4→	Marked positive stance	PAT:	Lovely.

DOC = doctor. PAT = patient. (.) indicates gap in talk of <0.3 seconds. A full stop at end of turn represents falling intonation. → = line of significance.

Box 3. Moving to close following displays of marked positive stance

Line	Action	Speaker	Excerpt
1	Announcement	DOC:	Which means that er you get given twelve free sessions at er
2			Weight Watchers which I think is in Citychester.
3			Is that something that you'd quite fancy doing?
4→	Marked positive stance	PAT:	Yes please.
5	Close	DOC:	Excellent.
6			Well we'll pass you forward to do that.

DOC = doctor. PAT = patient. (Number) indicates gap in talk, seconds. (.) indicates gap in talk of <0.3 seconds. A full stop at end of turn represents falling intonation. Comma at end of turn indicates slight rise in intonation. ? indicates strong rise in intonation. → = line of significance.

'acknowledgement' of the initial offer, rather than conveying a stance to its acceptability.[17] These analyses were corroborated by statistical results that showed no association between responses that were treated as a stand-alone affirmative response by a GP and subsequent attendance at the CWMS (for examples 'yes' 50%, $n = 8$, attended versus 50%, $n = 8$, not attended, Fisher's exact test $P = 0.97$). These are shown in utterance types 1, 3, 4, and 5 in Table 1.

Positive reception displays

This article focuses on two displays that an intervention was positively received, (utterances 2 and 7, Table 1). These occur early in the consultation following initial announcement of the offer of a free referral, shown in lines 1–4, Box 1.

Marked positive stance. One response type produced by participants following the announcement of the offer of a free CWMS referral was a 'marked positive stance', which displayed positivity when receiving or assessing an offer (utterance type 7, Table 1). These responses go beyond neutrally acknowledging the offer of free referral, and display some positive assessment or acknowledgement, such as 'yes please' or 'lovely', as in Box 2.

The patient's utterance of 'lovely' acts to display that the announcement of a free weight loss referral has been positively

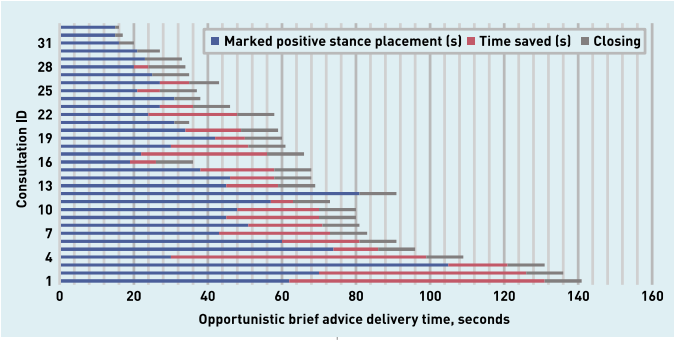


Figure 1. Placement and timing of marked positive stance within the consultation. Each 'Consultation ID' number represents a patient within this group. The number assigned is an arbitrary one which does not represent the sequence in which these consultations were delivered.

Box 4. Turn initial 'Oh' receipt

Line	Action	Speaker	Excerpt
1 2 3	Announcement	DOC:	It would be possible to go and see s- erm (.) one of these have you come across them, Rosemary Conley and the um that type of thing- (.) of weight loss things.
4→ 5	Announcement response	PAT:	Oh right, Okay.
6	Information delivery	DOC:	Where you go to various classes (.) basically.
7	Information receipt	PAT:	Oh right.
8	Account	DOC:	Because your weight is a bit high,
9	Continuer	PAT:	Yeah.
10	Information delivery	DOC:	And it would be very helpful for you to actually lose some weight.
11	Information receipt	PAT:	Okey dokey.
12 13 14	Explicit offer of referral	DOC:	That um they're suggesting that you might want to go and take that up and go and see them, I don't know if you'd be interested in that.

DOC = doctor. PAT = patient. (.) indicates gap in talk of <0.3 seconds. A full stop at end of turn represents falling intonation. Comma at end of turn indicates slight rise in intonation. → = line of significance.

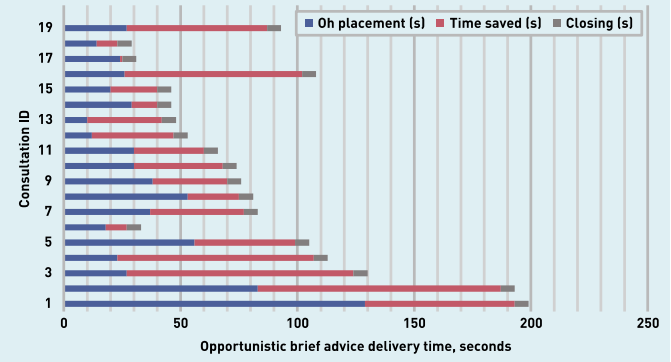
received. This response was typical of the types of marked positive stances produced by most participants, which could either be free standing, such as 'lovely' in Box 2, or with additional turn components. These responses were usually produced soon after the doctor had finished their turn, or in overlap with the doctor's turn. They were also often higher in pitch than surrounding talk, a feature associated with receiving good news.[18] This response type typically comprised of words that went beyond just acknowledgement, and conveyed the acceptability of the offer, although they often expressed varying levels of enthusiasm. A marked positive stance when a participant was informed of the news of a free referral, was commonly followed by displays of positivity throughout the remainder of the consultation, and acceptance of the offer of the free CWMS referral. A number of responses categorised as displaying a marked positive stance were prefaced with an acknowledgement token like 'yes' or 'yeah'. However, these utterances were combined with other turn components to assert positive positioning. This utterance type was frequently responded to by GPs as a PRD, as they typically closed the consultation soon after this response, and rarely engaged in further negotiation (Box 3).

Doctors who recognised a marked positive stance typically took ≤9 seconds to close a consultation.

Statistical analysis showed a significant relationship between a marked positive stance and subsequent attendance at the CWMS (79%, $n = 26$, attended versus 21%, $n = 7$, not attended, Fisher's exact test $P = 0.006$). The mean time for these discussions was 64 seconds (range 16–141 seconds), while a marked positive stance was produced at a mean of 39 seconds (range 15–105 seconds) (Figure 1). Recognising these utterances as PRDs, and moving to close, could have saved a mean of 16 seconds per consultation.

Turn initial 'Oh' receipts. Following announcement of the offer of a free CWMS referral some participants displayed a turn initial 'oh' receipt (utterance type 2, Table 1). These are responses where 'oh' is either a standalone utterance or prefaces an acknowledging response or marked positive stance, for example 'Oh right' or 'Oh definitely'. In Box 4 the GP formulates a treatment recommendation, and the patient responds with a turn initial 'oh' receipt at line

Figure 2. Placement and timing of turn initial 'Oh' responses within the consultation. Each 'Consultation ID' number represents a patient within this group. The number assigned is an arbitrary one which does not represent the sequence in which these consultations were delivered.



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Ethical approval

Ethical approval was granted by the NHS Research Ethics Service (reference: 13/SC/0028).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

Slimming World and Rosemary Conley donated free weight management courses for NHS patients enrolled in this trial.

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4. The patient says 'oh' immediately following the news of free referral, and this utterance is higher in pitch than this patient's prior talk. This is not responded to by the doctor as a PRD, as they enter into further explanation, and re-formulate their offer in line 15.

An 'Oh', in response to information can show that it is news.[19] In the current study data 'Oh' in this position was consistently followed by positive responses in that participant's subsequent turns, and by participant agreement to the recommended treatment. Similar to a marked positive stance, an 'Oh' often occurred in overlap with the doctor's talk and was higher in pitch than the patient's prior talk. Therefore, these 'Oh'-prefaced responses were identified as PRDs. Statistical analysis supported the findings (utterance 2, Table 1), and demonstrated an association between 'Oh'-prefaced responses and participant attendance at a weight loss service (84%, $n = 16$, attended versus 16%, $n = 3$ not attended, Fisher's exact test $P = 0.008$). Despite the positive characteristics of this utterance, doctors infrequently treated an 'Oh' response as indicative of positive reception. When they did, however, they were able to successfully close a consultation in ≤6 seconds without further discussion. The mean length of these discussions was 87 seconds (range 29–199 seconds) with 'Oh' occurring at a mean of 36 seconds (range 10–129 seconds) (Figure 2). Recognising 'Oh' as indicating future participant action regarding CWMS attendance, and providing a sign that closing may be initiated, could have saved an average of 45 seconds of brief advice discussion.

DISCUSSION

Summary

The authors have shown that brief interventions in primary care can be very brief when GPs attend to specific reception displays. Understandably, GPs frequently attended to 'yes' or 'yeah' as positive responses to the announcement of the offer of a free CWMS referral, yet the authors observed that such responses neither acted as positive reception displays within the consultation, nor were they associated with subsequent attendance at the CWMS. Therefore, these patients may require more information from their GP. The authors identified two types of participant response (displays of marked positive stance and turn initial 'Oh' receipts), which displayed that an offer was positively received. Statistical analysis demonstrated an association between these responses and future action, and established that in-consultation PRDs were associated with participant attendance at weight management services. Displays of marked positive stance and 'Oh'-prefaced responses occurred early in the discussion. Recognising these could have saved a mean of 31 seconds per consultation.

Strengths and limitations

A strength of this study was the use of audiorecorded data to identify exact participant responses to a brief opportunistic intervention and the time at which they were produced. Data were collected across a number of general practices and from diverse patient groups. It is relatively unusual for CA to combine primary care consultation data with reliable information about what happened next: in this case the researchers were able to make associations between real-time conversations and subsequent attendance at CWMS. A limitation is that audiorecorders were visible to both patient and GP, and this may have influenced discussions. Without video data it is possible that some gestures that indicate positive reception were not identified. The authors would recommend use of video recordings (increasingly available through archives such as 'One in a Million')[20] in future studies to complement this analysis of audiorecordings.

Comparison with existing literature

Previous CA of recorded brief interventions (to promote smoking cessation) have identified several ways in which clinicians can make effective brief interventions.[21,22] However, this is, to the authors' knowledge, the first time that behavioural advice has been associated with a patient's next action regarding CWMS attendance. The current results build on other conversation analytic work, which identified 'Oh' as indicating prior news has been good,[19] and foreshadowing future acceptance of advice,[17] by also identifying associations between 'Oh' and subsequent action.

Implications for practice

The GP consultation is tightly time limited raising concerns about how even a brief opportunistic intervention can be included. This analysis shows that, through attending to clues in what patients say, doctors can shorten delivery significantly. When delivering a brief intervention for weight loss, doctors can attend to displays of marked positive stance, and turn initial 'Oh' receipts. They occur early in the consultation and are clearly associated with uptake and attendance. Attending to these clues can avoid unnecessary negotiations and significantly shorten the delivery time of brief interventions for weight loss, thereby addressing one of the main concerns GPs report about intervening to change behaviour.

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Appendix 8 Linking as an overall consultation strategy

a. Linking weight with health and patient agreement-to-attend, and attendance at a free referral to commercial weight management services

				Univariable Analysis		**Multivariable Analysis***	
Linking placement	Outcome Measure	Action	Total	Odds ratio (95% Confidence interval)	P-value	Odds ratio (95% Confidence interval)	P-value
All placements	Agree-to-attend	Linking	83/110 (75%)	0.95 (0.53-1.70)	0.85	1.01 (0.55-1.84)	0.98
		No linking**	104/136 (77%)				
	Attend	Linking	50/110 (46%)	0.99 (0.60-1.65)	0.98	1.06 (0.63-1.78)	0.82
		No linking**	62/136 (46%)				

***Age and gender were adjusted for in these analyses**
****Comparator**

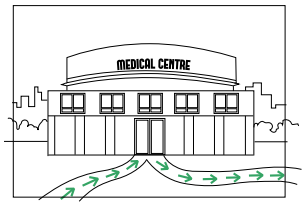
b. Linking weight with health and patient post-consultation reported satisfaction, and consultation length

				Univariable Analysis		Multivariable Analysis*	
Linking placement	Outcome measure	Action	Mean (SD)	Difference in means (95% Confidence interval)	P-value	Difference in means (95% Confidence interval)	P-value
All placements	Satisfaction	Linking	4.33 (1.14)	0.20 (-0.065-0.46)	0.14	0.20 (-0.060-0.47)	0.13
		No linking**	4.14 (0.85)				
	Consultation length	Linking	120 (80)	45.73 (28.65-62.81)	0.000	45.19 (28.41-61.99)	0.000
		No linking**	74 (54)				

***Age and gender were adjusted for in these analyses**
****Comparator**

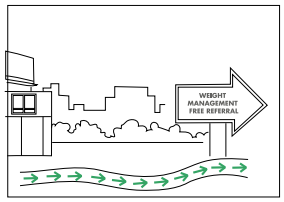
Appendix 9 Resource for training storyboard

Designed by A Dozen Eggs - https://www.adozeneggs.co.uk



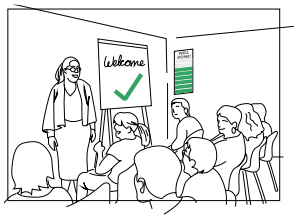
Guidelines say we should be opportunistically intervening on our patients' weight. One way to do this ...

Arrows appear like footprints, leading up to medical centre and then away toward shte next slide.



... is to offer patients with a BMI of 30 or over a free referral to a weight management service.

Following the arrows, we pass the sign recommending weight management. We keep panning into...

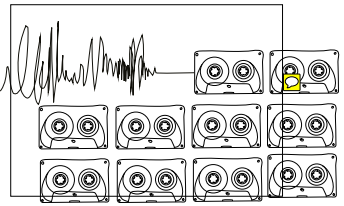


Evidence shows that commercial services, like Slimming World and Weight Watchers are more effective than trying to lose weight without support and are not only cost effective but cost saving, even if people put the weight back on.

...the weight management meeting.

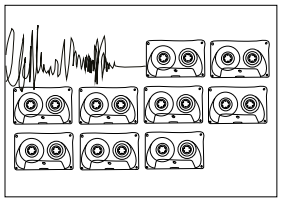


In many areas, these are available on the NHS, although no weight management service or other services might be available where you work.

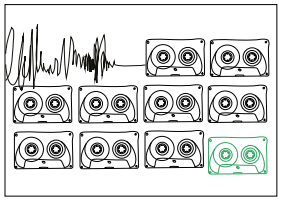


We've analysed hundreds of recorded consultations between GPs and patients, where the GP opportunistically offers referral to commercial weight management services, like slimming world or weight watchers.

Pan/zoom out to show the display of tape cassettes, all turning as they record.

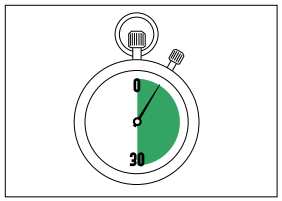


We found these conversations can easily fit at the end of a typical consultation, and that if you are positive about them, your patient is likely to be too.



We identified what you can say that will be well received by your patients and is also likely to lead to attendance at weight management services.

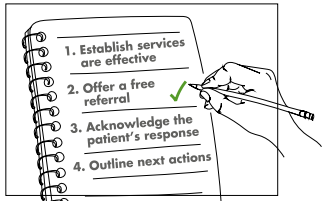
Last tape cassette slides into place



We've found you can have positive helpful conversations in around 30 seconds.

Zoom in on tape winder, which turns into stopwatch.

Stopwatch counts round to 30 seconds.



Offering a referral doesn't need to be complicated. Simply

1) Establish services are effective
2) Offer a free referral
3) Acknowledge the patient's response
4) Outline next actions



Key words 'ping!' onto the screen

V/O: The evidence about the best way to lose weight shows that commercially run weight management organisations, like Weight Watchers, have the best results.



V/O: I can actually offer you the opportunity for a free referral to a local one today, for twelve weeks.



V/O: Would you be interested into going along to one of those?



V/O:
Brilliant. I would very much encourage to take up the opportunity. I'll make a referral and you'll get a call from the weight management service soon.



Here are some techniques you can use at each of these four stages that will support you to have effective, brief, and well received conversations.

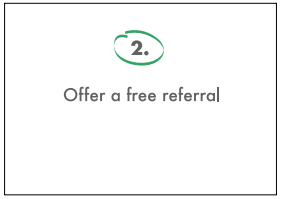


Before offering a referral, it's important to first say that commercial weight management services "like Weightwatchers" are the best way to lose weight.



If you don't do this, patients are unlikely to agree, as they may not know they are effective.

Woman nods



There are five important features of the referral, which should be simple, short, and jargon-free.



1) Be confident
Confidence is key. Remember, you're offering something that normally costs a lot of money for free. We found no evidence that patients are upset or offended by this. But if you sound reluctant or nervous, they are unlikely to want to attend.



2) Don't talk about other conditions
It may seem like a good idea to talk about the benefits of weight loss for a patient's existing condition, like diabetes or asthma. However, our research has shown that this is one thing that can make patients upset or defensive, so this strategy is best avoided.

Various conditions fade in and out , creating a confusing and overwhelming stream of conditions



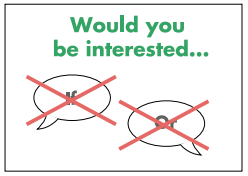
Simply say:

I can offer you the opportunity to have a free referral for twelve weeks at a commercial weight management service, like weight watchers or slimming wold. These are available free locally to support you to lose weight.

Hand comes in holding referral schedule. Second hand appears to take it.



Our research has shown that saying the words 'offer' 'opportunity' 'support' and 'local', are well received and address questions patients may otherwise ask later.
Saying the word 'free' is very important.



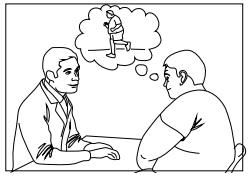
5) Would you be interested?

After you've outlined the offer ask the patient directly: would you be interested in that?
The way you make the offer is important: Don't use 'if' or 'or' as this is likely to open discussion further and take a longer time.

would you be interested in that?



Here's how to reply to patients in ways which are likely to keep the conversation brief and motivational. Remember it is very unlikely your patient will be upset or offended by these conversations.



1) Your patient may say they're already losing weight. Acknowledge and congratulate these current or past efforts.

Doctor nods



2) If they're already losing weight they can still attend a weight management service, and this could be really helpful to support them to keep up the good work.



If patients are unsure, or on the off chance they are upset, saying "I think this will be a really good thing', can support them in making their decision, Its unusual to be offered these referrals at the doctors' and patients may be unsure about accepting, but knowing that their doctor thought this was good and helpful, really supports patients in making their decisions.



3) Surprisingly, we found that when a patient said 'yes' or 'yeah' in response to an offer, they weren't always agreeing, they were actually requesting more information.

Man says 'yeah', but question marks appear round his head.

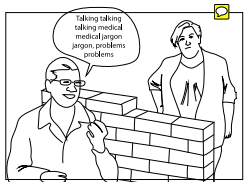


If your patient says 'yes' or 'yeah' try telling them a little more about what you are offering. However, our research showed that a positive response like 'yes definitely' or 'that sounds good' indicated enthusiastic receipt of the offer. If your patient responds this way be positive too and move to next steps.

Man smiles. Information appears as they discuss it.

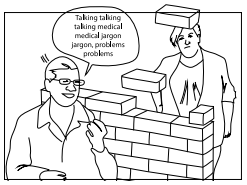


3) Listen for the word 'oh'- this shows an offer is well received and you can stop persuading and move to make the referral right away.

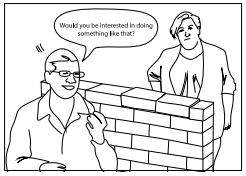


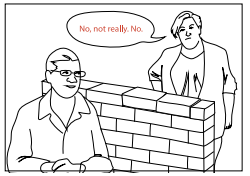
4) Some people don't want to accept the referral, and trying to convince or persuade people that had declined an offer doesn't work and is likely to make people frustrated and could sound like you aren't listening to them. If your patient does say "no", acknowledge their decision but remind them you're there to talk if they ever want to discuss their weight again

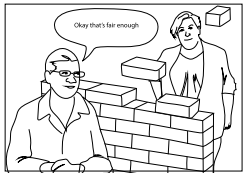
Doctor talks in a long stream, while patient looks unhappy



Bricks descend to build the wall higher



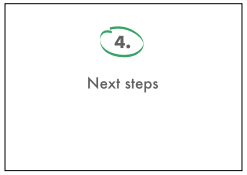




Doctor has more open face.



When he listens, patient smiles and bricks get removed.



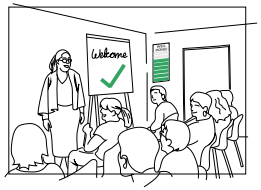
Let your patient know what will happen next, and how they can hear more about the referral



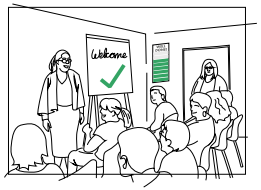
And ask them to come back in a month to see how they're getting on:



Woman nods
Might change words to a calender depending on the V/O



Remember, even if you don't follow all of our advice, it's very unlikely you will cause offence, as long as you sound positive and confident.



By offering a referral you are giving your patient the best opportunity for a supportive effective way to lose weight.

Woman appears at the door



If you have more questions check out the public health England guidelines 'let's talk about weight', available on the gov.uk website.

Appendix 10 References

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