The University Of Sheffield.

Exploring risk, resistance and closing talk in chronic diabetes routine consultations

By:

Sarah Gelcich

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

The University of Sheffield
Faculty of Arts and Humanities
School of English

July, 2017

ABSTRACT

Qualitative research is widely recognised as making a valuable contribution to healthcare practice and policy. One area of study that has noticeably relied on qualitative research is doctor-patient communication, due to the fact that practitioner-patient interaction is inherently dependent on talk. One methodology that has proven very useful in order to analyse practitioner-patient interaction is Conversation Analysis (CA). Little seems to have been done in terms of analysing practitioner-patient talk within chronic routine consultations. Routine consultations are especially important in the treatment of long-term conditions such as type 2 diabetes. This study analyses the talk between type 2 diabetic patients and a practice nurse during their routine consultations. The study will address four main points. Firstly, it will determine the differences between diabetic chronic routine consultations and acute primary care visits. Secondly, based on these differences, it will address the closing phase of these visits. Thirdly, it will establish how communication of risk takes place during these consultations and lastly it will demonstrate how disagreement takes place during these visits. Analysing these elements within chronic routine consultations can potentially inform best practice when it comes to closing a visit, communicating risk and identifying patient disagreement. The analysis and presentation of significant differences between chronic and acute visits could have an effect on patients presenting new concerns and in turn could affect their long-term care.

1 Introduction

According to Diabetes UK's latest statistics report (retrieved from www.diabetes.org.uk), since 1996 the number of people diagnosed with diabetes has more than doubled in the UK. There are an estimated 4.5 million people living with diabetes in the UK and 90% of people with diabetes have type 2 diabetes. This makes type 2 diabetes one of the most important health challenges in the UK. When diabetes is not managed properly it can create serious complications such as heart disease, stroke, amputation, blindness and kidney disease. Good management of diabetes i.e. controlling blood glucose levels effectively has been shown to reduce these complications.

The cost to people's lives is substantial and so is the financial cost to diabetes care. Diabetes UK estimates that the total cost linked to diabetes in the UK was £23.7 billion annually. It is estimated that 10% of the National Health Service (NHS) budget is spent on diabetes. The serious complications diabetes can cause, if not managed properly, has a direct impact on health services. Since, 1 in 7 hospital beds are occupied by a person who has diabetes, as they are twice as likely to be admitted to hospital.

There is an unquestionable need to explore why people with diabetes are struggling with managing their illness, evidenced by the complications that arise. One of standards identified in the 2001 Diabetes National Service Framework was empowering people with diabetes and the main interventions were to implement personal care plans, improve knowledge and facilitating patient care with patient held accessible records. Even though this strategy was written some time ago it is still relevant. Each of the standards within the framework had key interventions which were delivered by the 2003 National Service Framework for Diabetes: Delivery Strategy. One of these deliverables was: *put in place a*

systematic eye screening and treatment programme, including recall. This required Primary Care Trusts (PCT) to adopt a system where diabetic patients were given regular appointments to monitor their condition, as well as regular eye tests. In addition, the National Institute for Health and Care Excellence (www.nice.org.uk/guidance/ng28) provides guidelines and recommendations for the management of type 2 diabetes. The guidance focuses on patient education, managing glucose levels, as well as long-term conditions, and dietary advice. This guidance is to be considered along side policy documents such as "State of the Nation 2016: Time to take control of diabetes" provided by Diabetes UK (www.diabetes.org.uk). This document presents the latest evidence from audit reports on diabetes care and highlights recommended actions to improve diabetes care involving Healthcare Practitioners, Clinical Commissioning Groups (CCGs) and the wider NHS. Some of these recommendations focus on providing diabetic patients with a structured education, crucial for managing their illness, while others focus on the individual i.e. planning and developing patient goals which should be reviewed at least once a year during follow up consultations. Due to this, looking into these regular consultations seemed an obvious place to observe patients' management of their chronic illness. Likewise, it would provide insights on the practitioner –patient interaction, including their communication and also give an idea of what actually occurs during these regular visits. What is the structure of these consultations? Do patients mention any concerns regarding their illness? Does the practitioner talk about potential risks? Do patients talk about their treatment? All these questions were significant when thinking about the proposal and design for the study, as well as giving it strength in terms of its justification and motivation.

1.1 MOTIVATION FOR THE STUDY

The overall motivation for this study is researching practitioner-patient interaction, particularly how patients' manage their illness and the potential complications of living with type 2 diabetes, focusing on their routine chronic consultations. The study was funded by Medical Humanities at the University of

Sheffield.

Type 2 diabetes is a chronic illness that can deteriorate significantly over time if not managed properly. This can cause a series of health problems such as kidney failure, heart disease, blindness and amputation amongst others. One of the ways to prevent these issues is to have good blood glucose management. This can be done firstly via 6 monthly HbA1c tests, which measure glycated haemoglobin, and produce an overall picture of the average blood sugar levels over a period of weeks or months. Secondly, in some GP practices it is managed by 6 monthly diabetic chronic check-ups with a nurse or general practitioner, where other tests are performed.

Stenner et al (2011) suggest that diabetic patients prefer visits where their lifestyle and opinions are considered, enabling more of a partnership approach. According to patient views collated from interviews, the continuity of their relationship with nurse prescribers as well as their specialist diabetes knowledge is seen as beneficial as to how they manage their illness. However, despite attempts to engage in a partnership approach, social inequalities can affect the communication between the practitioner and the patient. As noted by Ricci-Cabello et al (2013) communication problems occur more frequently in consultations with patients who have a lower level of education. Hence their study, which trails a telephone reinforcement intervention for patients with lower educational levels to see if patient-provider communication improves. Nonetheless, despite these efforts and due to the fact that practitioner-patient communication is considered a key part of medical care (Meryn 1998, Heritage and Maynard 2006, Allen et all 2010,) it is important to analyse the actual talk during diabetic medical consultations.

The focus of this study is to observe and analyse these routine check-ups mentioned above. These visits involve practitioner – patient interaction, which is part of the study's motivation, in addition to potentially informing best practice in terms of how issues are talked about during these visits.

Doctor-patient communication is an important area of research. Byrne and Long's study *Doctors Talking to Patients* conducted in 1976 is widely recognised as one of the first major studies in the area. The study was seen as an intervention for physicians to review their behaviour and adapt it in a more patient-centred direction (Heritage and Maynard 2006a). Since then there have been many studies that analyse the interaction between doctors and patients and doctor-patient communication particularly in primary care. While there is extensive research on acute primary care consultations, to the best of my knowledge, there is a lack of research when it comes to linguistic analyses of routine consultations. McCabe et al (2002) and Bolden and Angell (2017) use conversation analysis to examine routine psychiatric consultations. McCabe et al (2002) analyse the engagement between doctors and patients with psychotic illness during routine consultations. Their findings suggest that patients attempt to talk about their psychotic symptoms. However, this produces some interactional tension and difficulty within the visit. Bolden and Angell (2017) focus on the treatment recommendation phase within chronic psychiatric care. When recommending treatment, psychiatrists seek more than just an agreement from the patient to a treatment offered. A fully informed decision is necessary when it comes to recommending psychotropic medications. Equally, Chatwin et al (2014) use conversation analysis to study Chronic Obstructive Pulmonary Disease (COPD) in review consultations. They describe 3 interactional formats used by patients when presenting new symptomatic concerns. Nevertheless, there is far less research in terms of conversation analysis and chronic routine consultations.

Analysing chronic check-up consultations will contribute to the knowledge base on medical consultation research, and more importantly it will provide new knowledge regarding the structure of routine consultations and the linguistic interactional organisation of these visits.

1.2 CONCEPTUAL FRAMEWORK

The interdisciplinary field of medical humanities is an area of interest not only to medics and practitioners, but also to social anthropologists, sociolinguists and conversation analysts. One of the methodologies that has proven very useful in order to analyse doctor-patient interaction, is Conversation Analysis (CA). CA is a rigorous empirical methodology that looks at naturally occurring talk. As noted by Goodwin and Heritage (1990) interaction is not a disorderly and random process, as it was once thought to be. There are implicit rules known and acted on by all participants that ensure the success of a conversation. Whilst CA can be applied to any context where talk occurs, medical interaction is one of the areas where CA has become an established methodology. Conversation analysis will be the methodology used in this study to analyse the talk in diabetic chronic routine consultations. The rationale for using CA will be discussed in chapter 3.

CA has been used successfully in other studies, yielding applicable findings. For instance, CA studies have suggested that patients report more satisfaction when consultations are initiated with open-ended questions such as: "What can I do for you today?" versus closed-ended questions like: "sore throat hey?" (Heritage and Robinson 2006). However, the distinction between open-ended and close-ended questions is not sufficient in terms of capturing question design differences in the opening phase of the consultation. Physicians' use of different question formats orient to the patients' reason for the visit (Robinson 2006). Physicians will adjust their question design depending on the suspected reason for the patient's visit. Follow-up concerns or chronic routine concerns will be solicited differently to new concerns. New concerns would be addressed with questions such as: "What can I do for you today?" However, it would be interactionally unusual to use this question design when opening a visit with a patient who is there for a follow-up or a chronic routine check-up.

Furthermore, CA has also made a significant contribution regarding its value as a diagnostic tool. Reuber et al (2009a, 2009b) suggest that there is a noticeable difference on how epileptic and non-epileptic patients use certain labels and

describe their seizures. Therefore, making it possible to use this difference in talk to aid the diagnosis between patient who are suffering from epileptic seizures and patients who are experiencing psychogenic non-epileptic seizures. This demonstrates the scope and applicability that CA can have within healthcare research. A detailed review of the literature in this regard will be presented in the next chapter.

CA will be an effective way of determining what occurs in chronic diabetic consultations, focusing on the overall structure, and issues of communication around risk and disagreement.

1.3 PURPOSE OF THE STUDY AND RESEARCH QUESTIONS

The purpose of this study is to analyse the talk in-interaction of chronic diabetic routine consultations in order to establish their structure and to identify any linguistic resources that might hinder or enable the communication within these consultations. This inductive study focuses initially on the differences between chronic routine consultations and acute primary care consultations. One of the main differences between them is the overall structure, which potentially has an effect on patients presenting new concerns. Patients in routine consultations do not have to present complaints as they are attending the visit for a check-up of an already known concern. Consequently, there is little sequential space for presenting complaints, which could prevent patients mentioning new or additional diabetic related concerns. Hence, increasing their risk by not mentioning symptoms, which could reveal additional illnesses or problems with their current treatment.

Within these routine consultations, communication of risk is another area of interest which this study focuses on and has an effect on the patient's self-management of their illness (Taylor and Siddiqi 2016). The study will address the following research question: How is risk communicated within chronic diabetic consultations? During the visits analysed, risk was talked about when relevant, namely associated to test results. If a patient's test presented an

undesired result, particularly regarding their HbA1c test, the practitioner would mention the potential risks associated to this result. As the consultations in this data set are conducted by the practice nurse, risk in these visits was always initiated by the nurse, via the introduction of a hypothetical scenario using an if-conditional clause. This format allows for risk to be individual and tailored to the patient's specific circumstances. Due to the grammatical structure of if-conditionals, namely: *if p, then q,* the risk symptom, explanation or information were expressed in the *p* clause followed by the practitioner's recommendation in the *q* clause. For example: if you take this tablet and do not eat, you run the risk of collapsing.

However, not all patients accepted the recommendations. So, disagreement is another area of interest analysed in this study. The research question is: how do patients disagree in chronic routine consultations? The data in this study suggest that patient disagreement is displayed by resistance, rather than explicit disagreement i.e. "no, I do not agree". Patient resistance takes the form of either silence, when talk is expected, or by the production of experiential evidence, that cannot be refuted by the practitioner, and which is designed to be understood in contrast to the clinician's suggestion. Linguistically, this can be constructed so as to not overtly contradict, but to present an alternative or expanded viewpoint for instance. Likewise acute primary care consultations, once agreement has been reached, speakers would move on with the consultation's progression until the closing.

There are several ways to indicate the closure of a consultation. Some of these closing resources include: summarising the visit, making future plans and using a final concern sequence ("anything else I can do for you today"). However, within these specific chronic routine visits, using one resource to close the consultation was not sufficient. So another research questions is: how are these visits being closed? The findings in this study suggest that the practitioner closes the consultation by initiating the closing with one resource and then reiterating or confirming the closing with other closing resources.

In summary, the 4 areas analysed within this study are: routine versus acute primary care consultations, closing, risk talk and patient disagreement within chronic diabetic visits.

All the visits are video recorded and analysed using conversation analysis. In addition, the data is supplemented by patient semi-structured interviews post consultations.

1.4 ORGANISATION OF THE STUDY

The study is organised into 9 chapters. The next chapter, chapter 2: Aggregating and Reviewing Conversation Analysis Findings within Medical Interactions, consists of a review of the literature in the form of a systematic review. The aim is to provide a robust, non-arbitrary overview of the literature, aggregated into categories for better understanding of CA findings, their contribution to healthcare research, and their relevance to the study in hand.

Chapter 3: Methods and Methodological Discussion, describes the methodological design for the study. It includes a justification for the chosen methodology, followed by a detailed account on how the study was conducted.

Chapter 4: Chronic Routine Consultations versus Acute Primary Care Consultations, is the first analysis chapter of this study. Its aim is to present a detailed analysis on the differences between both type of consultations, acute versus chronic. The analysis will be structured based on the chronological phases of the consultation, from the opening phase to the closing phase.

Chapter 5: Closing a Routine Diabetic Medical Consultation, is the second analysis chapter. It presents a more detailed analysis of the chronic routine closing phase presented in chapter 4.

Chapter 6: Risk via if-conditionals, is the third analysis chapter and establishes the use of if-conditionals as a means of presenting risk to patients.

Chapter 7: Disagreeing by resisting, is the fourth and final analysis chapter. It presents evidence to suggest that patients do not explicitly disagree during consultations, but instead they disagree by resisting. Furthermore, it details the linguistic forms patient resistance can take during the interaction.

Chapter 8: Discussing risk, closing and resistance, discusses the study's findings in relation to the aggregated categories from the systematic review of the literature in chapter 2.

Chapter 9: Conclusion and implications, is the final chapter of this study. It presents concluding remarks from the entire study together with the study's significance and implications for best practice.

2 Aggregating and Reviewing Conversation Analysis Findings within Medical Interactions

2.1 INTRODUCTION

The organisation of medical consultations is an important area of research. As stated by Drew et al (2001) 'much of the success of health-care provision depends on the quality of interactions between health professionals and patients'. Byrne and Long's study *Doctors Talking to Patients* (1976) is widely recognised as one of the first major studies in the area. Since then there have been many studies that analyse interaction between physicians and patients particularly in primary care.

One prominent research method for studying the organisation of medical consultations is Conversation Analysis (CA) despite it not being established specifically for the study of medical interaction. CA is a rigorous, empirical method that looks at naturally occurring talk. As mentioned earlier, Heritage and Robinson's (2006) research on doctors' opening questions is one example where interventions based on CA findings resulted in an increase in patients' satisfaction. As noted by Parry and Land (2013) 'healthcare delivery is largely accomplished in and through conversations between people' and CA has been key in terms of providing evidence regarding communication practices used in these conversations. However, there are many studies that address these practices. There is therefore, a need to make sense of large volumes of data and synthesise results from relevant research to this study in order to understand the value that CA has had as a methodology within studies addressing medical interaction. In order to do this, a systematic approach of the literature is desirable.

Medical and healthcare research has traditionally been quantitative in nature, and systematic reviews of this evidence have become an established method for

summarising and disseminating research findings. However, CA research has been mainly qualitative in nature and until relatively recently, systematic review methods have seldom been applied to this type of evidence.

The purpose of this systematic review of the literature is to provide a non-arbitrary literary background to the study focusing on findings from CA research within medical interactions. The aim is to identify applicable findings relevant to this research and to give an orderly overview providing some understanding on how CA, as a methodology, has contributed to the field of medical interaction.

2.2 SYSTEMATICALLY REVIEWING THE LITERATURE

Systematic reviewing is a methodology to search for, appraise and synthesise findings from primary or secondary studies. These reviews play an important role in informing evidence-based practice and policy (Dixon-Woods et al 2006, Parry and Land 2013, Barnett-Page 2009) and have become a foundation of evidence-based research in healthcare. Nevertheless, the methods used for systematic reviews have been focused almost entirely on quantitative research (mainly Randomised Control Trials). During their ESRC funded project Dixon-Woods et al (2006) stated: 'we experienced difficulty with matching the tasks and epistemological assumptions associated with qualitative research with the template offered by conventional systematic review methodology'. However, despite being somewhat ignored in the past (Borreani et al 2004), attempts to subject qualitative studies to systematic reviews have increased (Britten et al 2002). This is a significant task as qualitative studies are often so varied, making it difficult to review them in a systematic manner. However, CA research is methodologically and epistemologically coherent, producing evidence that better lends itself to systematic reviews rather than other more general qualitative approaches. The type of evidence produced by CA is based on rules and structured properties of interaction, therefore it could be successfully subjected to a systematic review. This chapter will aim to provide an overview of orderly and relevant CA findings within medical interaction, thus providing a robust

background to the research by using a systematic literature review approach.

2.2.1 REVIEW QUESTION AND PRELIMINARY SEARCH

CA is widely used for generating knowledge concerning the organisation of medical consultations. Whilst these have important implications for healthcare delivery, findings have not been brought together through a systematic review. Parry & Land (2013) provide a useful step-by-step guide for systematically reviewing CA-based research on medical interaction. However, whilst illustrating methodological issues, they do not provide a comprehensive account of the literature located. In other words, they establish a useful guide for carrying out a systematic review, but without the actual aggregated findings from a systematic review. In what follows I set about a systematic review of the literature with the purpose of providing an orderly account of relevant findings that CA has produced when used as a methodology for studying medical interactions. The research question for this systematic review is: *In what way does the use of CA in medical consultations inform practitioner-patient communication?*

The objective was to identify and aggregate findings from relevant studies in a replicable and transparent way that could provide an appropriate background to the research. Electronic databases were used, selecting journals from databases representing linguistics, medicine and social science. The search was carried out in February 2015. Five key search terms were identified and applied to each of the selected databases making the review process comprehensive and reproducible. The search terms were selected through an iterative process, identifying broad enough terms that would yield CA studies in medical interactions, but at the same time that would produce studies relevant to the review question. The inclusion and exclusion criteria were designed to identify studies of medical consultations using an appropriate methodology. Only studies written in English were included to avoid the need for translation. The search terms, details of the electronic databases, and inclusion/exclusion criteria are shown in Table 1.

Table 1: Systematic Review method

Electronic databases

- Linguistics Abstracts Online (LAO)
- Linguistics and Language Behaviour abstracts (LLBA)
- Science Direct (SD)
- Scopus (SCO)
- Web of Science (WOS) (includes databases: Core collection, BIOSIS, Current content connect, data citation index, Derwent innovation index, MEDLINE, Scielo citation index, Zoological record)

Key search terms

- Conversation analysis [IN] medical settings
- Conversation analysis [AND] medical communicat*
- Patient satisfaction and conversation analysis
- Discourse in medical settings
- Conversation analysis and medical consultations

Inclusion criteria	Exclusion criteria
● Qualitative studies using CA methodology (based on the presentation of verbatim transcripts) ● Studies with audio or video recordings of naturally occurring talk ● Studies written in English	● Studies involving participants with a particular communication disorder or impairment ● Studies involving psychotherapy sessions ● Studies where communication is mediated via family member (e.g. parent) or translator ● Studies involving emergency responses

Table 2 shows the results of the searches. There were substantial differences in numbers of items returned between the databases when using the same search terms. The search term "conversation analysis in medical settings" yielded only 7 hits in the Linguistics Abstracts Online database, however when applied to the Science Direct database it produced 18,365 results. Defining which studies should be included was done firstly by reading the studies' titles, discarding irrelevant ones, and then by reading the abstracts of the remaining studies. The eligibility of the articles/studies was defined following the inclusion and

exclusion criteria detailed in table 1. If in doubt the article was retrieved and read in full.

Table 2: First Search Results

Search terms	LAO	LLBA	SD	SCO	WOS
Conversation analysis in medical settings	7	26	18,365	174	149
Conversation analysis and medical communicat*	61	143	18,366	431	318
Patient satisfaction and conversation analysis	1	6	7,118	122	113
Discourse in medical settings	26	108	12,503	299	289
Conversation analysis and medical consultations	22	32	7,311	181	153
TOTAL	117	315	63,663	1,207	1022

There is a compromise between using search terms that will maximise the number of returns and their relevance. Some of the search terms were producing too many results making it unrealistic to check them all. Therefore, database filters were applied consistently across the 3 databases on the second search to narrow down the number of relevant papers. Filters were used on: Science Direct, Scopus and Web of Science databases, as these were the ones yielding an unmanageable number of results due to their general science nature. The filters used were: healthcare, patients, medicine, health, health profession, and English language. The results from the other 2 databases (Linguistics Abstracts Online and Linguistics and Language Behaviour abstracts) were manageable, being

specific to linguistics. The results of the second search were then sifted by reading titles and abstracts. Again, if in doubt the article was retrieved and read in full.

Table 3: Second Search Results		
Databases	Relevant titles/abstracts (based on titles and abstracts)	Relevant papers (based on titles, abstracts and full papers)
LAO	23	10
LLBA	49	19
SD	77	15
SCO	65	20
WOS	52	5
TOTAL	266	69

After narrowing down the search by reading titles, abstracts and full papers the total number of relevant studies was 69. Following the systematic retrieval process, the next stage was to formally appraise the selected papers.

2.2.2 APPRAISING THE LITERATURE

There is no guidance on how to appraise CA studies. However, there are some universal features shared by all qualitative research (Dixon-Woods et al 2004) which can be applied to develop prompts or checklists that aid the appraisal process. The Critical Appraisal Skills Programme tool (CASP 2013) was used in order to appraise the 69 identified studies. The checklist includes screening questions to help decide whether to continue to appraise the content of papers. These questions (*Was there a clear statement of aims of the research? Is a qualitative method appropriate?*) reduced the number of papers in the review from 69 to 28. A further 3 papers were removed due to their general discursive nature and lack of precise research findings. Paper SCO10 (Perakyla 1997) had a clear statement of aims and was using CA methodology. However, the findings

were about exploring the possibilities that CA could offer regarding doctor-patient communication, and there were only examples of how CA could potentially work in practice. Paper SCO6 (Lutfey 2004) also had a clear statement of aims, and despite the methodology used having general CA traits, the findings extracted were tailored towards a psychosocial study. Findings were focused on describing health behaviours more generally without specifically linking these behaviours to the conversation analytic evidence. Finally, paper LLBA11 (Gulich 2003) provided a clear statement of aims, but the methodology was not strictly CA. It was an observation of a mixture of different discursive practices, such as use of metaphors, exemplification, and reformulation amongst others, and the analysis was not conversation analysis but discourse analysis.

A further 3 papers (LLBA5: Ijäs-Kallio et al. 2010, SD6: Robinson and Heritage 2005. SCO9: Gill et al 2010) were removed for the purpose of this particular literature review as they were not relevant to the study since they addressed patient problem presentation. The routine diabetic consultations analysed are 6 monthly check-ups to monitor the illness therefore, the problem presentation phase of the visit is not present explicitly during these consultations.

The remaining 22 papers - details of which are given in Table 4 - were then interrogated against the following 8 questions from the remainder of the CASP checklist:

1. Is the research design appropriate?
2. Is the recruitment strategy appropriate?
3. Does the data collected address the research issue?
4. Is the researcher-participant relationship considered?
5. Are ethical issues considered?
6. Is the analysis rigorous?
7. What is the finding statement?
8. Is the research valuable?

Table 4: Papers selected during appraisal for data extraction			
Code	Publication	Author/Year/Vol/ pages	Journal
LAO2	Patient "Demand" for Medical Interventions: Exerting Pressure for an Offer in a Primary Care Clinic Visit	Teas Gill, V. 2005. 38 (4), 451-479	RES LANG SOC INTERAC
LAO3	Asymmetry in action: Sequential resources in the negotiation of a prescription request	Robinson, J. 2001. 21(1/2) 19-54	TEXT
LAO4	Breaking the sequential mold: Answering "more than the question" during comprehensive history taking	Heritage, J. Stivers, T. 2001. 21 (1/2) 151-185	TEXT
LAO5	Expert talk in medical contexts: Explicit and implicit orientation to risks	Adelswärd, V. et al. 2002. 35 (2) 195-218	RES LANG SOC INTERAC
LLBA2	Doctors' questions as displays of understanding	Depperman, A. Spranz-Fogazy T. 2011. 8 (2) 111-122	COMMUN MED
LLBA12	Agency and Authority: Extended Responses to Diagnostic Statements in Primary Care Encounters	Perakyla, A 2002. 35 (2) 219-247	RES LANG SOC INTERAC
LLBA19	Seizure, Fit or Attack? The Use of Diagnostic labels by Patients with Epileptic or non-epileptic Seizures	Reuber, M. et al 2009. 31 (1) 94-114	APPL LINGUIST
SD1	Nurses talking to patients: exploring conversation analysis as a means of researching nurse–patient communication	Jones, A. 2003. 40, 609-618	INT J NURS STUD
SD3	Closing medical encounters: two physician practices and their implications for the expression of patients' unstated concerns	Robinson, J. 2001. 53, 639-656	SOC SCI MED
SD4	'Unilateral' and 'bilateral' practitioner approaches in decision-making about treatment	Collins, S. et al 2005. 1, 2611-2627	SOC SCI MED
SD5	"Does it mean I'm gonna die?": On meaning assessment in the delivery of diagnostic news	Maynard, D. 2006. 62, 1902-1916	SOC SCI MED
SD7	Asymmetrical knowledge claims in general practice consultations with frequently attending patients: Limitations and opportunities for patient participation	Ariss, S. 2009. 69, 908-919	SOC SCI MED
SD8	Physicians' opening questions and patients' satisfaction	Heritage, J., Robinson, J. 2006. 60, 279-285	PATIENT EDUC COUNS

SD9	Patient resistance as agency in treatment decisions	Koenig, C. 2011. 72, 1105-1114	SOC SCI MED
SD19	Are there interactional reasons why doctors may find it hard to tell patients that their physical symptoms may have emotional causes? A conversation analytic study in neurology outpatients	Monzoni, C. et al 2011. 85, e189-e200	PATIENT EDUC COUNS
SCO1	Patient-initiated questions: How can doctors encourage them and improve the consultation process? A qualitative study	Murtagh, G.M. et al 2013. 3:e 003112	BRIT MED J Open
SCO15	Explanations in consultations: the combined effectiveness of doctors' and nurses' communication with patients	Collins, S. 2005. 39, 785-796	MED EDUC
SCO18	Using interactional and linguistic analysis to distinguish between epileptic and psychogenic nonepileptic seizures: A prospective, blinded multirater study	Reuber, M. et al 2009. 16, 139-144	EPILEPSY BEHAV
SCO19	Online commentary in acute medical visits: of method of shaping patient expectations	Heritage, J. & Stivers, T. 1999. 49, 1501-1517	SOC SCI MED
SCO20	Patient resistance towards diagnosis in primary care: implications for concordance	Ijas-Kallio, T. et al 2010. 14 (5) 505-522	HEALTH
WOS5	Initiating decision-making in neurology consultations: 'recommending' versus 'option-listing' and the implications for medical authority	Toerien, M. et al 2013. 35 (6) 873-890	SOCIOL HEALTH ILL
WOS6	The interaction order and clinical practice: some observations on dysfunctions and action steps	Heritage, J. 2011. 84, 338-343	PATIENT EDUC COUNS

2.2.3 DATA EXTRACTION

Systematically extracting data from qualitative research is a complex process that involves the researcher's perception, selection, abstraction and description within the analysis (Nowak 2011). The template used to extract the data from the selected studies was based on the categories set out in Parry & Land (2013), since their categories are tailored for reviewing conversation analytic research.

However, for the purpose of this systematic review two of the categories: *Phenomenon in brief* and *Phenomenon in author's own words* were amended and amalgamated into one category as they were producing significant overlap of information which seemed inefficient for this particular review. These categories were combined into *Phenomenon* in the list below. Therefore, the categories were (adapted from Parry & Land 2013):

1. Research question
2. Phenomenon
3. Number of episodes pertaining to this finding
4. Features of the talk in which the phenomenon is produced – i.e. aspects of the sequential/interactional context in which it arises
5. Sequence and/or turn design features of the phenomenon
6. What is the overarching function of the phenomenon
7. Author proposed implications
8. Any other implications

2.2.4 Results: Collating and Synthesising the Data

In this section I will present the results from the data extraction, followed by a discussion of these results in terms of their significance and relevance to this research.

According to the systematic review process the next step after extracting the data was to collate and synthesise it by organising it into logical categories. These categories were not pre-determined but emerged from the extracted data through a process of thematic analysis. The aim was to reflect the contents of those studies identified during the appraisal stage that were relevant for the study in hand.

Table 5 shows the categories established.

Table 5: Categories used in the collating and synthesising of data, and papers in each category	
Category	**Paper**
1. communicative resources available to clinicians, and their consequences for the interaction	LA05, LLBA2, SD1, SD3, SD8, SCO15, WOS6
2. communicative resources available to patients, and their consequences for the interaction	LA02, LA04
3. clinician-patient asymmetries	LA03, SD7
4. diagnosis and diagnostic delivery	LLBA12[1], SD5[1], SCO18, SCO19[1], SCO20[2], LLBA19, SCO1[1]
5. treatment decisions	SD4[1], SD9[1,2], SD19[1,2], WOS5[1]

There is potential for overlap between categories. Cross-categorisation is reflected by a superscript after the code: the position of the code reflects the primary categorisation of the article; the superscript captures other logical categorisations of the paper e.g. LLBA12[1] takes the primary category 4 (diagnosis and diagnostic delivery) but also speaks loudly to category 1 (communicative resources available to clinicians, and their consequences for the interaction). All papers were assigned a primary category.

In the next sections I present a synthesis of the papers following the primary and secondary categorisation set out in Table 5. The approach to synthesising the data is 'aggregative' (Parry and Land 2013), summarising and drawing together the findings of each study and relating these to one another. An aggregative approach works well for the purpose of this chapter, as the aim is to provide a robust and relevant background to the study with a detailed overview on how CA has been used to inform doctor-patient communication.

2.2.4.1 Category 1: communicative resources available to clinicians, and their consequences for the interaction

The use of different question types by clinicians within medical consultations has an effect on patients' responses. Study SD1 (Jones 2003) proposes that this notion is considered and used practically when nurses are completing an assessment interview with patients. The questions are designed to produce certain responses, which help the nurses complete the task in hand. For example, close-ended questions (questions that require yes/no responses only) are used in order to facilitate the completion of particular paperwork, as they purposely do not enable patient narrative. This particular resource is also used by the nurse during diabetic check-up consultations when the nurse is running through her list of tests. However, study LLBA2 (Depperaman 2011) notes that Yes/No questions are not as restrictive as previously thought and in some contexts they can be used to prompt patients in giving more information. Findings in study SD8 (Heritage and Robinson 2006) suggest that patients prefer open-ended questions and they have a positive effect and increase patient satisfaction. Question design is an important factor within doctor-patient interaction and it can be used strategically to obtain specific information from patients and/or improve the communication.

Paper WOS6 (Heritage 2011) advises that polar questions (Yes/No questions) communicate beliefs and expect certain responses. In situations where the physicians do not foresee problems, questions that portray positive social medical outcomes should be 'yes-preferring' (e.g. *are your bowel movements normal?)*. These types of questions expect a 'yes' answer, whereas questions such as *any ulcers?* expect a 'no' response. The physician's choice on inviting a 'yes' or a 'no' preferring design is referred to as the principle of optimization. In medical questioning this principle does not work on its own: it is counterbalanced by the principle of recipient design. Physicians should consider the patient's known circumstances and ask questions that fit appropriately with that particular circumstance. For example, it would be inappropriate to ask questions in an optimised way in circumstances where there is a need for the

patient to explain their symptoms. During medical questioning, the physician's expectations are reflected through the principle of optimization and the principle of recipient design. These principles also dictate the nurse's use of polar questions during diabetic routine consultations, and it is particularly noticeable when addressing routine tests during the visit. For instance, when the nurse did not foresee any problems with a patient's feet the questions would take an optimized design such as: have your feet been ok*?* Or any problems with your feet at all? In contrast, when the nurse was expecting potential problems questions were not optimized, as the nurse was considering the recipient's circumstances, hence producing non-polar questions.

Paper SCO15 (Collins 2005) focuses on the difference between doctors' and nurses' communication when providing explanations to diabetes patients. Findings suggest that explanations regarding tests and test results are attached to other activities and have different sources. The source of doctor's explanations start from a medical assessment perspective (explaining the test and its use) as opposed to the nurse's source which starts with the patient's behaviour or responsibility (asking how the patient has been getting on with their illness). This is reflected in the data from the diabetic routine consultations where the nurse asks the patients how they are managing their illness, focusing on their behaviour. In contrast, when the nurse addresses the results of the patients' Hb1aC test, an explanation about the test and its use followed. According to Collins' paper, patients noted that doctors' communication has a sense of direction and finality. The nurses' communication is seen as more 'open' allowing for more elaboration from the patient. The paper proposes that in cases where the final decision is not the nurses' and where the consultation has more of a supportive function, the communication was characterised as more open and patients had more room to engage. The management of explanations in both consultations (doctors and nurses) fulfil different roles and have value when combined.

Paper LAO5 (Adelswärd et al 2002) discusses different types of risk talk and suggests a possible model of the relations between contextual factors and aspects of risk talk within the healthcare system. Findings indicate three types of

risk talk depending on the context: explicit, over implicit (indirect) and avoidance. The study provides a hypothesis and states different contexts when explicitness is likely to be used. Findings from the research in hand i.e. from diabetic routine consultations with the nurse, support the claim of linking the context to the level of explicitness of risk talk. For example, explicit risk talk is produced when the patient can influence future risk and the patient is known to be at risk. However, there are some differences between both sets of findings in terms of explicitness of risk talk when it is being presented as new information rather than to patients that are already undergoing treatment.

Paper SD3 (Robinson 2001) suggests that patients often have more than one concern during their consultation. Once the main concern is addressed, due to turn taking rules within the doctor-patient interaction, it is difficult for patients to raise additional concerns. The findings advise that doctors using a 'final concern sequence' (i.e. is there something else?) give the patient the opportunity to topicalise any additional concerns they might have, as opposed to the 'arrangement sequence' (i.e. doctor securing patients' acceptances to the first concern). Therefore, a way for physicians to ensure that patients have raised all their concerns is by using a final concern sequence. This is also present in the diabetic check-ups, however it is used as a communicative resource to shut down the conversation and close the visit, hence occurring during the closing phase of the consultation.

As a secondary category, paper SD5 (Maynard 2006) suggests that physicians should deliver diagnoses together with an explanation for the illness. This resource avoids the disruption of the doctor-patient relationship. Papers SCO1 (Murtagh et al 2013) and LLB12 (Perakyla 2002) propose that explicating diagnoses with evidence i.e. x-ray or scan, result in a better response from the patient making it a useful resource for physicians when delivering diagnoses. Although patients have already been diagnosed with T2DM while attending their consultation in this study, there is a case where the diagnosis is very recent. In this particular case the nurse relies on the HbA1c test result in order to reinforce the diagnosis and suggest potential treatment. When patients present a 'no problem' diagnosis, paper SCO19 (Heritage and Stivers 1999) notes that a useful

physician resource is the use of online commentary while examining the patient. By commenting what they are hearing, seeing or feeling during the examination, physicians can build a case for a 'no problem' diagnosis and pre-empt any patient resistance. As stated by papers SD9 (Koenig 2011) and SD19 (Monzoni et al 2011) patient resistance is a resource that can allow physicians to uncover the reasons why a patient is refusing a particular recommendation and gives physicians the opportunity to involve patients in the decision-making process regarding treatment. Resistance is a resource used by diabetic patients during their chronic routine consultations in order to express disagreement.

In terms of treatment decisions, if patient input is required, a bilateral approach is more conducive than a unilateral approach. Paper SD4 (Collins et al 2005) suggests that a bilateral approach presents options slowly and separately, giving the patient more opportunity to input. Conversely a unilateral approach lists options quickly or recommends one, making patient input more difficult. This is supported by paper WOS5 (Toerien et al 2013), which states that option listing provides more opportunity for patient participation than a recommendation. Both option listing and recommendations are present during the diabetic check-ups data regarding on-going treatment decisions.

2.2.4.2 Category 2: communicative resources available to patients, and their consequences for the interaction

Despite doctor-patient communication being fairly rigid in terms of the overall structure of the interaction during a consultation, patients can still shape and influence the trajectory of the consultation namely by their use of non-explicit requests. According to findings in study LAO2 (Teas Gill 2005) patients can apply a certain amount of pressure on doctors to offer diagnostic tests. This pressure is applied subtly by using indirect questions that act as pre-requests. Notwithstanding the patients' subtleties when doing this, doctors can perceive these questions as demands and this becomes a 'tug of war' that can have repercussions for the patient's participation and also for the doctor's responsiveness. It is important for physicians to identify and interpret these

questions as requests and deal with them accordingly to avoid any misunderstandings that could potentially affect the doctor-patient interaction.

Patients can also influence the trajectory of the consultation by introducing their own agenda during the history-taking phase of the consultation. Physicians will often ask patients about their medical history and lifestyle in the form of closed-ended questions (yes/no questions) almost like going through a checklist. However, there are occasions when patients move from the checklist type responses and expand their reply further to introduce their own agenda or concerns. Paper LAO4 (Heritage and Stivers 2001) describes this resource as narrative expansions. Narrative expansions can allow physicians to learn more about the patient's concerns, and ultimately assist with their care. In the routine diabetic consultations narrative expansions tend to occur near or during the closing of the consultation, since history-taking is not appropriate during these visits as they are check-ups and the patient's history has already been noted. Notwithstanding, these narrative expansions, even during the closing phase of the consultation, can still provide valuable information for the nurse in terms of learning about the patients' concerns and assisting in their care.

As a second category, paper SCO20 (Peräkylä et al 2010) suggests that a resource patients use to resist a diagnosis is to offer alternate information about their symptoms, refer to their own experiences regarding the candidate illness or refer to other information given by a different physician. This will enable doctor-patient discussion and further negotiation. This negotiation facilitated by patient resistance can also be seen during treatment recommendation as stated in papers SD9 (Koenig 2011) and SD19 (Monzoni et al 2011).

Patient resistance also presents itself within the diabetic check-ups, particularly as a resource for patient disagreement on diagnosis, treatment change, and diet changes. Patients will produce alternate information that is discrepant to the physicians' diagnosis or to the need for treatment or lifestyle change.

2.2.4.3 Category 3: clinician-patient asymmetries

The intrinsic asymmetric relationship between clinicians and patients is a well-established concept. The fact that clinicians have the knowledge and the patient is there to be assessed by the doctor inevitably makes the interaction asymmetric. LAO3 (Robinson 2001b) shows that doctors, rather than patients, usually initiate actions and solicit responses. This is also true for nurse-patient interaction. During the diabetic check-up consultations the nurse is the one initiating actions and asking the questions.

Paper SD7 (Ariss 2009) advises that the difference in epistemic authority between the physician and the patient actually assists the interaction. Patients will claim and demonstrate inferior knowledge about diagnosis or treatment, allowing the doctor to proceed with the consultation. Furthermore, if a patient were to explicitly disagree with the doctor, findings suggest that speakers 'retreat' to their boundaries of epistemic authority allowing for the disagreement to be resolved rapidly. Therefore, asymmetry facilitates the progression of the conversation and ultimately the progression of the consultation.

2.2.4.4 Category 4: diagnosis and diagnostic delivery

According to papers LLBA12 (Perakyla 2002) and SCO1 (Murtagh et al 2013), patients respond better and ask more direct questions when diagnoses are delivered and explained with evidence (x-ray, test results, etc.) Paper SD5 (Maynard 2006) suggests that physicians should define the disease when delivering a diagnosis and not withhold auspicious meaning assessment, as this undermines the relationship and disrupts the encounter. However, if patients do not fully agree with the physician's diagnosis there are ways in which they resist it. Paper SCO20 (Ijas-Kallio et al 2010b) notes that patients resist by either offering different or additional information about their symptoms, referring to past experiences and similar symptoms, and by providing information given in other consultations with a similar illness. These resources not only allow

patients to contest the physician's diagnosis, but also help facilitate the doctor-patient negotiation in terms of reaching a shared understanding about the diagnosis and potential treatment, referred to in this paper as concordance. These resources used by patients in order to resist diagnosis are also present during chronic diabetic routine visits and are transferred to other phases of the consultation. For example, patients resist a diagnosis, a change in medication or a lifestyle change by offering additional information that is discrepant to the nurse's suggestions.

A 'no problem diagnosis' by physicians can also involve patient resistance, as it implies no medical intervention and therefore it can leave patients unsure whether their visit was justified. Paper SCO19 (Heritage and Stivers 1999) notes that using online commentary during the medical examination i.e. physicians describing what they are seeing, hearing, and feeling during a physical medical examination of a patient, is a way for them to build a case for a 'no problem diagnosis' or a 'no prescription diagnosis' and pre-empt any resistance. Online commentary can be a useful resource with which physicians can resist pressure for antibiotic prescription as well as reassuring patients of the rightness of their visit.

In some situations CA evidence can assist with uncertain diagnoses. Papers LLBA19 (Reuber et al 2009a) and SCO18 (Reuber et al 2009b) suggest that there is a noticeable difference on how epileptic and non-epileptic patients use certain labels and describe their seizures. Findings from paper LLBA19 (Reuber et al 2009a) state that linguists using CA with no prior information about the patients predicted a correct diagnosis in 17 of 20 patients, making this is the first attempt to provide a linguistic tool that has differential diagnosis value.

2.2.4.5 Category 5: treatment decisions

Paper SD4 (Collins et al 2005) suggests that there is a distinction between bilateral and unilateral approaches when negotiating treatment during a

consultation. Unilateral approaches present the decision as news, necessity or information, running through options like a list without giving the opportunity of patient input. Whereas bilateral approaches present the decision as a decision yet to be finalised or a choice, presenting options slowly, separating them, allowing for the patient to input in each one. Paper WOS5 (Toerien et al 2013) describes the difference between physician recommendations versus physician option-listing. Recommendations set up a steeper epistemic gradient between the physician and the patient, making it more difficult for the patient to resist them. Option-listing provides more opportunity for the patient to engage in the decision-making process. However, paper WOS5 also suggests that the machinery of option-listing can be biased towards a particular decision, making it a recommendation disguised as option-listing.

Findings from this study's diabetic check-up data demonstrate both approaches regarding treatment decisions. When on-going treatments were reviewed but not altered a unilateral approach was taken whereby recommendations were offered by the nurse with little room for patient participation. However, when on-going treatments were changed then a more bilateral approach was taken and option-listing was adopted.

Paper SD9 (Koenig 2011) proposes that when negotiating treatment decisions, resistance is a resource used by patients to assert their agency, express their disagreement, and negotiate a recommendation acceptable to them. Likewise, paper SD19 (Monzoni et al 2011) claims that in cases where physical symptoms have emotional causes and psychological treatment is offered, patients' overt resistance allows physicians to deal with the exact reasons why patients reject the recommendation.

2.2.5 DISCUSSION

A general trend which can be observed in the papers reviewed concerns the importance of patient participation. This does not mean that the research is particularly trying to encourage patient-centred approaches in healthcare, but

provides empirical evidence of what actually goes on regarding doctor-patient interaction in the consultation (Reuber et al 2015). Principles of optimization and recipient design are considered by doctors and polar questions are designed according to these principles. These same principles also operate during diabetes check-up consultations, and are considered by the nurse when designing questions.

Bilateral approaches used by physicians during the diagnostic and treatment phases allow for more patient participation (Ijäs-Kallio et al 2010a, Collins et al 2005). This can mean that patients are more responsive to treatment decisions. During diabetic check-ups bilateral approaches were taken when on-going treatments were reviewed and altered.

Patient satisfaction increases when physicians open the visits with open-ended questions as opposed to close-ended questions (Heritage and Robinson 2006). It is reasonable to assume that it is advantageous to design talk specifically giving patients the chance to offer their input. Narrative expansions allow them to depart from the current topic and set their own agenda (Heritage and Stivers 2001). These are present in diabetic check-ups, however, they tend to occur during the closing phase of the consultations.

Patients can use discursive resources to set their own agenda and show disagreement. Patient disagreement is often expressed as resistance: patients can resist by non-acceptance, which opens an opportunity for negotiation (Koenig 2011, Gill et al 2010, Ijas-Kallio et al 2010b). Findings suggest that if there is explicit disagreement this is soon resolved due to the asymmetry between the doctor and the patients' type of legitimate knowledge claims (Ariss 2009). Diabetic patients in this study also disagree by expressing resistance. This can take the form of silence or non-acceptance by offering additional information that contradicts the nurse's suggestions.

The level of explicitness of risk talk is determined by contextual factors. The hypothesis states that risk is explicit if the information is presented as new,

patients are known to be at risk, can influence future risks, and risk is an agenda point (Adelswärd, V et al. 2002). Explicit risk talk within diabetic routine consultations presents itself slightly differently. Patients are known to be at risk and can influence its trajectory, however, in these particular consultations patients are already under treatment and risk is not a topic. Risk is presented in this study by the use of an if-conditional structure.

The first 3 aggregated categories mentioned above: 1) communicative resources available to clinicians, 2) communicative resources available to patients, and 3) clinician-patient asymmetries), will be revisited in the main discussion (chapter 8) in terms of their relevance to the findings produced in this study. However, most of the findings within this systematic review are relevant to the research in hand. The key conversational principles operating are the same despite the fact that the data analysed originated from check-up consultations performed by a nurse not a doctor. In routine diabetic consultations bilateral and unilateral approaches are used when dealing with treatment decisions, particularly on-going ones due to the check-up nature of the visits. Unilateral approaches are taken when on-going treatments are reviewed and not altered. In contrast, bilateral approaches are taken when on-going treatments are changed. Diabetic patients also produce narrative expansions to set their own agenda. However, these are done during the closing phase within these particular consultations, since the history-taking phase is not present during routine consultations, as the nurse already has this information. Diabetic patients also disagree by resisting and by offering additional information. Likewise, disagreement is soon resolved as both the patient and the nurse "retreat" to their own domain of epistemic knowledge. Final concern sequence can also be seen within the chronic diabetic consultations. Whilst it can serve as a way for assuring that all patients' concerns are mentioned, findings in this study suggest that its main purpose is to initiate the closing of the consultation.

2.2.6 CONCLUSION

CA data from studies on medical consultations relevant to the research in hand have been systematically identified, appraised and extracted. The findings have been synthesised using an appraisal checklist (CASP 2013) and a CA data extraction guide (Parry and Land 2013). There is no doubt that subjecting qualitative research to a systematic review is a challenging task (Dixon-Woods 2006), though it is a particularly useful exercise as it provides a significant background on the use of CA within medical interactions. However, this review is not without its limitations. First, the review only captures research published in journals within a particular time frame. The review was carried out in February 2015, therefore, any relevant journal publications after this date will not be captured. For instance: Health Care Professionals' Assertions and Women's Responses During Labour: A Conversation Analytic Study of Data from *One born every minute*, Jackson et al, 2017, and Inviting end-of-life talk in initial CALM therapy sessions: A conversation analytic study, Shaw et al 2017.

Second, a different set of search terms might have yielded a different set of results. These limitations are common to all reviews of this type. Third, for consistency, electronic databases were used in the searches. While the databases were carefully selected other databases could have been used, as well as book chapters, such as: Question design in conversation (Hayano 2013) and Conversation analysis in medicine (Teas Gill and Roberts 2013) which might have yielded different results. Due to this, it is necessary to mention the volume "Communication in Medical Care: Interaction between primary care physicians and patients" that presents a rigorous analysis of doctor-patient interaction. In addition some papers could have been missed out from the systematic review if they were published by journals that do not use a keyword search approach, such as "Health Communication" and "Social Psychology Quarterly". Therefore I would like to mention 2 additional papers relevant to this study.

It was important to engage in a systematic approach that provides a methodical and relevant background to the research in terms of CA and its use in medical interactions as opposed to an arbitrary literature review. Aggregating the CA

findings presents an informative and advantageous body of knowledge for conducting CA research in the context of medical interactions.

2.3 OTHER LITERATURE CONSIDERATIONS

The volume "Communication in Medical Care: Interaction between primary care physicians and patients" (Heritage and Maynard 2006) provides a comprehensive discussion on doctor-patient communication using conversation analysis techniques in primary care settings. After a thorough introduction to the methodology and its application on medical encounters the collection of papers discusses findings from the different phases of a primary care consultation. In order to present a coherent review of the literature I will synthesise the findings of 2 chapters, which are the most relevant ones to this study. These chapters are:
1) Treatment decisions: negotiations between doctors and patients in acute care encounters (Stivers 2006)
2) Coordinating closings in primary care visits: producing continuity of care. (West 2006)

2.3.1 TREATMENT DECISIONS

Stivers (2006) states that treatment has to be accepted in order to move on to the next phase of the consultation. Equally, in routine diabetic consultations on-going treatment change needs to be accepted by the patient in order to move on with the visit. Physicians will pursue this acceptance to the point of proposing concessions and even offering inadequate prescriptions. Physicians will offer treatment recommendations in two ways, either 'for' or 'against' the treatment. This has consequences regarding the patients' acceptance or resistance to the recommendation. Physicians will encounter a higher degree of patient resistance to the treatment offered when the recommendation is formatted 'against' e.g. 'there is no treatment necessary', 'it's bacterial, so no point in taking antibiotics'. Therefore, it is important for physicians to minimise patient resistance by

offering specific action in terms of next steps even if it does not involve taking medication.

During diabetic consultations, even if the treatment recommendation is offered 'for' the treatment, patients can still produce resistance. For instance, a change in a patient's medication dosage can cause some resistance. Particularly as the patient is already under going the treatment and has knowledge of his/her illness and medication.

2.3.2 CLOSINGS IN PRIMARY CARE VISITS

The closing phase of the consultation is when the doctor and the patient bring the visit to an end. Unlike casual conversations, primary care visits do not end just because both parties have "nothing more" to say. One of the ways to initiate the closing phase of the consultation is by introducing a preclosing sequence which will then enable the terminal exchange (i.e. the goodbyes). The party who initiates the preclosing sequence is the doctor regardless of the doctor's speciality. Likewise, within the nurse-patient interaction of diabetic routine check-up consultations, it is the nurse that initiates the closing of the visit. The majority of the visits initiate the closing phase by the introduction of a preclosing sequence of 'making future arrangements'. Many of which have already been proposed earlier during the visit. Nevertheless, initiations of preclosings do not always guarantee that the closure will soon follow. In some cases patients responded to the doctor's preclosing with hesitation or delays indicating reluctance to agree and when probed patients revealed further concerns. In other cases patients agreed with the doctor's preclosing, however, the doctor then starts adding more information. Notwithstanding, in this paper making future arrangements is the most frequent preclosing sequence doctors use in order to initiate the closing of the consultation.

Findings from the routine diabetic consultations' data suggest that making future arrangements, using a final concern sequence ("anything else?") and

summarising the visit are resources used by the nurse to initiate the closing of the consultation. Nevertheless, likewise findings presented by West (2006) these resources do not guarantee closure as patients or physicians can use these to initiate a new topic.

2.3.3 PHYSICIANS' OPENING QUESTIONS

While producing a systematic review of the literature provides a structured approach to relevant research, as mentioned above, it can undoubtedly omit research papers from journals that do not use keywords in their search. Due to this, I would like to mention 2 papers published in Health Communication. These are: Heritage and Robinson (2006) The structure of patients' presenting concerns: physicians' opening questions and Heritage and Robinson (2015) How patients understand physicians' solicitations of additional concerns: implications for up-front agenda setting in primary care.

Both papers deal with what is referred to as the problem presentation phase i.e. where the physician initiates the solicitation for the patients' medical problem. As noted by Robinson and Heritage (2006a) this is the only phase where the patient can explain and fully describe their illness. Physicians' question designs will have an effect on how patients' report their concern. Findings suggest that the most frequent question formats used are general inquiries ("what can I do for you today") and requests for confirmation ("I understand you are having sinus problems today"). Patients provided longer and more detailed problem presentations when asked via a general inquiry as opposed to a confirmatory question. However, Robinson and Heritage (2015) note that most patients have more than one medical concern when attending a consultation. Opening questions used to solicit patients' problems favor the presentation of one major concern potentially leaving the patient with unmet concerns. One way of addressing this issue is by using "up-front agenda setting" where the physician continues to ask the patient about additional concerns after attending to the chief concern. This communication skill is specifically used for soliciting totally new concerns. So how do practitioners deal with opening questions and

soliciting patients' concerns in chronic routine consultations? Findings from the analysis of diabetic consultations suggest that these chronic routine visits lack a specific delineated problem presentation phase, as both the practitioner and the patient know the reason for the visit and the major health concern. The data in this study suggests that the nurse's opening questions could also function as problem solicitation, making these questions borderline between the two phases (opening phase and problem presentation phase) of the visit.

2.3.4 DISCUSSION

The general trend within these 4 papers is the ability to analyse doctor-patient communication practices within talk-in-interaction and extract empirical linguistic patterns. These patterns can then be used to make recommendations about specific practices. For example, proposing treatment in one way as opposed to another in order to minimise patient resistance.

The aim of the foregoing discussion mentioned in the literature review is to provide a coherent overview on previous conversation analytic research within medical settings, focusing particularly on elements relevant to the study in hand. Therefore, papers on physician and patient communicative resources, treatment decisions, asymmetries, diagnosis and closings have a bearing on this work.

Conversation analytic findings have an implication for medical practice as they inform meaningful communication practices and can assist in medical training which in turn can potentially enhance doctor-patient communication.

2.4 CONCLUSION

A systematic review of the literature regarding conversation analysis and its application within communication in healthcare consultations relevant to this study has been presented. An additional 4 papers were considered focusing specifically on doctor-patient interaction during treatment decisions, closings

and patients presenting concerns has also been presented.

Methodologically speaking, the findings from this review demonstrate that conversation analysis is a robust and appropriate methodology to use when studying interaction within medical visits. It provides applicable findings on how physicians and patients communicate during consultations, which benefit future research as well as having an implication on practice and training.

The aggregated findings provide a useful background to the study and a valuable starting point in terms of the current knowledge base on the use of CA in medical interactions. This background sets up the context and provides an overview on how CA will be used for this particular study, focusing specifically on the difference between chronic and acute primary care visits, risk talk, patient resistance and closing within routine consultations.

The next chapter will present the methods for the study and more detail on CA as the chosen methodology.

3 Methods and Methodological Discussion

3.1 METHODOLOGY IN SOCIAL RESEARCH

There are a number of methodological approaches available for social scientists when studying communication. When it comes to focusing on social interaction the role of discourse is particularly crucial. As noted by Wooffitt (2011) methodologies that approach the study of talk have extensive implications on the understanding of social interaction. Through the study of discourse researchers can identify certain social actions which are reflected in language. The organisation of discourse, may it be talk or text, is 'doing' something. For example, a particular political text can be persuading individuals to think in a certain way about a specific issue. Or during a casual conversation a speaker can be requesting an action from another speaker. Language makes visible social action. Choosing a specific method to study social action through discourse is dependent on the analyst's interests.

This particular study is a qualitative design and the main methodology used is CA. The aim of the study is to analyse the talk in chronic diabetic routine check-up consultations and find differences between these and acute primary care consultations, as well as linguistic patterns within routine visits that could have an impact on best practice. I will begin by justifying the choice of methodology (CA), followed by a description of the study's qualitative design.

3.1.1 WHY CONVERSATION ANALYSIS?

Conversation Analysis is a methodology that focuses on social interaction by analysing specifically talk-in-interaction. It is a rigorous, empirical method that looks at naturally occurring talk. As mentioned earlier, interaction is not a disorderly and random process, as it was once thought to be (Goodwin and Heritage 1990). All speakers follow certain rules that ensure the success of a conversation. CA can be applied to any context where talk occurs making it an interdisciplinary method. However, as noted by Antaki (2008) it differs from the other discursive methodologies in that CA's attempt is to stay as close as possible to the actual talk without offering an interpretation or speculation regarding the speakers' motives for the talk. It focuses on what was said during a particular interaction and how, as opposed to why it what said. CA analyses the minute details within the talk, how participants organise turn taking, collaborate and resolve problems (Ten Have 2006). Via detailed transcriptions of either video or audio recordings, CA explores how speakers systematically organise their talk-in-interaction. CA attempts to uncover systematic patterns of talk, which in turn provide applicable findings that can be used to inform best practice.

Medical interaction is one of the areas where CA has become an established methodology. For example Heritage et al (2007) addresses the issue of patient's unmet concerns in primary care consultations. They argue that patients often arrive at their medical consultation with more than one concern, however the consultation's structure lends itself for the presentation of one major health concern only. Therefore, a linguistic intervention was conducted whereby a number of physicians were told to use the word "any" in the utterance: "is there anything else you want to address in the visit?" and the other half were told to use the word "some" in the same utterance: "is there something else you want to address in the visit? The conversation analysis concluded that when physicians used the word "some" instead of "any" patients gave more affirmative responses 90.3% vs 53.1%. In other words 90.3% of the time patients mentioned their unmet concern when asked "is there something else you want to address in the visit?" as opposed to only 53.1% when asked with the word "any". They also

noted that the unmet concerns mentioned were often considerably serious and mentioning these did not increase the length of the consultation compared to the visits where "any" was used. This study was both qualitative and quantitative, however, most of conversation analytical studies are qualitative due to the level of detail the data is subjected to. Due to CA's robustness and accuracy, important findings can be replicable enhancing the validity of CA research practices. This is evidenced in the consistency of findings within medical interaction. For example, Koenig (2011), Stivers (2006, 2007) and Perakyla (2002, 2006) have consistent findings regarding patients' resistance to recommendations in medical consultations. Patients resist diagnosis or treatment by offering minimal acknowledgments or by offering additional information discrepant to that of the practitioners'.

Conversation analysis is a robust and empirical methodology that is "data-driven" (Ten Have 2006). Hypotheses arise from the data itself instead of them being drawn from theoretical preconceptions making it an inductive reiterative process. It discounts ideological or political perspectives as well as the ethnographic background of speakers. Due to this and the fact that it studies talk-in-interaction from no preconceived theories, CA is the most appropriate methodology for the study of talk in chronic diabetic routine consultations. The research interest does not lie on talk as a reflection of speakers' demographics, motivations, or how they voice social inequality. This study aims to uncover the structure of chronic diabetic consultations and the linguistic patterns within these by analysing the sequencing of talk in a particular patient – nurse interaction. Therefore, conversation analysis would be most effective methodology for the study.

A qualitative design is required for this study as it is the only way to conversationally analyse the data from the consultations (naturally occurring talk) in sufficient detail. In terms of data analysis the level of depth needed to produce the relevant findings could only be achieved qualitatively.

3.2 DATA

The data include 10 audio and video recordings of actual chronic primary care visits between type 2 diabetic patients and a GP practice nurse. Due to the qualitative approach taken and the level of detail required by the methodology, 10 consultations of 20-25 minutes each would suffice. CA focuses on the minutiae of conversational detail. Therefore, every turn, word and pause is analysed. Hence, 10 consultations would provide enough data to undertake a detailed, in-depth and high quality analysis.

The 10 visits were collected from a GP practice in the Sheffield area. All data collection was approved by the Yorkshire and The Humber –Bradford and Leeds- Research Ethics Committee established by the UK Health Research Authority. The video recorded consultations were not initial visits but 6 monthly check-up consultations. The researcher was not present in the consultation room during the recording in order to avoid any disruption to what patients were already used to during their visit.

In addition to the main video recordings, patients were given a short pre-consultation questionnaire as well as a short post-consultation interview. The practice nurse was given a short post-consultation questionnaire only.
The aim of the patients' pre-visit questionnaire was to assess what patients expect from the consultation before attending.

The aim of the post-visit interview was to elicit information on the patients' experience, opinions and other comments about the consultation.
Likewise for the nurse, the aim of the post-visit questionnaire was to elicit data on how she thinks the consultation went. The post-visit data was subjected to a basic thematic analysis where the main themes for the patient interviews were: diet, family, no worries/other worries, and patient satisfaction. Patients talked about how they have tried to adjust their diet and some patients find it more difficult than others. Two patients took responsibility for their increase in blood sugars due to their diet, while one patient was reluctant to accept the diagnosis.

Five patients mentioned other health issues they experience which they consider more serious. Nine out of ten patients reported to be satisfied with the consultation and felt they had opportunities to ask questions during the visit.

The main theme in the nurse's post-visit questionnaire was patient engagement and understanding. She referred to how easy or difficult it was to engage in conversation with the patients, to "get answers" from them, as well as hoping they understood everything that was mentioned and explained to them.

Pre and post-visit data gives greater depth to the research and also serves the purpose of providing contextual data to support the CA data analysed from the consultations. For example, it was useful in terms of learning how long the patient had been living with the type 2 diabetes. This fact could potentially have an impact on their resistance when it comes to ongoing treatment change. In addition, it was interesting to note that 8 out of the 10 patients expressed not being overly worried about their illness, despite its seriousness.

The video recorded data from the 10 patients was watched many times until the researcher was familiarized with all the data. The data was then transcribed in full and the researcher completed an inductive data driven analysis to find patterns of talk within the interaction. Once a few patterns emerged these were reviewed in terms of a coherent model or rule to explain their occurrence. Many patterns were considered coincidental, as there was not enough instances or evidence to support their occurrence. However, when certain patterns followed a clear model of occurrence, these were taken further into a more detailed CA analysis as presented in the analysis chapters (4, 5, 6, and 7).

3.2.1 RECRUITMENT

The GP practice was recruited via the University of Sheffield supervisors' contacts and also contacts in Medical Humanities Sheffield.

After the practice agreed to take part, the practice nurse met with the researcher who explained the study. The nurse then contacted potential patients to participate in the study identified using an inclusion and exclusion criteria.

The inclusion criteria were as follows: Adult patients with type 2 diabetes and with enough command of English language to fully understand the research and give consent.

The exclusion criteria consisted of individuals with language impairments or significant communication problems as determined by the professional responsible for their care, individuals with mental health problems determined by their clinician, which would make their participation particularly problematic, individuals who need interpreters/translators, individuals under the age of 18 and children.

A small but diverse convenience sample was selected with both male and female patients between the ages of 40-70.

Table 1: Participants

Patient	Gender	Diagnosed with type 2 diabetes (according to the patient)	Age
1	Female	A few months ago	Over 70
2	Male	5 years ago	Over 60
3	Female	10 years ago	Over 60
4	Male	2 years ago	Over 40
5	Female	2 months ago	Over 60
6	Female	4 years ago	Over 50
7	Male	7 years ago	Over 50
8	Male	11 years ago	Over 70

9	Female	10 years ago	Over 60
10	Male	1 year ago	Over 50

This sample was diverse enough to provide a wide range of responses and experiences offering a better quality of interactions and data. Participants were given a project information sheet and in turn they provided informed consent, recorded prior to the visit. Participants were aware of the video recording and gave consent for its anonymised use in presentations and publications.

3.2.2 DATA COLLECTION

Selected participants who had consented to take part in the study met the researcher 3 minutes before their appointment in the practice where they replied to the pre-visit questionnaire. Following their video recorded appointment they met the researcher again, in a room adjacent to the consultation room for a 5-minute post-consultation semi-structured interview. In the meantime, the nurse having finished the consultation answered her questionnaire to the camera. The researcher was not present during the patients' consultations or during the nurse's response to the questionnaire.

The patients' pre-visit questionnaire was designed to quickly get an idea on how the patient views him/herself in terms of their health and also on their general expectations on the visit.

The patients' pre-visit questionnaire consisted of 4 questions.

1. How would you describe your health?
Excellent, Good, Fair, Poor.
2. What is the most important thing you hope to get out of your visit today?
3. What worries you the most about your diabetes?
4. Do you have any specific questions you would like to ask the practitioner today?

The patients' post-visit interview was semi-structured and the questions were designed to elicit as much patient talk as possible about their illness and about their views on how things were discussed in the actual visit.

Some of the questions from the patients' post-visit semi-structured interview were:

1. When were you diagnosed?
2. Have you met with this practitioner (nurse) before?
3. What kind of things did you talk about during your appointment?
4. Did the nurse talk to you about the risks attached to diabetes or to the treatment?
5. What are your main concerns regarding your diabetes?
6. Did you get opportunity to ask questions?
7. Was the consultation what you were expecting? Anything you wanted to discuss that you didn't get a chance to?

Equally, it was important to get the nurse's view on the chronic check-ups and 2 questions were designed in order to elicit her views on the consultations.
The nurse's post-consultation questions were:

1. Do you think the patient understood everything he/she was told?
2. Do you think the consultation went well?

This data was useful in terms of providing background information and to give some context to the conversation analysis in the video recordings. Asking patients what their concerns are regarding their diabetes was useful as this was potentially made visible in the actual talk during the consultation. For example, the two patients that asked the most questions during the visit were the only 2 that mentioned concerns during the interview. Therefore, being concerned about their condition in some way is displayed by asking more questions during the visit.

3.2.3 CHALLENGES OF DATA COLLECTION

The main challenges of collecting data during this study were firstly to gain ethical approval for the research. The NHS ethical approval process is extensive and requires a thorough protocol, particularly for video recording consultations. Secondly, access to the data is also challenging. In order to collect data a GP surgery has to be willing to cooperate and grant permission to work with them. This is a difficult task in itself, as most GP surgeries do not have the time or resources to help researchers. Thirdly, once a GP surgery has agreed to support the study, a member of staff will have to assist in terms of contacting suitable participants/patients on the researcher's behalf, as patient information is confidential. Finally, once patients have agreed to take part, understand the project and have signed a consent form, many drop out or miss their appointment. Contingency plans are necessary and over recruiting participants will ensure enough data is collected.

In this particular study, the difficulty and inability to recruit a second practice resulted in a limitation for the study. It would have been beneficial to have data from a second practice and another practitioner. This would have potentially resulted in more evidence for patterns of talk within chronic visits. Recruiting another practice could have yielded additional data on new interactional phenomenon or provided more evidence for phenomenon already accounted for, strengthening the arguments presented. However, more data would have involved more transcription and analysis extending the work and subsequently the time to complete the research. More details on the study's limitations are addressed in chapter 8, section 8.5.

Another difficulty is designing and setting out a methodology that will yield relevant data for the research questions in hand. When it comes to researching chronic consultations, due to the lack of literature on CA and chronic visits, a useful process would have been to conduct a small pilot study. Obtaining knowledge of what occurs during these visits would have helped in terms of the overall design of the research. However, conducting a pilot study entails an extra layer of consent in addition to it being time consuming for the practice and

creating more work for the practitioner. Perhaps sitting in one of the consultations before collecting the data would have sufficed in terms of providing a general notion of what occurs during these visits. This would have, for instance, helped produce the pre and post-consultation questionnaires. That said, it could be argued that not knowing what occurs during these visits eliminates any bias or preconceived ideas one might have acquired by observing one single consultation.

Finally, on a more practical note, having an additional audio recorder as well as the video recorder proves very useful in case the video is not captured correctly, there are audio problems, or the practitioner just forgets to press record. More details on the actual video recording procedure are detailed in the next section.

3.3 VIDEO RECORDING PROCEDURES

A small video camera was placed on a tripod in the nurse's consultation room. This was strategically positioned in order to visually capture both speakers clearly. A practice run was conducted with the nurse and the researcher. In addition, an audio-recorder was also placed in the room, specifically on the table between the nurse and the patient in case there were any problems with the camera. This measure was effective as there was one case were the video camera stopped recording half way through a visit, but the audio was captured and the data could be used.

The data from the video recordings was the main data to be analysed. Video recordings from the recording device were transferred to a password protected/encrypted data stick/drive at the clinical site, immediately after recording. They were then securely stored for analysis. The video recordings were transcribed using standard CA conventions to assist in the analysis and presentation of the findings.

3.4 TRANSCRIPTION

The transcript notation used in this research was developed by Gail Jefferson and it was devised to demonstrate how talk-in-interaction actually occurs.

3.4.1 TRANSCRIPTION SYMBOLS

Jefferson's notation includes the following symbols.

Table 2 Transcription Notation Symbols

Symbol	Name	Use
[text]	Brackets	Indicates the start and end points of overlapping speech
(# of seconds)	Timed pause	A number in parenthesis indicates the time in seconds of a pause in speech
(.)	Micropause	A brief pause, usually less than 0.2 seconds
↓	Period or down arrow	Indicates falling pitch
-	Hyphen	Indicates an abrupt halt or interruption in utterance
>text<	Greater than/Less than symbol	Indicates that the enclosed speech was delivered more rapidly than usual for the speaker
<text>	Less than/Greater than symbols	Indicates that the enclosed speech was delivered more slowly than usual for the speaker
°	Degree symbol	Indicates whisper or reduced volume speech
ALL CAPS	Capitalized text	Indicates shouted or increased volume
:::	Colon(s)	Indicates prolongation of an utterance

(hhh)		Audible exhalation
(.hhh)	High dot	Audible inhalation
((italic text))	Double Parenthesis	Annotation of non-verbal activity

Jefferson transcription notation as described in Gail Jefferson, "Transcription Notation", In J. Atkinson and J. Heritage (eds), *Structures of Social Interaction*, New York, Cambridge University Press, 1984.

In summary, the study's data is collected mainly from video recorded chronic diabetic consultations from one GP practice in the Sheffield area. In addition, the study also collects data from pre-consultation questionnaires and post-consultation semi-structured interviews. However, the main focus is the conversation analytic data and its findings which are presented in the next 4 analysis chapters (Chronic routine consultations versus acute primary care consultations, Closing a routine diabetic medical consultation, Risk Communication via if-conditionals, and Disagreeing by resisting).

4 Chronic Routine Consultations versus Acute Primary Care Consultations

Routine check-up consultations consist of visits where patients have a chronic illness, which needs monitoring (i.e. diabetes), and therefore visit the physician regularly. The purpose of these consultations is to monitor the on-going condition as well as dealing with any new concerns the patients might have. Due to this, diabetic routine consultations have a different format to standard primary care acute consultations. It is essential to distinguish between these 2 types of consultations as they have different aims and this reflected in their structure. Moreover, analysing chronic visits as a separate entity, but under the medical consultations umbrella, is crucial for the successful management of long-term conditions such as type 2 diabetes. I believe that what happens during these visits could play a significant role on the patients' self-management, which in turn has an effect on their overall health outcome (Adams 2010).

The originality of this chapter lies on the fact that there are significant differences between acute and chronic visits and it is necessary to forefront and understand these differences in order to inform best practice and potentially comprehend how patients manage their illness. These differences will be presented in the sections below.

Robinson and Maynard (2006) suggest an overall structure for acute primary care consultations consisting of 6 phases:
1) opening 2) presenting complaint 3) examination 4) diagnosis 5) treatment and 6) closing. However, check-up consultations in this data set do not quite follow the overall structure mentioned above and I believe this could be applicable to other routine consultations.

In the following sections I will present each of the 6 phases mentioned above and demonstrate how they are differ from routine chronic consultations.

4.1 OPENING PHASE

In chronic diabetic routine visits there is an opening phase where the patient and physician establish a relationship likewise in acute primary care visits. Nevertheless, in this data set the relationship for diabetic patients and the nurse is generally pre-existent as patients have met the nurse before and have their chronic routine checks with her regularly.

Routine consultations eliminate the problem of "legitimate doctorability" (Heritage and Maynard 2006b). The patient does not have to account for the visit or give any particular reason why he/she is there, as this is already known. This changes the structure of the consultation as it removes one of the key components in acute primary care visits which is patients presenting their problems and providing their reasons as to why they are seeking medical advice. Diabetic patients already have a legitimate reason to be in the consultation room and do not have to provide an explanation for it. In chronic diabetic check-up consultations the reason for the visit is common knowledge for the patient and the nurse. Hence the nurse opening most of the visits with utterances such as "How have you been since I last saw you" as detailed in the extracts below (in bold).

Extract 4.1
(N: nurse P: patient)

01 N: that's it there we are so it's started rolling now so er
02 uh:: so **how ave you been since I last saw you**↓ you been
03 [all right
04 P: [just yeah]
05 N: av' you been all right yeah ok

Extract 4.2

(N: nurse P: patient)

01 N: **so how's things been from when we last saw ye↓**
02 P: not too bad not too bad
03 N: yeah
04 P: °not too bad
05 N: no (.) so no problems from your perspective nothing
06 P: not really no

Extract 4.3

(N: nurse P: patient)

01 N: **right(.) any problems since I last saw you↓**
02 P: no not really

Extract 4.4

(N: nurse P: patient)

01 N: **so: you've been all right since I last saw you**
02 P: yeah been good
03 N: yeah cause we saw you in between didn't we
04 P: yeh ye did yeh

Extract 4.5

(N: nurse P: patient)

01 N: **so 'av you been↓**
02 P: <fine>
03 N: good th' hospital are pleased with ye aren't they
04 P: yeah

Extract 4.6

(N: nurse P: patient)

01 N: **any problems since we last saw you↓**

02 P: no
03 N: no
04 P: I had a couple of hypos
05 N: have ye'

These opening sequences orient to chronic routine visits where the reason for the visit is known and the consultations occur on a regular basis. It would be interactionally unusual for the nurse to open these visits with sequences such as "what can I do for you today?" as they would orient the visit to new concerns which have not been mentioned before. This would be an inadequate question design for routine check-ups as the patients are visiting due to a chronic illness that needs reviewing and not due to new concerns which are non-diabetic related. Robinson (2006) states that there are different ways in which physicians design their questions during the opening phase and these are dependent on whether they are dealing with patients' new concerns, follow-up concerns, or chronic-routine concerns. In this data set the nurse follows the question design orienting to chronic routine concerns. However, it could be argued that although patients are attending their check-up consultation they still might have new concerns which need raising. Due to this, I believe the nurse's opening questions in extracts 4.1-4.6 are functioning as opening questions, but also as problem solicitations, as addressed in the next section: presenting complaints.

4.2 PRESENTING COMPLAINTS

Acute primary care consultations differ substantially from chronic routine consultations during this particular phase. This is the phase where the patient expresses their concern and the reason for the medical visit. As mentioned earlier, diabetic patients are attending the visit as a matter of course and are not there necessarily due to a particular complaint, other than their on-going condition. Therefore, there is no need for them to explain the reason for the visit. The nurse is also aware of the reason for their visit, so it would be unnecessary for the patient to explain this.

However, it could be argued that patients might still have a new complaint which

they would like to present to the nurse. If the presenting complaints phase is not explicit during chronic visits, how and where would patients raise their new concerns? The data suggests that patients generally present their new complaints during other phases of the consultation, namely within the examination phase and the treatment phase of the consultation. That said, patients could mention their new concerns during the opening phase of the consultation. In extracts 4.1-4.6 above the nurse opens the visit with questions such as: "how have you been since we last saw you?" As the problem presentation phase does not appear explicit within chronic visits, these questions could also function as problem solicitations. The nurse's questions are designed to solicit a response from the patients which includes new concerns. This would make opening questions in these consultations borderline between the opening phase and the tacit problem presentation phase. Interactionally they can function as opening questions but also as problem solicitations. Asking "how have you been since I last saw you?" initiates the visit, but also orients the patient to respond with any new diabetic related concern they might have since their last check-up. Nevertheless, despite the nurse's potential intention to provide a space for patient problem presentation, during these visits most patients did not interpret the opening question as a problem solicitation, as they did not provide one. However, this could be due to not having a particular problem to raise. For example, in extracts 4.1 -4.5 patients' responses to opening questions such as: "how have you been since we last saw you?" are: "fine", "not bad", "yeah been good" comparable to responses of a more causal conversation as opposed to institutionalised questions from a practitioner in a medical consultation.

In extract 4.6 the patient does treat the opening question as a potential problem solicitation since she mentions a hypo she has experienced. However, even in this case the patient still starts with "no" (as in "no problems since I last saw you") and then immediately in her next turn mentions the hypo, treating the opening question as a borderline problem solicitation.

Patients' responses to this borderline opening question and problem solicitation

phase could be due to its sequential placement within the consultation. Since, the opening question phase is at the beginning of the visit this might deter patients in interpreting the opening questions as problem solicitations too. Hence, patients do not respond with their concerns straight away. It could also be due to the pre-existing relationship patients already have with the nurse, or the fact that patients did not have additional or new diabetic related concerns. However, in some cases new concerns were mentioned at a later stage during the visit, for instance during the examination or treatment phase. That said, the new concerns mentioned were related to the actual examination or treatment in hand. The findings in this study suggest that problem solicitation within chronic visits is not as straightforward as in acute primary care visits.

4.2.1 PRESENTING NEW COMPLAINTS DURING THE EXAMINATION PHASE

As mentioned above, due to the lack of a clearly delineated complaint presenting phase some patients present their new concerns during the examination phase. The concerns raised below by the patients in this data were somewhat related to the examination in hand.

In extract 4.7 below, the nurse is proceeding to the examination phase and has some blood tests results to deliver to the patient.

Extract 4.7
(N: nurse P: patient)

```
01   N:   […] any worries about your diabetes though since I last saw
02        ye I'm going to chat about yer blood test results in a
03        minute but [anything from your
04   P:              [not (0.5) really
05        ((N and P talk about self testing strips))
06   N:   how do you feel your diabetes control's been↓
07        (1.0)
08   P:   all right I think there is times although I know myself I'm
09        not eating like I should do
```

10 N: right(.)in what way do you miss
11 P: I just don't (1.0) feel like eating
12 N: right so would you eat what you fancied because you don't
13 feel like eating you're having more of what you fancy
14 rather than what you should have because of your diabetes
15 P: yeah
16 N: all right yeah
17 P: I find I'm eating more crisps
18 (2.0)
19 N: mm
20 P: than maybe a solid meal

Before the nurse delivers the actual HbA1C result (which in this particular case indicates high blood sugar levels - hyperglycemia) she asks the patient her opinion in terms of her diabetes control (line 6). The patient replies in line 8 with a turn initial "all right" in line 8. However she repairs her talk with "although" and admits that she is not eating adequately. This lack of appetite is significant and due to the extent of her unsuitable diet the nurse is not able to prescribe a certain medication which would lower her blood sugars as the medication needs to be taken together with an adequate and regular diet.

In the following extracts (4.8, 4.9 and 4.10), the nurse is performing a foot check which consists of observing both feet, looking out for any sores and checking their circulation. Patients raise concerns during this examination phase.

Extract 4.8
(N: nurse P: patient)

01 N: umm because umm ye know yer feet are precious really
02 P: yes
04 N: with diabetes
05 P: yeah
06 N: ye know(.)so we're keen to make sure yer uhh::
07 P: **it's just me ankle bone hurts really bad at the moment**
08 N: yeah that's causing ye the pain
09 P: yeah
10 N: 'ave ye got painkillers for that
11 P: yeah but it doesn't take it off

The patient raises a concern about her ankle and how it hurts (line 7). The patient takes the opportunity to raise her new complaint while the nurse is doing the foot check. The patient mentions her ankle pain as something that she considers relevant and related to her overall feet check.

Extract 4.9
(N: nurse P: patient)

```
01   N:   if that's all right, any problems with these
02   P:   (0.5) yeh they 'urt full stop ((laughs))
03   N:   they what(.)they hurt
04   P:   they hurt me full stop especially this left under there
05   N:   to do with your rheumatoid
06   P:   I don't know whether it's rheumatoid o:r
07   N:   are you all right with this ((starting the monofilament
08        test))
09   P:   a bit of, yeah
10   N:   ok or yer diabetes
```

The nurse asks the patient if she is having any problems with her feet (line 1) during the examination. The patient replies in line 2, expressing her discomfort and complains about her feet hurting. In line 4 she reinforces her complaint by giving more details of where it actually hurts.

Extract 4.10
(N: nurse P: patient)

```
01   N:   do you cut 'em or file them which do you do
02   P:   I've been filing them
03   N:   wonderful(.) good
04   P:   but
05        (1.0)
06   N:   >go on<
07   P:   this big toe's really driving me nuts this left one umm I
08        'ad that one off but it's growing
09   N:   mm
```

10 P: and it's growing back into it
11 N: oh: is it
12 P: yeah

The nurse is examining the patient's feet and asks her if she files or cuts her toenails. The patient notes that she files them and the nurse follows this up in line 3 with a positive assessment. At that point, immediately after the positive assessment, the patient provides a "but" (line 4) in some way discordant with the nurse's previous positive assessment on her feet. There is a pause after the "but" in line 5 indicating some hesitation on the patient's part. The nurse encourages the patient to carry on with her account in line 6 and the patient proceeds to present a new foot related complaint in line 7. Presenting the new concern at that point enables the nurse to examine the toe which is causing the problem.

It seems logical to present a new complaint about feet during the feet examination. However, patients also present new concerns during the treatment phase as seen in the next section.

4.2.2 PRESENTING NEW COMPLAINTS DURING THE TREATMENT PHASE

Some patients raise new concerns while reviewing their on-going treatment. These concerns were deemed diabetic related by the patients hence, raising them during the treatment review phase.

Extract 4.11
(N: nurse P: patient)

The nurse is reviewing the patient's medication as part of his on-going treatment.

01 N: any problems **any side effects with any of your medication**
02 [any
03 P: [no
04 N: has there been any problems with them

05 P: **not bad not bad**
06 N: no (1.0) ummm well they're doing the job
07 P: mm
08 N: >like I say< they're uhh they're keeping your blood sugars
09 down
10 P: **I'm not I'm not eating very well °don't know**
11 N: aren't you(.)is you(.)have you lost your appetite
12 P: sometimes I'm all right sometimes, I still eat but I used
13 to be a right good eater d' ye know what I mean
14 N: yeah
15 P: it's uh it's uhh me daughter is a nurse she said just keep
16 getting things while you want to eat ye know or I go to me
17 daughter's everyday for me tea
18 (1.0)
19 N: so you get an evening meal at least there
20 P: ai ai

The nurse explicitly asks the patient if he is having any side effects or problems with his current medication (lines 1 and 4). The patient initially responds "no" in line 3. However, in line 10 he indicates that he is having problems with his appetite and is not eating well. His initial "no" in line 3 could be accounted for by the use of the nurse's "any" which prefers a no response. Heritage et al (2007) state that using "any" when trying to elicit patient's unmet concerns produces less affirmative responses than when using "some". Nevertheless, the patient manages to raise his concern about his loss of appetite within the treatment phase, while the nurse is reviewing his medication, potentially implying that it could be the medication that is causing his lack of appetite. Hence, raising it at the point when the nurse asks him specifically about side effects of his medication. This conversation about the patient's lack of appetite results in the nurse reminding the patient about hypoglycemic symptoms and recommending certain courses of action if he ever does experience a hypoglycemic episode.

Extract 4.12
(N: nurse P: patient)

The nurse is reviewing the patient's on-going treatment, in particular a certain tablet the patient has been prescribed (Metformin).

01 N: right I k' I can put you like **are you getting any side**
02 **effects with yer tum as well**
03 P: **yeah**
04 N: do ye get-
05 P: yeh
06 P: **I do with I get really bad diarrhoea with it**
07 N: umm
08 P: but I think it's metformin that starts it
09 N: is it

The nurse asks if he is experiencing any side effects in his "tum" (lines 1-2). The patient admits he does experience side effects in lines 3 and 6. Although prompted by the nurse, the patient manages to express a complaint in line 6. This complaint results in a change of medication to an alternative slow release tablet, which should prevent the undesired side effect produced by the patient's current medication.

Extract 4.13
(N: nurse P: patient)

The nurse is reviewing the patient's on-going treatment and medication as part of the treatment phase. The patient takes medication for erectile dysfunction as part of his diabetes treatment.

01 N: yeah ummm (0.5) **the only thing that's outstanding as well**
02 **is about erectile dysfunction** I think we didn't ask you
03 that last time
04 P: mm
05 N: ye know it's the new word for impotence really (.hhh)
06 P: mm
07 N: but as you'll know(.)
08 P: **I'm struggling a bit with that but mm especially with these**
09 **tablets**
10 N: mm
11 P: they do help me but
12 N: yeah cause yer on Tada is it Tadalafil
13 P: yeah I've just got some more

14 N: yeah

The nurse mentions erectile dysfunction as something outstanding to review (lines 1-3), since it was not discussed in the last visit. The nurse has not yet asked about any side effects, however, the patient mentions a complaint in line 8. This complaint results in the nurse reviewing the actual medication and discussing changing his current dosage.

In extracts 4.11, 4.12 and 4.13 patients mention their diabetic related complaints while the nurse reviews their treatment. In all 3 cases the complaints were related to the on-going treatment, making the complaint relevant during that phase of the consultation. Furthermore, the new complaints presented in all 3 cases proved to be significant enough to require a treatment alteration or a strong recommendation in terms of treatment going forward.

These new complaints presented by the patients are not treated as the focus of the consultation. This could be due to the fact that they are not presented by the patient as the main reason for their visit. The main reason for the patients' visit is to check their chronic illness, making it difficult interactionally for the patient to present another main concern. More importantly, the overall structure of the chronic routine check-ups does not allow for a clear delineated presenting complaints phase. Therefore, patients generally have to raise their diabetic related concerns during the examination or treatment phase. This is why it is key to analyse chronic consultations as they have a different format to acute primary care visits and in turn these differences could be influencing the patient's self-management of their illness.

Equally, patients raised non-diabetic related concerns during the examination and treatment phases of the visit. However, these were treated quite differently by the nurse. If other concerns were raised by the patients that were not directly related to their diabetes, patients were directed to their GP or to other relevant physicians as shown in the section below.

4.2.3 PRESENTING NON-DIABETIC RELATED CONCERNS

The remit of the chronic diabetic routine consultations is demonstrated by the examples below to be solely and strictly on diabetic related checks and diabetic related concerns. If patients raise other complaints, which are deemed by the nurse not to be related to the illness and check-up in hand, they are directed immediately to other specialists.

Extract 4.14
(N: nurse P: patient)

The patient has walked into the consultation room and sat down.

```
01   N:   right(.) how are you↓
02        (1.0)
03   P:   not too good
04   N:   no(.) what in general or with your diabetes
05   P:   no in general
06   N:   in general
07   P:   yeah
08   N:   right(.) something that you need to see the GP about do you
09        think
```

The patient notes that she is "not too good" in line 3. The nurse follows this up by clarifying if the patient is referring to her health in general or to her diabetes. This displays the nurse's orientation towards distinguishing the visit from a general consultation to a specific chronic diabetic routine consultation. The patient replies "in general" in line 6 and the nurse suggests visiting her GP (line 8) marking a clear distinction between a general visit and a chronic routine one. The nurse does not ask the patient further regarding her general health, but directs her to her GP.

Extract 4.15
(N: nurse P: patient)

The patient had previously complained of "feeling unwell" and noted that she is not sure what it is that is making her feel unwell.

```
01   N:   but we see in more often than not that when people are
02        unwell their blood sugars run higher (.hhhh) so::
03        it's deciding is that what's happening with you cause
04        you've gone from having perfect control t' now not feeling
05        particularly a' hundred per cent and then yus blood sugars
06        'ave gone up
07   P:   mm
08   N:   uhhh so:
09        (1.0)
10   N:   I don't know how you feel about it whether you want to sort
11        of see your GP first(.) <see what's going off basically>
12   P:   um hum
```

The nurse explains what can happen when "feeling unwell" in terms of blood sugars. The patient provides a minimal token in line 7 and after a pause in line 9 the nurse suggests to the patient seeing her GP (line 11).

Extract 4.16
(N: nurse P: patient)

The patient has complained about her difficulty in losing weight at the moment despite changing her diet.

```
01   P:   yeah I have them at night
02   N:   for [yer supper
03   P:       [bit of fruit umm
04   N:   right yeah is anybody seen ye [about
05   P:                                  [jelly
06   N:   to give you sort of any pointers is there anybody that you
07        can-
08   P:   no I've [not
```

09 N: [**tap into a specialist**
10 P: seen anybody yet
11 N: umm
12 (1.0)
13 P: I s'pose could do
14 N: the thing is(.) you're going [to
15 P: [yeah I would if you've got a
16 contact number
17 N: yeah **I've got a contact number**(.) you're going to get
18 disheartened aren't you if you:
19 P: well yeah I am a bit

The patient has expressed her concern about not being able to lose weight. The nurse asks the patient if she has seen anybody (line 4) that could help and give her "any pointers" (line 6). The patient says she has not seen anyone and the nurse mentions visiting a specialist (line 9). She later mentions having a contact number for her in line 17.

The nurse has delineated the boundary of this particular consultation to diabetic checks only and although it does include weight, and the patient raised the concern during the weight examination phase, the nurse refers her to a specialist to help her lose weight, as this is not the remit of the check-up visit.

Extract 4.17
(N: nurse P: patient)

The patient has complained about pain in her leg as the nurse is checking her feet.

01 P: I do have it ye know up at back of leg but now I'm
02 beginning to wonder if it's arthritis
03 N: right yeah(.) **ye could see yer GP**

Similarly to extract 16, the patient complains about pain in her leg during her foot check. The patient produces a candidate diagnosis (Gill and Maynard 2006)

that it could be her arthritis in line 2. The nurse directs her to her GP displaying the boundary of this particular visit.

Extract 4.18
(N: nurse P: patient)

The nurse is checking the patient's feet.

```
01   P:   I've been filing them
02   N:   wonderful good(.)
03   P:   but
04        (1.0)
05   N:   >go on<
06   P:   this big toe's really driving me nuts this left one umm I
07        'ad that one off but it's growing
08   N:   mm
09   P:   and it's growing back into it
10   N:   oh: is it
11   P:   yeah
12   N:   right(.) you need to see the doctor about it
```

The patient complains about her toenail in line 6. The nurse is already examining her feet so looks at the toe briefly and directs the patient to a doctor in line 12.

Extract 4.19
(N: nurse P: patient)

The patient is concerned about the amount of tablets he is taking as he suffers from ischemic heart disease as well as diabetes. The nurse has gone through the full list of all the tablets he is currently prescribed to take.

```
01   N:   ye know the choice ultimately is yours
02   P:   yeah
03   N:   but like I say we do recommend
04   P:   it's just that I 'av been talking to people and ye know
05        people that's got heart disease trouble same(.)>exactly the
06        same as me<
```

07 N: yeah
08 P: and they're only on two or three tablets a day
09 N: right
10 P: and I'm on like NINE
11 N: yeah yeah you've got
12 P: it's like why are you taking all them for
13 N: mm
14 (1.0)
15 N: **you could always have a discussion with your GP** and see
16 whether they can ye can
17 P: yeah well it doesn't matter if I've got to take 'em I've
18 got to take 'em >I'm not bothered<

The nurse explains to the patient that it is his choice in terms of taking or not taking the tablets prescribed. The patient explains how he knows of other people suffering similar conditions who take fewer tablets. After a pause in line 14 the nurse directs him to his GP for a discussion on the amount of tablets he takes.

Extracts 4.14-4.19 above show that if new concerns are raised and these are not directly related to the patients' diabetes, the nurse refers them to their GP or to another specialist. The boundaries of the diabetic check-up become clear and the nurse will not deal or treat unrelated concerns. This informal referral is another difference between chronic visits and acute primary care consultations. The former deals with diabetic related issues only, as opposed to the latter where patients are expected to explain their symptoms and their history allowing for doctors to consider a range of potential issues.

4.3 EXAMINATIONS PHASE

Regarding the examination phase, as per Heritage and Maynard's (2006a) description, the nurse does conduct a verbal and many times a physical examination as well. However, the examination is based on known issues that need monitoring i.e. feet check, blood glucose check, weight check. The examination is not based on any new concerns presented by the patient. Moreover, the patient is expecting this monitoring examination as part of the

chronic routine visit. The examinations are not performed in order to diagnose a patient. They are tests being done on a regular basis to review the patients' on-going illness hence, they do not seem to require an explanation beforehand. For instance, when the nurse performs a foot examination there is no explanation for it. Likewise when she performs a finger prick examination there is no explanation for it. However, this is not problematic for the interaction due to patients already experiencing these tests and also expecting them as part of their visit, as demonstrated in the examples below.

4.3.1 FOOT CHECK EXAMINATION

The nurse examines feet as part of the routine check-up. This consists of looking closely for any sores, checking pulses and circulation and also performing a monofilament test to check any loss of sensation.

Extract 4.20
(N: nurse, P: patient)

```
01        (1.0)
02   N:   right ok so I need to check your feet
03   P:   yeah
04   N:   all right so uhh any problems with them
05   P:   no
```

Extract 4.21
(N: nurse, P: patient)

```
01   N:   right I'm going to do your feet next
02   P:   ok
03   N:   do your foot check if I may
04   P:   I'll just take me shoes off
05        (1.0)
06   P:   uhh
07        ((P getting up to take shoes off))
08   N:   you all right
```

Extract 4.22

(N: nurse, P: patient)

```
01   N:   can I have yer feet then
02   P:   yes
03   N:   if that's all right, any problems with these
04   P:   (0.5) yeh they 'urt full stop ((laughs))
05   N:   they what(.)they hurt
```

The nurse does not explain what she will be doing with the patients' feet or why she wants to check them. In extracts 4.20 and 4.21 she notes that she will perform the foot check and proceeds. In extract 4.22 she asks if she can "have" the patient's feet implying that she will proceed with the foot check. The patients know what the examination consists of, having experienced it before, and they proceed with what is required from them (i.e. taking shoes and socks off, lifting feet up etc).

Likewise with the finger prick test in extracts 4.23 and 4.24. This test consists of a quick finger prick using a small device that extracts a droplet of blood, which is then used to measure the patients' immediate blood glucose. However, the nurse does not explain what the test is actually measuring and the patients do not ask. They appear familiar with the actual test, as well as its function, as per the extracts below.

4.3.2 FINGER PRICK TEST

This test consists of performing a small incision in the patient's finger with a special device and checking the droplet of blood extracted for an immediate reading on blood sugar levels.

Extract 4.23

(N: nurse, P: patient)

01 N: **ok right so I'm going to do a quick finger prick on you**
02 **just to see(.)** I've just washed my 'ands just prior to you
03 coming in are your hands clean
04 P: yeah
05 (10) ((nurse getting finger prick device ready))
06 N: so this just tells us the here and now(.)like I say I know
07 sort of the averages really don't I bu::t uhh that we're
08 doing all right. So it's just a quick prick of your finger
09 (2.0)
10 N: thank you

The nurse notifies the patient in line 1 that she will be performing the finger prick. She proceeds by getting the device ready. In line 6 she mentions to the patient that this test just shows the "here and now". She does not explain what is actually being measured "here and now" i.e. measuring immediate blood glucose, as this information is already known.

Extract 4.24

(N: nurse, P: patient)

01 (0.9)
02 N: **right lets uh see how we go with um with your finger prick**
03 **shall we**
04 ((Nurse getting the finder prick device out))
05 N: so how are you going with your diet↓
06 ((patient stretches her hand out to the nurse))
07 N: I know we we sort of chatted haven't we about you liking
08 your °chocolates
09 P: diet <yeh>
10 N: and things like that (0.5) are your hands clean I've just
11 washed mine just prior to you coming
12 P: well the' were [when I come out
12 N: [they're all right, ok that's fine

In the same way to extract 4.23, the nurse indicates that she will be performing the finger prick test in line 2 and she does this in a way that suggests the patient is already familiar with the test. This is evidenced by her lack of explanation about the test itself, and also by the patient's acknowledgement and movement of bringing her arm forward placing it in a position ready for the test (line 6). The patient does this without being asked displaying her previous experience with the finger prick.

Equally with the patient's weight check, the purpose of this examination is not discussed as shown in the examples below.

4.3.3 WEIGHT CHECK

The nurse has to weigh the patients during every visit to monitor their weight as a measure of their diet and lifestyle habits, which are influential in their diabetes.

Extract 4.25
(N: nurse, P: patient)

```
01          (2.0)
02    N:    right if you're just careful of the tripod there but if you
03          just want to hop on the scales for me
04          (1.0)
05    N:    an we'll just see (2.0) what yer weight's up to you may've
06          lost some weight with your appetite not being so good so
07          you're twelve stone four there thank you
```

Extract 4.26
(N: nurse, P: patient)

```
01    N:    do you know what you weight at the minute (0.5) cause are
02          you weighing yourself regularly
03    P:    uh they weighed me up at the hospital a fortnight ago
04    N:    yeah
05    P     and it was uhhh
```

06 N: just to save going round the back of the [camera
07 P: [one
08 N: I'll take your [word
09 P: [wait a minute umm (1.0) nineteen one
10 N: nineteen one ((writing it down on paper))

Extract 4.27

(N: nurse, P: patient)

01 N: […] so I'll just write these as we go down, **have you**
02 **weighed yourself recently or shall I just**
03 P: no yeh
04 N: I'll just bring the scales down just round here
05 P: ok love
06 N: so you don't trip on the tripod
07 (2.0)
08 N: do you know your weight or shall I weigh you
09 P: no ye better weigh me

Checking the patients' weight is part of the examination and likewise it is not explained. It is part of the routine checks being performed during these visits. In extracts 4.25 and 4.26 the nurse offers the patients a chance to notify their weight instead of checking it herself. This reflects an element of trust between the nurse and the patient as the nurse will record the weight given directly by the patient (extract 4.26) without checking it herself. Likewise in extract 4.27, the patient is given the chance to provide her weight without checking. However, the patient decides it is necessary for the nurse to check the weight herself. Due to the routineness of the visits and the familiarity the patient possesses with them, examinations in these consultations appear to have more of a collaborative nature. Both parties know what is involved and are familiar with all the examinations being performed. Patients know what to expect and therefore, are prepared for the examinations.

4.3.4 HbA1C Test result delivery

When it comes to the examination of the patient's HbA1C test results, the nurse does provide explanations. When these results are delivered the nurse provides an explanation, or reminds the patient of what the figures actually mean in terms of ideal results demonstrating a well-controlled diabetes.

Extract 4.28
(N: nurse, P: patient)

```
01        (1.0)
02   N:   uhhh the blood test that we do looks at yer diabetes
03        control over the last three months
04   P:   yeah
05   N:   and it gives us the averages all right and we like the
06        results to be between a reading of <fifty and sixty>
07   P:   yeah
08   N:   so yours came back at fifty-four
09   S:   yeah
10   N:   so as you can tell it's well controlled it's well within
11        those parameters
12   P:   yeah yeah
13   N:   all right
14        (1.0)
```

Before delivering the test results the nurse explains what the test reflects i.e. shows the averages over the last 3 months. She then proceeds to explain what the ideal figures are in terms of the results (lines 5-6). Following this, she gives the patient his test result in line 8, and then provides an assessment in line 10.

Extract 4.29
(N: nurse, P: patient)

```
01   N:   uhh ye blood test results you know you did prior to coming
02        today
03   P:   yeah
```

04 N: well **it looks at your diabetes control over the last twelve**
05 **weeks** really
06 P: mm
07 N: so **it doesn't give us the highs and the lows it just gives**
08 **us the average**
09 P: yeah
10 N: and your average like this time just excuse me while I look
11 at the screen (2.0) °while I pick up your last one
12 (3.0)((nurse is checking her computer screen))
13 N: but when we saw you in the summer last year your diabetes
14 control was excellent
15 P: yeah
16 N: we **the blood test that we do >just for your information< we**
17 **like it to be between fifty and sixty**
18 P: yeh
19 N: and you were at fifty one so perfect that was brilliant(.)
20 this last result that we've got done is sixty fi:ve so it's
21 took you slightly above that
22 P: yeah

In this extract the nurse also explains the test's function (i.e. measuring the average blood glucose over the last 12 weeks, lines 4-5 and 7-8) and explains what figures display a good diabetic control (i.e. between 50 and 60, lines 16-17).

Extract 4.30

(N: nurse, P: patient)

01 N: well the last one that we did was October last year you
02 were fifty and **as you perhaps remember but just to recap we**
03 **like that blood test that we do:**
04 P: yeah
05 N: **it's really assessing what your control's been like over**
06 **the last twelve weeks** so when I looked at it I can't even
07 say well Christmas is part of that
08 P: no
09 N: cause Christmas is been and gone hasn't it
10 P: it's[been me
11 N: [within that three months, but **we like it to be between**
12 **fifty and sixty**
13 P: so >what's it gone to<

14 N: so you've gone to seventy-one
15 P: oh: GOD that's a bit much

Likewise in extracts 4.28 and 4.29 the nurse explains that the test measures the averages over 12 weeks and the ideal result is a figure between 50 and 60.

Extract 4.31
(N: nurse, P: patient)

01 N: the latest result was uh >let me just pick it up< sixty two
02 so you're just slightly above(.) ok
03 P: right
04 N: we work on uhhmm **cause ye know this test looks at your**
05 **diabetes control over the last three months**
06 P: three months [yeah
07 N: [int' it yeah
08 P: yeah
09 N: **we umm want it to be between fifty and sixty**
10 P: oh right

The nurse informs the patient of his latest result in line 1. She then starts to explain how the test works in the beginning of line 4: "we work on". However she repairs her talk after a hesitation in line 4 and provides an explanation on what the test measures i.e. "diabetes control over the last three months" in line 5. Following this, in line 9 the nurse mentions what the expected results should be i.e. "fifty to sixty".

Extracts 4.28-4.31 demonstrate that despite patients having done the HbA1c test before, the nurse still explains what the test is measuring and what the numerical outcome indicates in terms of satisfactory diabetic control. Her explanation on this particular test over any of the other tests could be due to the fact that this test is measured numerically and these figures needs some interpretation. The nurse might feel the need to explain or remind the patient what these numbers mean. However, it could be argued that performing blood pressure tests would require some explanation as well, as they too are based on

numeric figures. Nonetheless, these do not get explained and instead the nurse assesses whether the results reflect “good” or “high” blood pressure. Either way, the Hb1Ac test is the only one that is accompanied by an explanation regarding what it measures and its results.

4.4 DIAGNOSTIC PHASE

Continuing though the consultation phases (Heritage and Maynard 2006) in terms of the diagnosis phase, routine diabetic consultations differ again to acute primary care consultations as diagnoses are not present in the former. Patients have already been diagnosed with a chronic illness and their check-up is the reason for their medical visit. In this data set the nurse does not have to inform the patient of an unknown diagnosis, as the patients are aware of their condition. Consequently, this phase of the consultation seems to be bypassed and the nurse proceeds to the treatment phase. It could be argued that patients could potentially raise other concerns and these would need diagnosing. However, as seen in section 4.1.2 (Presenting Complaints), non-diabetic related concerns are not dealt with and patients are directed to other specialists. Therefore, there is no diagnosis of other concerns.

This reinforces the notion whereby the function of these visits is not to diagnose but to review a chronic illness. Hence, omitting the diagnosis phase.

4.5 TREATMENT PHASE

Regarding the treatment phase, the main difference between these diabetic routine consultations and acute primary care visits is that diabetic patients are already following certain treatment. These consultations serve the purpose of reviewing this on-going treatment and potentially changing it if need be. The patient is aware of their illness and has an understanding of their treatment. Nevertheless, there are cases whereby changes to treatment need to be implemented due to the patients’ diabetes’ progression. Some patients might be experiencing hypoglycemia or hyperglycemia and therefore might need to adjust

their medication in order to maintain satisfactory blood sugar levels.
Likewise in acute primary care visits, treatment in both types of consultations is negotiated and decided between the physician and the patient. As seen in the literature (Stivers 2006, Koenig 2011, Ekerg and LeCouteur 2015) as well as in chapter 7, treatment proposals can cause resistance. In this data set patient resistance is displayed by providing evidence that contradicts the nurse's suggestions. Chronic and acute consultations are similar in terms of resistance providing a space for the nurse and the patient to negotiate treatment. However, regarding the actual negotiations, patients attending routine consultations arguably have more knowledge about their illness. They have not been diagnosed in the previous phase during the same visit, they have had more time with their diagnosis and living with their illness. Furthermore, they already have had some form of treatment and therefore understand their diagnosis better. This would allow them to exert their agency on the decision-making process, which in turn could make negotiations between the patient and the practitioner more extensive if there is disagreement. Nevertheless, as noted by Ariss 2007, even if there is disagreement speakers 'retreat' to their epistemic domains, which allows for a resolution as seen in chapter 7.

This brings us to final phase of the consultation known as the closing phase detailed in the next section.

4.6 CLOSING PHASE

The closing phase is that last phase of the consultation where an agreement is reached between the patient and practitioner that the consultation will be terminated.

The data from diabetes routine visits differs from acute primary care visits as during the closing phase the nurse often asks the diabetic patient if she has indeed performed all the expected tests and/or done everything the patient is expecting as part of the check-up, demonstrated by the 5 extracts below (extracts 4.32-4.36, marked in bold).

Extract 4.32

(N: nurse, Patient: P)

01 N: **do you think we've crossed all the Ts and dotted all the Is**
02 P: yeah
03 N: as the saying goes all: right that's lovely

Extract 4.33

(N: nurse, P: patient)

01 N: right thank you **we've covered everything haven't we**
02 P: yeah

Extract 4.34

(N: nurse, P: patient)

01 N: right **from my perspective I don't need to do anything else**
02 **if you're happy**
03 P: yeah I'm all right yeah fine
04 N: yeah ok

Extract 4.35

(N: nurse, P: patient)

01 N: umm asthma check we've done so **is there anything else that**
02 **you think I should've done that I've not done**
03 P: no: I think that's all int' it

Extract 4.36

(N: nurse, P: patient)

01 N: **anything else (2.0) you thought I were gonna do and I've**
02 **not done** it or uhhh you wanted to ask
03 P: no uhh what were my bloods↓

Extracts 4.32-4.36 display the nurse's acknowledgement that both her and the patient possess shared knowledge when it comes to their routine consultations, making it a more collaborative interaction. The nurse emphasises an equal claim of knowledge between herself and the patient in terms of the processes followed within the visits. By presenting a final concern sequence in the formats above, the nurse indicates closing as well as her acknowledgement that the patients possess the relevant knowledge and experience which would allow them to notice if something has been missed or not done during these visits. I believe this could be characteristic of chronic routine consultations. It would be unusual for a physician to ask a patient who is presenting a new concern during an acute primary care consultation if he/she has done everything or if there is anything outstanding. In fact, it could potentially reflect a lack of competency as the physician is in a position where he/she should know exactly what to do.

Due to the routineness of the consultations and the fact that patients have expert knowledge about what happens during these visits, asking patients if everything has been done encourages patient participation and emphasises equal claims of knowledge.

In addition to asking the patient if everything has been done, and acknowledging their experience within these consultations, the nurse uses certain resources when closing these chronic visits.

There are specific resources used by speakers in order to indicate that the conversation is shutting down and the consultation is finishing. These include: summarising the visit, clarifying next steps and shifting the talk to future plans (Robinson 2001, White et al 1997). However, using these resources does not always guarantee an immediate closure. Terminating the medical encounter needs to be agreed upon by the physician and the patient. Furthermore, the interaction cannot end by simply stopping the talk or exiting the consultation room (Robinson 2001, Schegloff and Sacks 1973). There needs to be collaboration between both participants where the end of the encounter is agreed.

Schegloff and Sacks (1973) suggest that the organization of turn taking via adjacency pairs plays an essential role in closing a conversation. Adjacency pairs consist of 2 adjacent utterances each of which are produced by a different speaker e.g. question/answer, greeting/greeting, offer/acceptance (Schegloff and Sacks 1973). Since both speakers have to agree on the closing of the encounter two utterances are required in order for closing to occur: "by an adjacency positioned second, a speaker can show that he understood what a prior aimed at, and that he is willing to go along with that" (pg 75). Other research suggests that closing sequences require at least two sets of adjacency pair exchanges: one for the initiation of closing and another for the terminal exchange (Goldberg 2004). The next chapter will demonstrate how closing is achieved within routine consultations.

4.7 SUMMARY

In routine consultations it is more difficult for patients to raise new concerns due to the sequential lack of a clear delineated 'presenting complaints' phase. The purpose of these visits is to review the patient's illness and therefore, the structure limits the opportunities for the patient to address new concerns, unless they are addressed as part of the opening question (in the opening phase) or they are tied to agenda points during the visit.

Due to the overall structure within chronic routine check-ups new concerns are generally raised within the examination phase or the treatment phase. The overall structure of chronic routine diabetic consultations in this data set consists of 4 phases and not 6 as per acute primary care consultations. The 4 phases are: 1) opening phase 2) examination and test results 3) treatment review 4) closing.

On the one hand, this 4-phase structure might limit the opportunity for patients to raise new complaints since there is no clear 'Presenting Complaints' phase as mentioned above. This in itself has an impact on the trajectory of the visit as

lacking a delineated complaints presentation phase sequentially eliminates the following phase which would be the diagnosis phase. On the other hand, this structure is purposeful for the check-up consultation. It almost takes a 'checklist' like format (Jones 2003, Chatwin et al 2014) whereby the nurse runs through all the necessary tests that need performing and checks the current results against previous results. This checklist style approach enables the nurse to complete all the necessary tests without wandering into other remits that are not considered relevant to the visit in hand. Hence, directing any non-diabetic concerns raised by patients to other specialists.

There are noticeable differences between chronic routine consultations and acute primary care ones. One of the main differences that could have an impact on the patients' self-management of their illness is the lack of a clear delineated complaints presenting phase. This could hinder the patients ability to interactionally present a complaint, that in turn could be diabetic related and potentially serious.

The next chapter will present a detailed analysis on how the nurse closes a chronic diabetic routine consultation.

5 Closing a Routine Diabetic Medical Consultation

This chapter will begin by providing a theory on closings in chronic type 2 diabetic check-up consultations. It will then present and analyse 11 extracts (5.1-5.11) of closing initiations by the nurse together with the patients' response. These 11 examples correspond to all the closing encounters in the data set. Next, it will provide examples of specific closing resources and their use within the interaction and finalise with a conclusion.

As mentioned previously (chapter 4) speakers use specific resources to indicate the end of a conversation and the end of a consultation. These include: summarising the visit, clarifying next steps and shifting the talk to future plans (Robinson 2001, White et al 1997). Nevertheless, using these resources does not necessarily assure an instant closure. Both parties, in this case the nurse and the patient, need to work together and agree on the termination of the medical visit.

This chapter will focus on the initiation of the closing phase, what Schegloff refers to as "pre-closing", as opposed to the actual terminal exchange i.e. the exchange of goodbyes. The reason for focusing on the initiation of closing is because I believe it is within this initiation where the negotiation between speakers on the actual closing takes place. The novelty of this particular chapter lies on its treatment of initiation of closing as a topic in its own right rather than a sequence within closing. Once the initiation of closing is achieved speakers can move on to the terminal exchange. It would be interactionally insufficient to move straight into the terminal exchange without an initiation of closure i.e. just producing a "goodbye" in order to close the encounter (Robinson 2001) is simply not enough. For example, if a physician produces a "bye" after the patient's physical examination or even after recommending treatment it would appear sequentially unexpected and possibly not considered a serious closure.

As noted by West (2006) there have been insufficient studies that focus on "closing as a topic in its own right" (pg. 380). Studying closures in detail could firstly, improve doctor-patient communication to avoid the potential "by the way syndrome" (Rodondi et al 2009, White 1994). This syndrome presents itself when patients raise last minute concerns during the closing phase, which can be serious, however, there is no time to address them. Secondly, it could provide knowledge on best practice regarding closing a medical visit successfully without leaving patients' concerns unaddressed.

This chapter aims to shed more light on the closing phase of consultations by focusing specifically on the initiation of closing during type 2 diabetic routine consultations. This will be accomplished by analysing the talk between a nurse and diabetic patients during the negotiation of closing. Namely by examining how the nurse initiates the closing and how the patients respond to it.

5.1 CLOSING CONSULTATION MODEL

So, how do the nurse and the patient negotiate the closing of the diabetic check-up consultation?

The practitioner and patient must work in collaboration via the turn taking machinery (Schegloff & Sacks 1973) to successfully manage closing the consultation. In other words, both speakers have to work together sequentially through their turns in talk to successfully achieve the closing of the consultation. The analysis from this data set suggests the theory that the closing phase involves multiple moves within a framework consisting of an initiation of closing and a reiteration of closing

The practitioner must indicate the initiation of the closure by using one of the closing resources mentioned previously. The patients must then identify this initiation as the closing phase initiation and accept the transition from the education and information exchange to the closing phase (White et al 1997).

Once the physician has had acceptance of the initiation, via the closing resource, he/she must pursue the actual closing by reiterating it using other closing resources. In turn the patient accepts the full closure and the interaction can move on to the terminal exchange.

The data in this study suggests that using closing resources during the initiation of closure (e.g. summarising, clarifying treatment or shifting to future plans) is not interactionally sufficient to close the consultation and proceed to the terminal exchange. Previous research (Schegloff and Sacks 1973, White et al 1997, Robinson 2001, Wright 2011) states that closing conversations are managed via a two-unit design. Whereby the first unit addresses the shutting down of the previous sequence and second unit makes relevant the action of closing (Wright 2001). However, in these chronic diabetic consultations there appears to be multiple moves in order to close the visit. There is a need to restate the closing in order for both parties to move on to the terminal exchange (the 'goodbyes'). This format is consistent across all the closures in this data set.

The analysis indicates that the closing of a chronic consultation requires an initiation of closing and a reiteration of closing in order to proceed to the terminal exchange. Unlike the suggestion of previous findings where two utterances are required, the findings in this data indicate that closing rarely occurs within two utterances, as closure seems to involve multiple moves. Two utterances are required in so far as speaker A proposes a closing and speaker B accepts it. However, this could take several attempts. In this study an additional sequence of closing is observed that consists of a reiteration of the closing itself and a further acceptance from the patient within these diabetic routine consultations with the nurse. This could be due to the turn taking machinery within the structure of the consultations.

We have already mentioned above examples of closing resources used in order to shut down a conversation. Therefore, for example, if a physician initiates closing by summarising the visit, the patient will be expected to accept the summary at the same time as identifying and accepting the closure. The

acceptance is two-fold since summarizing the visit has two functions in this context. One is to actually summarise the visit and the other is to act as a closing resource. However, the patient might accept the summary but not the closure, as he/she might still have questions. Due to the basic rule of adjacency pairs, the first pair part requires the second pair part, therefore, the patient will have to accept or not accept the summary, the closure, or both. Nonetheless, this is all performed in one turn, so how does the physician know which element of the utterance the patient is agreeing on (or not agreeing)? In order to establish this, I believe there is a need for the physicians to reiterate the closure. This would sequentially ensure that the patient has agreed on the summary and agreed on the actual closure of the consultation. Initiation of closing via the other resources mentioned i.e. clarifying next steps or arranging future plans would also be subject to the same interactional sequencing.

5.1.1 CLOSING CONSULTATION ANALYSIS: STRAIGHTFORWARD CLOSURES

Extracts 5.1-5.4 present straightforward closings in so far as a clear pattern consisting of an initiation and a reiteration of closure can be identified. The nurse initiates the closing, and the patient accepts this closure (marked in bold on the transcripts). This is followed by the nurse reiterating the actual closure and the patients accepting it by either physically standing up or collecting their belongings (marked in bold and italics on the transcripts).

Extract 5.1
(N: nurse, P: patient)

The patient in extract 5.1 has had diabetes for approximately 5 years. His test results have come back satisfactory and the nurse has also performed a foot test and weight check standard to this type of routine consultation.

01 (1.0)
02 N: **right↓** I think from my perspective that really sums every
03 everything up ‘ave you **got any questions** for me or any
04 worries o:rrr anything
05 P: **no**
06 N: no
07 P: I’m all right, I’m all right
08 N: ok ummm so:: ***carry on as you are doing*** basically(.)umm
09 you know where to find me if there’s a problem any
10 trouble be yer diabetes, feet, breathing(.) there’re them
11 pots for the urine samples ((hands over containers))
12 P: ***yeah***
13 N: ok ye know yer happy with what you’re doing with that
14 P: yeah
15 N: ummm and ***we’ll see you in six months time*** for your
16 breathing an for yer diabetes
17 ***((patient stands up))***
18 N: yer’ all right
19 P: yes dear
20 N: coo:l
21 (2.0) ((patient getting his belongings))

The nurse initiates the closing environment, with a “right” in line 2, following a pause in line 1. This “right” is immediately followed by a statement noting explicitly that she has completed everything she needed to from her perspective (line 2-3). She then provides a final concern sequence in line 3 (“any questions?”). The patient responds in line 5 with the preferred response: “no” and the nurse repeats this “no” aligning with the patient’s response in line 6. In line 7 the patient reassures the nurse that he is “all right”. In line 8 the nurse reiterates the closing by providing an encouraging future recommendation: “carry on doing what you’re doing” followed by the offer of interim contact if needed. The patient responds with a minimal token of acknowledgment “yeah” in line 12. The nurse then reiterates future arrangements in line 15 and the patient accepts the closing in line 17 as he physically stands up from the chair in preparation to exit. The nurse pursues agreement in line 18 and the patient produces the preferred response in line 19: “yes dear”. In line 20 the nurse provides an informal assessment and the patient starts gathering his belongings.

The initiation of closing is performed by the nurse's use of "right" (line 2) followed by a final concern sequence in lines 3-4 ("any questions, worries"). The patient answers the question/ accepts the initiation in lines 5 and 7. The nurse then reiterates the closing by mentioning a positive assessment in line 8 ("carry on as you're doing") followed by a future arrangement in line 15("see you in six months' time). The patient accepts the closure through the physical action of standing (line 17).

Extract 5.2
(N: nurse, P: patient)

The patient in extract 5.2 was diagnosed with type 2 diabetes 10 years ago. She reported during this particular visit that she has been feeling unwell generally. Her test results have come back higher than average which could be problematic. Treatment options have been discussed and the patient will be visiting another specialist for her breathing problems.

```
01        (4.0)
02   N:   so yer next review will be six months
03   P:   uh huh
04   N:   I'm just seeing that we've got a a recall for your
05        breathing we have haven't we as well in this in that next
06        one
07        (2.0)
08   N:   so you happy with what you're doing
09   P:   yeah
10   N:   urine sample
11        (1.0)
12   N:   doctor (0.5)
13   P:   yeah
14   N:   although cardiology obviously will be looking at their
15        angle an then that blood test in a month's time
16   P:   yeah
17   N:   and your urine spe specimen is fine that's not changed
18        what so ever so we're ok on that(.)right↓ anything more I
19        can for you today
```

20 *P:* ***no: I don't think [so***
21 *N:* ***[do you think we've crossed all the t's***
22 ***and dotted all the i's?***
23 *P:* ***ye[ah***
24 N: [as the saying goes all right that's lovely I'll take you
25 through back to Sarah then ((Sarah: researcher))
26 P: yeah
27 N: if that's ok she'll just ask you a few more questions(.)
28 there's yer prescriptions and uhh I'll see you soon
29 P: right ((looking at the desk))
30 N: all right are you ok
31 P: yeah the sheets that lady gave me >is that them<
32 N: yeah there
33 (2.0)
34 P: mm ((getting things together))
35 N: right thank you we've covered everything haven't we
36 P: yeah
37 N: ok ((patient walks out of room and goes next door))

Once again the closing initiation begins after a pause (line 1). In line 2 the nurse refers to the patient's next appointment indicating the start of the consultation's closing phase. The patient produces a minimal token of agreement in line 3 and the nurse offers more information about the next appointment mentioned in her previous turn (line 2). There is a silence in line 6 and the nurse decides to make sure the patient is "happy" with what she is doing (line 8). The patient offers an acknowledgment "yeah" (line 9) and the nurse proceeds to mention the future steps the patient needs to take which were discussed previously during the visit. In line 17 the nurse attempts a shutting down of the conversation by producing a final concern sequence. The patient responds with "no, I don't think so" in line 20 and the nurse pursues this further by asking the patient if she thinks they have covered everything (lines 21-22). She uses an idiomatic phrase for this: 'dot the i's and cross the t's' as a way of making sure they have been meticulous enough during the consultation. The patient responds "yeah" (line 23) accepting the closure and in line 24 the nurse agrees and makes an assessment: "that's lovely". She then proceeds to mention an immediate arrangement i.e. to take her to the researcher next door (Sarah). In line 28 she ends her turn mentioning the closing

statement “I’ll see you soon”. The patient’s response (“right”) in line 29 is not perceived by the nurse as acceptance hence, the nurse’s utterance double-checking if the patient is in fact “ok” (line 30). The patient seems to be looking for some paperwork and is getting her things together to leave, indicating that she has recognised and accepted the closure. She then starts gathering her belongings. In line 34 the nurse produces the start of the terminal exchange: “right, thank you we’ve covered everything haven’t we” to which the patient offers a minimum token “yeah” and the nurse replies “ok” in line 36. This ends the conversation and the patient stands up and leaves the room.

In this extract the nurse initiates the closing by using resources such as: scheduling next appointment in line 2 (“next review in six months”) and a final concern sequence in line 8, (“so you happy with what you’re doing”). The patient accepts the initiation via the future arrangement in line 3 (“uh-hu”) and the final concern sequence in line 9 (“yeah”). The nurse then reiterates the closure by using another final concern sequence in line 18 (“anything more I can do for you today”) followed by yet another final concern sequence in line 21 (“ do you think we’re crossed all the i’s.). The patient accepts the closure in lines 20 and 23 enabling the successful completion of the consultation.

Extract 5.3
(N: nurse, P: patient)

The patient below has had type 2 diabetes for 7 years. His test results have come back higher than expected and a few options in term of managing this have been discussed. The nurse also completed the standard tests that are routinely performed as part of these consultations.

```
01          (5.0)
02    N:    right so we've done urines we've done foot check(.)
03          your eye screening is up to date(.) we've done
04    P:    weight
05    N:    weight(.)BP(.)told ye about that(.)blood test in three
06          months time
```

07 P: right
08 N: sorted your prescription so anything else I think we've
09 pretty much covered everything
10 P: **nice one yeah**
11 N: yeah do you(.)not have ***anything else you want to ask me***
12 ok
13 P: ***don't think so***
14 N: ***right marvellous*** I'll let Sarah have ye' ((pointing next
15 door))
16 P: ***right ((patient collecting his things))***
17 (2.0)
18 P: right thanks Bev ((standing up))
19 N: you're welcome
20 P: see ye later
21 N: all: right have a good 'oliday
22 P: bye
23 N: bye bye

After a significant pause (line 1) the nurse initiates the closing by summarizing what has been done (White et al 1997) particularly around the tests which were performed as part of the patient's chronic check-up consultation (lines 2-3). The patient aligns his response to the nurse's and collaborates by mentioning an additional test which was also done (weight check). In lines 5-6 the nurse proceeds to stating future arrangements specifically the recommendation of another blood test in 3 months' time. The patient accepts the recommendation in line 7. In line 11 the nurse pursues the closing further with a final concern sequence "anything else". The patient responds in line 13 with "I don't think so" and the nurse is satisfied with that response, hence proceeding to her next closing resource in line 14 where she produces a "right" followed immediately by a positive assessment ("marvellous"). The patient identifies the closure and accepts it in line 16. He repeats the nurse's "right" and starts collecting his belongings, again indicating that he is getting ready to exit the consultation room.

The nurse initiates the closing with a "right" (line 2), summarising the visit (lines 2-6) and producing a final concern sequence (line 8). The patient accepts the initiation via the summary in line 10 ("nice one, yeah"). The nurse reiterates the

closing by using another final concern sequence (line 11) and a positive assessment (line 14). The patient accepts the final closure with “right” (line 16) immediately followed by a physical action of collecting his belongings.

Extract 5.4
(N: nurse, P: patient)

The patient in extract 5.4 was diagnosed with type 2 diabetes a year ago. His test results have come back higher than desired and there has been discussion regarding his diet and its impact on his high blood sugars. A course of action has been agreed that involves changing some of his daily eating habits.

```
01        (1.0)
02   N:   are we happy then [are
03   P:                     [yesss
04   N:   we with uh every[thing
05   P:                   [yes I do the
06   N:   that we talked about for now ok [blood test like ye say
07   P:                                   [I'll put it on me
08        calendar
09   N:   an then we'll take it from there
10   P:   I'll put it on me calendar to uh ring down for an
11        appointment in mid October
12   N:   okie doks
13   P:   an' we'll see what happens
14   N:   yeah yeah more late really just cause we don't we want to
15        get rid of these
16   P:   NO I'll RING in mid October
17   N:   yeah ring in mid October
18   P:   so cause by the time I ring in mid October >it'll be a week
19        before I can an appointment anyway< so
20   N:   yeah it's true that though cause we don't want any of these
21        high blood sugars being on that
22   P:   no
23   N:   right [ok
24   P:        [ok marvellous ((collecting his belongings))
25   N:   so we'll take it from there, I'll take ye through to Sarah
26        if that's ok
27   P:   yeah that's fine ((starts standing up))
```

28 N: thank you for that an' I'll see y' soon ((nurse stands up))
29 N: I'll just turn this off ((nurse approaches camera))

The nurse initiates the closure in line 2 following a pause (line 1) by asking the patient if he is happy with everything (lines 2 and 4) which has a similar function to the final concern sequence, but prefers a "yes" response. The patient provides the preferred response in overlap (lines 3 and 5). The nurse then produces a future arrangement in the form of a recommendation which is to repeat his blood test (line 6). The patient accepts the recommendation and suggests a further action of putting in his calendar to call for an appointment. In lines 14-20 the nurse and the patient are negotiating the exact time to call to book an appointment, and having agreed on a time the nurse provides another closing "right ok" with falling intonation in line 23. In line 24 the patient accepts the closing and in fact overlaps repeating "ok". Immediately following this the patient provides a positive assessment and starts gathering his belongings. The nurse reiterates a future arrangement in line 25 and the patient accepts this final closure (line 27) while standing up. He has fully accepted that the consultation is finalising and he is getting ready to exit the consultation room.

The closing initiation is done by the nurse's use of a final concern sequence in lines 2-4 ("are we happy with everything") followed by future arrangement (line 6). The patient accepts the initiation via the acceptance of the future closing sequence in line 5 ("yes…") and the future arrangement in line 10 ("I'll put it my calendar"). In line 23 the nurse proceeds to reiterate the closing with a "right ok". The patient accepts the final closure with a positive assessment immediately followed by the physical action of gathering his belongings (line 24).

5.1.2 CLOSING CONSULTATION ANALYSIS: SEVERAL ATTEMPTS

In extracts 5.5-5.11 the nurse has to produce several attempts of closing initiation in order for the patient to finally accept the consultation closure.

Extract 5.5
(N: nurse, P: patient)

The patient in this extract has recently been diagnosed with type 2 diabetes. Her test results have come back satisfactory and she is doing well with her current treatment. The nurse is trying to close the consultation, however, several attempts are required.

```
01        (1.0)
02   N:   for now we'll just leave things as they are with yu with
03        yer treatment(.)but when we come to do that final test at
04        the end of the twelve weeks umm that'll really sort of
05        decide as to what stage what step we take next time, all
06        right
07        (2.0)
08   N:   err um[mm
09   P:         [I shall be seeing you next week I think it is for me
10        ((jab movement))
11   N:   oh:: for what ((looking at computer))
12        (2.0)
13   P:   that B one
14   N:   oh:: for your B twelve(.)right ok
15   P:   yeah
```

All the tests have been done, so the nurse introduces a future action in lines 2-5 in the form of a recommendation. This future arrangement sets the initiation of the consultation's closing phase (Schegloff & Sacks 1973) and she seeks an acceptance from the patient in line 5-6 ("All right"?). The patient does not reply with the expected acceptance tokens (e.g. okay, all right, yeah) and there is a significant pause in line 7. The patient has not accepted the nurse's future-arrangement sequence as a means of creating a closing-relevant environment (Robinson 2001a). The nurse then initiates more talk in line 8 with some hesitation and the patient overlaps slightly in line 9 mentioning that she will be coming in for a jab next week, initiating another topic, but implicitly acknowledging that the topic is future arrangements. This initiation of topic could be seen as a way of recognising the closure. According to Jefferson (1983)

managing topic shifts is a common practice when closing conversations. However, the closure does not occur and there is a further initiation from the nurse to close the conversation by using a final concern sequence (Robinson 2001a) in the extract below.

Extract 5.6

(N: nurse, P: patient)

(2.0)
N: **so anything you need to ask me** then about anything
(1.0)
N: err uhhh
(2.0)
N: I know we've sort of **explained along the way haven't we**
(1.0)
P: no: <I sort of seem> ye kn[ow
N: [ok
P: all right
N: yeah **we seem to be doing all right** but we'll wait for that final blood test result and **everything else is all in place** so when you know with all screening and everything so::
P: they call me wonder woman >up our end<
N: do they yeah
P: she's 'ere wonder woman
N: he he he
P: ah: I mean uhh all my friends we're all in they're all in eighties like ye know
N: yeah
P: and I think I'm fittest of ALL [them
N: [are y' really well done you
P: ye know
N: mm
P: ye know oh dear oh dear all moaning
N: it's a state of mind sometimes isn't it
P: [yeah
N: [it's a state of mind so
P: yeah you know you just ger' on with it can't do nowt about it
N: yeah, it happens to us all in't it the aging process yeah
P: **yeah I mean me mum lived to be eighty-nine ye' know**

```
33   N:   so you've got genes there haven't you as well
34   P:   errr uhh
35        (2.0)
36   P:   I mean all me brothers both me brothers lived to be eighty
37        six but me dad died when he was uhh thirty nine
```

In line 1 there is a pause and in line 2 the nurse attempts to close the conversation again by using a final concern sequence. The final concern sequence (Robinson 2001a) in the format "anything else?" is designed to prefer a "no" response, hence its use to terminate a conversation (Heritage and Robinson 2006). However, the patient still does not respond with the preferred "no", instead there is a pause in lines 3 and 5. The nurse initiates further talk in line 6 referring to how they have had talks in the past about issues. She summarises their previous encounters and at the end of her turn says: "haven't we?" overtly seeking a yes preferring response from the patient. In addition, she also leaves some time and pauses in order for the patient to agree (line 7). In line 8 and 10 the patient replies that she seems "all right" and the nurse provides a further summary (lines 11-13) of the current situation and next steps, reiterating future arrangements. This summary is a further attempt of shutting down the conversational topic (West & Garcia 1988). Nevertheless, the patient's response in line 14 is still on the topic of her "feeling all right" and she provides an account with her own evidence that proves her wellbeing i.e. her friends call her "wonder woman". This is followed by another account in lines 18 and 21 where she explains that she is the "fittest" of her friends who are all in their eighties. The nurse acknowledges the patient's account and aligns her response in line 26 and 28 noting that age can be a state of mind. In line 32 the patient shifts topic slightly and pursues the topic of aging explaining her family history.

This shift has not created the relevant closing environment therefore, the conversation is not closed. The topic has indeed shifted, but it has not served the purpose of closing, quite the opposite, as the patient elaborates further on her family history, their illnesses and their subsequent deaths. Finally, in the extract below the patient accepts the closure after a further attempt from the nurse to close the consultation.

Extract 5.7

(N: nurse, P: patient)

```
01          (1.0)
02    N:    ((exaggerated nod)) right↓ well keep up the good work then
03          you're doing well
04          ((patient stands up to put jacket on))
05    P:    no no good moaning you can't do nowt about it you got to 06
just ger' on with it
07    N:    no(.) it's good that you don't
08          (4.0) ((patient putting on jacket))
09    N:    so I shall see you then ok
```

The patient has just finalised a story about how her father died of cancer when he was very young. The nurse makes a final initiation of closing after a short silence (line 1) with a gesture followed by a "right". The gesture consists of an exaggerated nod which indicates affiliation with the patient's story (Stivers 2008) displaying an endorsement to it. However, in this case the nod comes after the story is finalised not in mid-storytelling. Therefore, indicating affiliation to the end of the story or the story as a whole. In addition, the exaggerated manner in which the gesture is delivered suggests an understanding that the story is complete. This is evidenced by the silence produced in line 1 and lack of continuing talk by the patient.

The nurse's "right" (line 2) is followed by a statement of encouragement: "keep up the good work" in line 2 and an assessment: "you're doing well" in line 3. In this instance the patient identifies and accepts the closure of the consultation, as she physically stands up and starts reaching for her jacket (line 4). In line 5 the patient provides a response to the nurse's assessment in the previous turn (line 3) in the form of a 'life-style principle' ("just get on with it"). The nurse replies in line 7 by starting to compliment the patient however, her turn is not grammatically complete and the patient starts putting her jacket on accepting the final closure. After the patient has put her jacket on, 4 seconds later, the nurse moves on to the terminal exchange.

The nurse initiates the closing by using “right” (line 2) followed by a positive assessment (line 3). The patient accepts the closure by physically standing up (line 4). The nurse reiterates the closing by using a positive assessment (line 7). The patient accepts the final closure through physical action of putting her jacket on getting ready to leave (line 8).

Extract 5.8
(N: nurse, P: patient)

The patient in the extract below has only recently been diagnosed with type 2 diabetes (two months ago). She admits being in denial about her illness. However, the nurse still has performed the routine checks. Having completed these checks, the nurse is trying to initiate the closing of the consultation. Nevertheless, the patient is either not identifying this initiation of closure or is not accepting the closure yet.

```
01        (3.0) ((Nurse checking file on computer))
02   N:   so we've done the two urines as well haven't we
03        (1.0)
04   P:   yeah
05   N:   yeah so like I say we've done [everything
06   P:                                 [and they were clear
07   N:   wonderful
08       (25) ((Nurse typing on computer, updating records))
19   N:   these results will be back in a couple of days ok
10   P:   right
11   N:   so like I say I can't imagine it's jst sud'ly gone sky high
12        [so we'll say now
13   P:   [sure
14   N:   unless you need us for anything is that we'll see ye six
15        monthly if a recall's not set up already to call ye I'll
16        make sure that one's in now
17   P:   yeah
18   N:   so [it's once a year
```

P: [it's no point me taking an appointment now cause be February cause that's when it'll be I'll have forgot
N: right ok what I'll do uhhm (0.8)
P: I came (0.5) the other day
N: did you(.) you got yer days muddled
P: muddled frm I got it up on on shelf and I looked and I says due on the seventh but what they'd put is the eleventh
N: ohh right
P: where I were looking
N: [from a distance
P: [I were looking at were looking at that the seventh
N: he he he
P: yeah
N: well let me just get yer yer record back up err for yer medication umm that you're on yer repeats
(2.0)
N: what we'll do is because we send an annual recall out but we like to see you twice a year
P: yeah
N: of which we don't send a recall out for so what I'll do is **I'll update yer medication now for six months**(.) so you'll see the count down on your repeat side of your prescription to know how many prescriptions you've got remaining
(1.0)
N: so does that make sense
P: uhh I nev I never seen it
N: so that you know they're getting down **we're putting a note saying ye need you're review then that's yer prompt for yer February review**
P: well Boots will tell [me
N: [right
P: I jst leave it to Boots cause they make my prescriptions up
N: yeah
P: ye know
N: so yeah people jog yer memory and if if you don't see yer repeat [side
P: [I believe I owe my life to Boots
N: do ye
P: umm because that Clopidogrel that Mary put me on for nine months

61 N: mm
62 P: they kept me on it TWO years here

Following a silence in line 1 while the nurse looks at the patient's file on the computer, the nurse initiates the closing environment in line 2 by noting that the tests are done and in line 5 she overtly mentions that she has "done everything". In addition, the nurse explains when the results should be back and what to expect. In line 14 the nurse initiates the closing again by mentioning the patient's future appointment, unless she has any problems in the interim. The patient replies in line 19 with an account detailing how she will forget if she books her next check-up appointment now. This becomes a topic and in line 22 the patient starts offering a narrative on how she got the date wrong for her previous appointment. In line 33 the nurse initiates a change of topic by using a turn initial "well". This indicates the departure from the previous topic (Heritage 2015). She suggests reviewing the patient's prescription and in lines 39-43 she determines a course of action specifically updating her prescription for the next six months. Following a silence in line 40 the nurse requests an acceptance from the patient regarding her course of action suggested in lines 39-43. There is no acceptance from the patient, instead in line 46 the patient notes that she has never seen the count down on her prescriptions, indicating that this action will not work for her. The nurse then suggests a note on the prescription to remind the patient of her next review appointment in February (lines 47-49). The patient notes in line 50 that the pharmacy (Boots) will remind her. The nurse aligns her response to the patient's in lines 55-56, however, in line 57 the patient overlaps slightly with the nurse and initiates a new topic about how the pharmacy (Boots) saved her life. This narrative continues and the closing initiation is not achieved. Nevertheless, the nurse attempts another closing following the patient's narrative in the extract below.

Extract 5.9
(N: nurse, P: patient)

The patient finally accepts the closure.

01 N: **right ok are we all right with everything** then so er uh
02 **((patient starts collecting belongings))**
03 like I say about Thursday half day ring up Friday for
04 your results and if everything's all right we'll see ye in
05 February you'll need to come for ye flu jab though in
06 the meantime(.)>are you having ye flu jab<
07 P: ah October
08 N: start about October for that so ok is that right
09 P: yeah I usually book us both in for that
10 N: yeah good stuff so er ***I'd perhaps see you on a Saturday***
11 clinic for that(.)so:
12 ***((patient stands up))***
13 N: I'll take you through, Sarah's just next door

In line 1 the nurse initiates a further attempt in initiating the closing of the consultation with: "right, ok" indicating a shift in topic and activity followed by a final concern sequence ("are we all right with everything"). This time the patient identifies the closure and accepts it, evidenced by her starting to collect her belongings. The nurse proceeds with future arrangements (lines 3-6) in particular the patient's flue jab which will be due soon. The patient replies in agreement (line 7 and 9). The nurse provides an assessment in line 10 ("good stuff") and then reiterates a future arrangement of maybe seeing the patient when she is in for her flu jab on Saturday clinics. At that point the patient stands up indicating that she is fully aware the consultation is finalised and she is ready to leave. The nurse then also stands up and they both exit the consultation room.

The nurse uses "right ok" (line 1) to initiate the closing, followed by a final concern sequence in line 1 ("are we all right with everything"). The patient accepts the initiation of closure by the physical action of collecting her belongings (line 2). The nurse then reiterates the closing by mentioning a future arrangement in line 10 ("perhaps see you on a Saturday clinic"). The patient accepts the final closure through the physical action of standing up (line 12).

Extract 5.10
(N: nurse, P: patient)

The patient in the extract 5.10 was diagnosed with type 2 diabetes 4 years ago. In addition, she has other underlying health conditions. The nurse has completed the routine tests as part of the check-up consultation. The nurse is attempting to initiate the closing by using a final concern sequence. However, this resource does not provide the expected closure, instead it produces a re-initiation of another topic.

```
01        (0.8)
02   N:   so eye screen is done(.)we've done yer foot check(.)yer
03        blood pressure is great(.)weight we've discussed(.)yer
04        blood tests are all all right
05   P:   yes
06   N:   umm asthma check we've done so is there anything else
07        that you think I should've done that I've not done
08   P:   no I think that's all int' it
09   N:   you just mentioned [tablets
10   P:                       [just tablets
11   N:   yeah I'll update everything there
12   P:   they seem all right
13   N:   ok so I don't think anything's changed has it
14   P:   no
15   N:   I'm just going to look at the screen just run down and an
16   P:   [yes
17   N:   [just to make sure everything's correct
18   N:   got yer amitriptylin
19   P:   yes
20   N:   that ye take at night(.)yer bendroflumethiazide(.)yer
22        citalopram(.)ye co-codamol(.)yer calcium tablets are on
23        there
```

Following a short pause in line 1 the nurse initiates the closing by summarizing what has been done particularly around the tests which were performed as part of the patient's check-up consultation (line 2-4). The patient agrees in line 5 and the nurse then provides a final concern sequence i.e. asking the patient if there is anything else she should have done. The format "anything else?" is designed to

prefer a “no” response, hence its use to terminate a conversation (Heritage and Robinson 2006). The patient produces the preferred response in line 8: “no, I think that’s it, in’t it”. However, the nurse then recalls that the patient had previously mentioned her tablets which the patient also recalls in overlap (lines 9 and 10). This introduces a new topic in terms of checking the patient’s medication and prescriptions. In line 15 the nurse explicitly states that she is going to run through all the patient’s medications to check they are all in order. She then proceeds to list all the tablets needed. Therefore, the consultation is not finalised and the nurse will have to make another attempt in closing the talk.

Extract 5.11
(N: nurse, P: patient)

The nurse pursues the closing initiation having already dealt with the previous topic about the patient’s tablets and this time the patient accepts the closure.

01 N: they’re all doing what they’re prescribed for
02 P: yes
03 N: I’ll update all of those for another six months for you(.)
04 right marvellous ok and you’re all right for yer
05 prescription today or do you need it
06 P: yes I’m all right
07 N: **ok that’s great so wonderful**
08 P: yeh
09 N: **right so we’ve done everything**
10 P: **right**
11 N: so ***we’ll see ye in six month’s time*** I hope everything
12 goes well for ye
13 P: ***so do I ((laughs and stands up))*** *mind you* ***I might be seeing***
14 ***you in September***
15 N: yeah I’ll see you September

After updating the patient’s medications the nurse attempts another closing initiation by summarising what she has done in line 3 followed by a “right” (falling intonation) and by a short assessment “marvellous” (line 4). She then asks the patient a question about needing her prescription today which has a

final concern sequence function. The question prefers a 'yes' response as it is phrased almost like a statement: "and you're all right for yer prescription today". The patient provides the preferred response in line 6. The nurse follows this up by another assessment (line 7) and again repeats the "right" with falling intonation (line 9). The patient accepts the closing initiation repeating the word "right" (line 10). The initiation of closing has begun evidenced by neither of the speakers choosing or caring to continue that topic (Schegloff and Sacks 1973). This allows the nurse to reiterate her closing by mentioning a future arrangement of seeing each other in six months (line 11) which is initiated by "so" and "well" indicating a shift towards closing. The patient is assured that the consultation has ended and she proceeds to reply while she stands up ready to exit the consultation room.

The initiation of closing is done by the nurse's use of a positive assessment in line 7 ("ok that's great so wonderful") followed by an assurance that everything has been covered in line 9 ("right so we've done everything"). The patient accepts the closure initiation by agreeing with the nurse's assurance in line 10 ("right"). The nurse proceeds to reiterate the closing by mentioning a future arrangement in line 11 ("so well see ye in six months' time") and the patient accepts the final closure by physically standing up and mentioning another future arrangement in line 13 ("I might be seeing you in September").

5.1.3 SUMMARY OF EXTRACTS ANALYSED

Extracts 5.5-5.11 are examples that demonstrate that within chronic diabetes routine check-ups, closing the consultations is attained by initiating a closing environment via the use of several closing resources followed by a reiteration of the closure with additional closing resources.

The nurse will initiate the closing by either summarising the visit, providing a recommendation, reviewing the future treatment, checking the patient's prescription, making future plans, or scheduling the next visit. The patient will

identify the initiation of the closing resource and at some point accept it. The nurse will reiterate that the visit is closing assuring the patient that the consultation is finally over and the patient will in turn accept this final closure. The next section will present examples of specific closing resources as seen in this data set.

5.2 SPECIFIC CLOSING RESOURCES

There are several closing resources which have been well documented and are also present in this data set. These resources for closure are: summarising the visit, making future arrangements, reviewing the treatment plan or medication, scheduling the next visit, and producing a final concern sequence (Robinson 2001a, White et al 1997, West 2006). However, in this data, lexical items such as "right" produced with a falling intonation also have a closing function in so far as they indicate the closing of one activity and the start of another.

5.2.1 USE OF "RIGHT"

I will present 10 examples (extracts 5.12-5.21) where "right" with a falling intonation is used as a closing initiator by indicating the completion of the previous activity.

Extract 5.12
(N: nurse, P: patient)

```
01          (1.0)
02    N:    ((exaggerated nod)) right↓ well keep up the good work then
03          you're doing well
04          ((patient stands up to put jacket on))
```

Extract 5.13

(N: nurse, P: patient)

```
01        (1.0)
02   N:   right↓ I think from my perspective that really sums every
03        everything up have you got any questions for me or any
04        worries orrr anything
05   P:   no
06   N:   no
07   P:   I'm all right, I'm all right
```

Extract 5.14

(N: nurse, P: patient)

```
01   N:   and your urine spe specimen is fine that's not changed
02        what so ever so we're ok on that(.)right↓ anything more I
03        can for you today
04   P:   no I don't think [so
05   N:                    [do you think we've crossed all the t's
06        and dotted all the i's
07   P:   yeah
```

Extract 5.15

(N: nurse, P: patient)

```
01   P:   yeah the sheets that lady gave me is that them
02   N:   yeah there
03        (2.0)
04   P:   mm ((getting things together))
05   N:   right↓ thank you we've covered everything haven't we
06   P:   yeah
07   N:   ok ((patient walks out of room and goes next door))
```

Extract 5.16

(N: nurse, P: patient)

```
01       (5.0)
```

02 N: **right↓** so we've done urines(.)we've done foot check(.)
03 your eye screening is up to date(.)we've done
04 P: weight
05 N: weight(.)BP(.)told ye about that(.)blood test in three
06 months' time

Extract 5.17

(N: nurse, P: patient)

01 N: yeah do you(.)not have anything else you want to ask me
02 ok
03 P: don't think so
04 N: **right↓** marvellous I'll let Sarah have ye' ((pointing next
05 door))

Extract 5.18

(N: nurse, P: patient)

It is not only the nurse that produces "right" in order to indicate closure. In line 3 and 5 the patient also indicates closure with "right".

01 N: **right↓** marvellous I'll let Sarah have ye' ((pointing next
02 door))
03 P: **right↓** ((patient collecting his things))
04 (2.0)
05 P: **right↓** thanks Bev ((standing up))
06 N: you're welcome

Extract 5.19

(N: nurse, P: patient)

01 N: yeah it's true that though cause we don't want any of these
02 high blood sugars being on that
03 P: no
04 N: **right↓** [ok
05 P: [ok marvellous ((collecting his belongings))
06 N: so we'll take it from there

Extract 5.20

(N: nurse, P: patient)

```
01   N:   right↓ ok are we all right with everything then so er uh
02        ((patient starts collecting belongings))
```

Extract 5.21

(N: nurse, P: patient)

```
01   N:   right↓ so we've done everything
02   P:   right
03   N:   so we'll see ye in six months' time I hope everything
04        goes well for ye
05   P:   so do I ((laughs and stands up))
```

The "right" in these exchanges indicate that a certain point or matter within the conversation has been concluded. They function like a discourse marker denoting a certain relationship between two segments where their interpretation is both context and linguistically bound (Fraser 1999). This closing lexical item "right" has a similar function to other closing lexical items such as "okay" and "well" (Schegloff and Sacks 1973, Goldberg 2004). The "right" in these interactions are not isolated agreement tokens, they display a sequential end of one topic and a start of a new one. This is evidenced by the 10 examples (extracts 5.12-5.21) presented where one topic or activity is closed by the use of "right" and another is initiated. Moreover, the patients orient their talk or behaviour towards the closing. This is done by either agreeing with the nurse (extracts 5.13, 5.14, 5.15, 5.16, 5.19, 5.21) or by physically orienting their behaviour ready for the closure, for instance gathering belongings or standing up (extracts 5.12, 5.17, 5.18, 5.19, 5.20).

5.2.2 USE OF POSITIVE ASSESSMENTS

In addition to the use of "right" as a closing activity device, positive or encouraging assessments are also used as a closing resource in this data set. I will present 8 extracts (5.22-5.29) where this occurs.

Extract 5.22

(N: nurse, P: patient)

```
01          (1.0)
02    N:    ((exaggerated nod)) right↓ well keep up the good work then
03          you're doing well
04          ((patient stands up to put jacket on))
```

Extract 5.23

(N: nurse, P: patient)

```
01    P:    I'm all right(.)I'm all right
02    N:    ok ummm so:: carry on as you are doing basically umm
03          you know where to find me if there is a problem any
04          trouble be yer diabetes(.)feet(.)breathing
```

Extract 5.24

(N: nurse, P: patient)

```
01    N:    do you think we've crossed all the t's and dotted all the
02          i's
03    P:    ye[ah
04    N:      [as the saying goes all right that's lovely I'll take
05          you through back to Sarah then
```

Extract 5.25

(N: nurse, P: patient)

```
01    N:    yeah do you(.) not have anything else you want to ask me
02          ok
```

03 P: don't think so
04 N: right↓ **marvellous** I'll let Sarah have ye'

Extract 5.26
(N: nurse, P: patient)

01 P: yeah I usually book us both in for that
02 N: yeah **good stuff** so er I'd perhaps see you on a Saturday
03 clinic for that(.)so:
04 ((patient stands up))

Extract 5.27
(N: nurse, P: patient)

01 N: I'll update all of those for another six months for you
02 right↓ **marvellous** ok and you're all right for yer
03 prescription today or do you need it
04 P: yes I'm all right
05 N: ok **that's great so wonderful**
06 P: yeh

Positive assessments are not only used by the nurse, they are also used by the patients in the closing phase of the consultations. For instance:

Extract 5.28
(N: nurse, P: patient)

01 N: yeah it's true that though cause we don't want any of
02 these high blood sugars being on that
03 P: no
04 N: right↓ [ok
05 P: [ok **marvellous** ((collecting his belongings))
06 N: so we'll take it from there

In line 5 it is the patient that provides an evaluation following the nurse's "right ok" in the previous turn (line 4).

Extract 5.29

(N: nurse, P: patient)

```
01   N:   sorted your prescription so anything else I think we've
02        pretty much covered everything
03   P:   nice one yeah
```

In line 3 the patient provides a positive assessment as a means of acknowledging that everything has indeed been covered satisfactorily.

These assessments are similar to what Antaki et al (2000) refer to as turn initial high-grade assessments. In his paper, positive assessments produced by interviewers after answers from interviewees were analysed. It was demonstrated that these assessments mark a transition from one topic to another rather than merely assessing a response, which makes them talk-oriented instead of content oriented.

In further work on positive assessments Antaki et al (2000) argues that they not only have the function of positively reviewing the visit, they also signal a closing that might have been previously 'suspended'. Hence their occurrence during the closing phase. Correspondingly to the data in Antaki (2000) this study demonstrates that some of the positive assessments occur as a way of resuming the initial closing sequence.

The data in this study shows that positive assessments can be used as a closing resource. They signal a transition from one topic to another and can be used as a resource to reinitiate a closing that has been previously suspended. Furthermore, their function of assessing and reviewing is also conducive to closing, as one of the ways in which physicians initiate the closing phase of the consultations is by summarising and reviewing the visit. In these cases using a positive assessment would be an effective way of displaying a positive summary of the visit as well as indicating closing.

5.3 NON IDENTIFICATION OR ACCEPTANCE OF CLOSURE

Despite the use of several different closing resources (White et al 1997) there are cases where patients either do not identify or do not accept the closing phase of the consultation and until they do the physician will have to make several attempts to pursue the closure.

Extracts 5.30-5.32 demonstrate that patients sometimes do not recognise or accept the nurse's closing and instead, resist the closing with a non-acceptance or shift to another topic.

Extract 5.30
(N: nurse, P: patient)

```
01          (2.0)
02    N:    so anything you need to ask me then about anything
03          (1.0)
04    N:    err uhhh
05          (2.0)
06    N:    I know we've sort of explained along the way haven't we
07          (1.0)
```

The patient does not provide a response to the final concern sequence initiated by the nurse. Instead there is some resistance via the use of silence in lines 3, 5 and the more silence in line 7.

Extracts 5.31
(N: nurse, P: patient)

```
01    N:    yeah we seem to be doing all right but we'll wait for that
02          final blood test result and everything else is all in place
03          so when you know with all screening and everything so::
04    P:    they call me wonder woman >up our end<
05    N:    do they Yeah
```

The nurse attempts another closing in lines 1-3 by assessing and establishing the future arrangement of waiting for the blood test as all else in in place. The elongated "so" at the end of line 3 suggests a transitional relevance place for the patient to accept the recommendation mentioned above, however, the patient does not accept it and shifts the topic in line 4.

The patient starts a new topic about how she is the "fittest" of all her friends. She then proceeds with an account regarding her family members' health (see section 5.1.2, extract 6 for the full account). Eventually there is 1 second of silence where the nurse produces a "right" followed by a positive assessment and the closure finally gets resolved.

```
(1.0)
01   N:   right↓ well keep up the good work you're doing well
02   P:   no no good moaning you can't do nowt about it you got to
03        just get on with it
04   N:   no(.)it's good that you don't
05        (1.0) ((patient putting on jacket))
06   N:   so I shall see you then on
```

The patient has finally accepted the closure after several attempts from the nurse. This is evidenced by the patient's action of standing up and starting to put her jacket on in line 5 indicating that she is getting ready to leave.

Extract 5.32
(N: nurse, P: patient)

```
01   N:   so that you know they're getting down we are putting a
02        note saying ye need you're review then that's yer
03        prompt for yer February review
04   P:   well Boots will tell [me
05   N:                        [right
06   P:   I jst leave it to Boots cause they make my prescriptions up
07   N:   yeah
08   P:   ye know
```

09 N: so yeah people jog yer memory and if if you don't see yer
10 repeat [side
11 P: [**I believe I owe my life to Boots**
12 N: do ye

In line 1 the nurse is finalising future arrangements for the patient's next review. The patient will be reminded of her next appointment via her prescription. In line 4 the patient accepts the arrangement and in lines 9-10 the nurse agrees. However, the conversation does not conclude, the patient does not accept the final arrangement as closure and shifts to another topic, mentioning an account where the pharmacy saved her life in line 11.

She proceeds with her account for over 1 minute and eventually after some laughter from both speakers the nurse attempts to reinitiate the suspended closing by producing a "right".

01 N: right↓ ok are we all right with everything then so er uh
02 **((patient starts collecting belongings))**
03 like I say about Thursday half day ring up Friday for
04 your results and if everything's all right we'll see ye in
05 February you'll need to come for ye flue jab though in
06 the meantime >are you having ye flue jab<
07 P: ah October
08 N: start about October for that so ok is that right
09 P: yeah I usually book us both in for that
10 N: yeah good stuff so er I'd perhaps see you on a Saturday
11 clinic for that(.)so:
12 ((patient stands up))
13 N: I'll take you through(.)Sarah's just next door

The patient finally accepts the closure evidenced by her action of collecting her belongings in line 2, and getting ready to exit the consultation room. There is some further talk about future arrangements while the patient is collecting her things, and then she stands up in line 12.

There are also cases where the closing phase of the consultation has started, but the final concern sequence ("anything else?") does not serve the purpose of closing and instead opens up a question or a new topic, as per the extracts 5.33 and 5.34 below.

Extract 5.33
(N: nurse, P: patient)

01	N:	umm asthma check we've done so **is there anything else**
02		that you think I should've done that I've not done
03	P:	no I think that's all int' it
04	N:	you just mentioned [tablets
05	P:	[just tablets
06	N:	yeah I'll update everything there
07	P:	they seem all right
08	N:	ok so I don't think anything's changed has it
09	P:	no
10	N:	I'm just going to look at the screen just run down and

The nurse's question "is there anything else" in lines 1-2 does not result in the closing of the consultation, but in a check of all the patient's tablets and a full update of these on her file, including a concern from the patient as to the number of tablets she is taking and how she would like to reduce these. After checking all the tablets on the patient's prescription and updating them for the next 6 months the nurse attempts a closure by the use of a positive assessment followed by a "right".

01	N:	I'll update all of those for another six months for you
02		right↓ **marvellous** ok and you're all right for yer
03		prescription today or do you need it
04	P:	yes I'm all right
05	N:	ok **that's great so wonderful**
06	P:	yeh
07	N:	right↓ so we've done everything
08	P:	**right**

09 N: so we'll see ye in six months' time I hope everything
10 goes well for ye
11 P: so do I **((laughs and stands up))** mind you I might be seeing
12 you in September
13 N: yeah I'll see you September

The patient agrees on the closure in line 8 by also using "right" and in line 11 she stands up getting ready to leave the consultation room.

Extracts 5.34
(N: nurse, P: patient)

01 (2.0)
02 N: **anything else**
03 (2.0)
04 N: you thought I were gonna do and I've not done it or
05 uhhh you wanted to ask
06 P: no: uhh what were my bloods
07 N: thee:
08 P: last
09 N: blood result was seventy-five on the HbA1c
10 P: oh right
11 N: yeah
12 (1.0)
13 N: so ye know if you want one re-checking umm in three
14 months you're more that welcome to
15 P: yeah
16 N: get another blood test so if you can tweak any

The nurse initiates the closing with the final concern sequence "anything else" in line 2. The patient starts her turn with the preferred response "no". However, she hesitates and proceeds by asking what was her last blood count. The nurse responds in line 9 with the last blood result as requested by the patient: Seventy-five. This figure is a high reading for a diabetic patient and the patient accepts the information with an: "oh right". This "oh "acknowledges the information given as new and acts like a 'change of state token' (Heritage, 1998). There is a pause and the nurse recommends a course of action to try and improve the

patient's next blood test (line 13). This becomes a new topic and therefore consultation is not closed.

After discussing a potential new blood test the nurse tries to change the topic and reinitiate the closure by producing a "right" in line 2.

```
01   P:   yeah I think so
02   N:   right↓ and you're all right for yer prescriptions are we up
03        to date
04   P:   umm
05   N:   on those you're not quite due yet are ye
06   P:   no: next week
07   N:   >they're not coming on screen anyway<
08   P:   but then I've got to take some cause I'm away for-
09   N:   ok your Anne will sort ye will she
10   P:   °yeah
11   N:   okie dokie
12   P:   ok ((gathering her belongings))
13   N:   right lovely
14   P:   nice to see you
15   N:   and you:
```

Having reviewed the blood tests and arranged for another test the patient accepts the closure of the consultation in line 12 by gathering her belongings indicating that she is getting ready to leave.

Initiating and reiterating closing within routine diabetic consultations is a useful resource for practitioners to use when wanting to close a consultation successfully. It provides a clear warrant of the closing, avoiding any ambiguity about whether the visit is being terminated or not. It also gives patients space to ask questions or raise unmet concerns between the initiation and the reiteration. Once the closing has been accepted participants can proceed with the terminal exchange. However, the data shows that in some of these consultations the terminal exchange is noticeably absent as per discussed in the next sections (5.3.1 and 5.3.2).

5.3.1 INFERRED TERMINAL EXCHANGE

The literature on closing medical consultations (Schegloff and Sacks 1973, White et al 1997, West 2006) suggests that talk generally ends with a terminal exchange between the physician and the patient. Nevertheless, this study demonstrates that in some cases the terminal exchange is inferred and not realised by the participants resembling casual conversations as per the 3 extracts below (5.35-5.40).

Extract 5.35
(N: nurse, P: patient)

The patient has accepted the closure, he has stood up and is putting his jacket on.

```
01:       (4.0)
02   N:   I'm just going to take you through to Sarah now(.)just next
03        door(.)ye know the lady that you saw earlier
04   P:   yeah
05        (3.0) ((nurse stands up))
06   N:   just round the corner here((pointing outside to the right))
07        (2.0)((Patient walks out))
08   N:   ye ok
09   P:   right dear
10        ((nurse shut the door and sits back down))
```

The patient walks out of the consultation room as she is directed to meet the researcher in the adjacent room. In line 8 the nurse asks if he is "ok" and the patient replies in line 9. However, there is no exchange of good byes. The patient does not offer a "goodbye" in line 9 hence, no goodbye from the nurse. Nonetheless this does not seem troublesome for the interaction. In terms of the turn taking machinery there is no terminal exchange, neither of the parties offer a 'goodbye' therefore, there is an implied terminal exchange.

Extract 5.36

(N: nurse, P: patient)

The nurse has just finalised reviewing the patient's prescriptions.

```
01   N:  as the saying goes >all right that's lovely< I'll take you
02       through back to Sarah then if that's ok
03   P:   yeah
04   N:   there's yer prescriptions and uhh I'll see you soon
05   P:   right↓ ((patients stands up))
06   N:   all right are you ok
07   P:   yeah the sheets that lady gave me is that them
08   N:   yeah ((handing over the papers))
09        (2.0)
10   P:   °uhh
11   N:   right↓ thank you we've covered everything haven't we
12   P:   yeah ((patient leaves the room and goes next door))
```

The patient has accepted the closure and starts getting ready to leave evidenced in line 5 by her standing up. The patient gathers her belongings including some paperwork (line 5). In line 11 the nurse thanks the patient and double checks that everything has been done. The patient replies in line 10 with a "yeah" and exists the consultation room. Similarly to extract 8.1 there is an implicit terminal exchange both parties withhold the 'goodbyes'.

Extract 5.37

(N: nurse, P: patient)

The nurse has reiterated the closure by providing a future arrangement.

```
01   N:   yeah good stuff so er I'd perhaps see you on a Saturday
02        clinic for that(.)so I'll take ye through Sarah is jst next
03        door just in the side room
04        ((Patient stands up, nurse follows))
05   N:   Thanks Joan
06   P:   all right dear
07        (2.0)
```

```
08   N:   ok you'll just see her in 'ere ((nurse pointing to the
09        right from the doorway))
10   P:   yes I saw her when [I came in
11   N:                      [ahh did you when you came in all right
12        ((nurse goes back into consultation room and shuts the
door))
```

The patient accepts the closure and stands up in line 4. The nurse immediately follows and indicates where the patient needs to go next (next door). The patient provides an account noting that she is aware where she needs to be as she has seen the researcher in the side room on her way in. Likewise in the other examples, there is no goodbye from the nurse or from the patient, instead there is an inferred terminal exchange.

The implicit terminal exchange is present in consultations where the nurse has instructed the patients to proceed to the adjacent room to see the researcher Sarah for the semi-structured interview. This occurs after the patient has accepted the closure and is getting ready to exit the nurse's consultation room. In cases where the nurse does not instruct the patients to proceed next door there is an explicit terminal exchange as shown in the next section.

5.3.2 EXPLICIT TERMINAL EXCHANGE

Exchange of 'goodbyes' in these routine diabetic consultations occurs when the visit is brought to an end without further instructions for the patients to continue next door for a semi-structured interview.

Extract 5.38
(N: nurse, P: patient)

The patient has accepted the closure and is already standing up ready to leave.

```
01   N:   wonderful I'm sure if you do that you'll be back to well
02        within the limits ((nurse stands up))
```

03 P: **right ok thank you**
04 N: **right cheers,** just be wary with uhh (pointing at the tripod
05 cable on the floor)
06 P: right
07 N: floor, all right **see ye' then**
08 P: **see ye'**
09 N: **bye**

In line 3 the patient thanks the nurse for the consultation and the nurse responds with another thank you "cheers". In line 7 the nurse proceeds to the terminal exchange and offers a "see ye then" as a way of saying goodbye. The patient replies accordingly with "see ye" and the nurse reiterates her goodbye with "bye" in line 9. In this interaction the nurse does not ask the patient to proceed next door. Instead there is a terminal exchange which is explicit and it occurs after the closure.

Extract 5.39
(N: nurse, P: patient)

The nurse has finalised all the checks, initiated the closing and is now reiterating the closing.

01 N: yeah do you(.)not have anything else you want to ask me ok
02 P: don't think so
03 (2.0)
04 P: right↓ thanks Kay
05 N: you're welcome
06 P: right↓ ((patient collecting his things))
07 (2.0)
08 P: right↓ thanks Bev ((standing up))
09 N: you're welcome
10 P: **see ye later**
11 N: **all right have a good 'oliday**
12 P: **bye**
13 N: **bye bye**

The patient accepts the closing in line 4 and subsequently in line 6 by producing "right" indicating a shift and by physically collecting his belongings. The nurse does not indicate at this point to proceed next door. Instead there is another thank you by the patient in line 8 as he stands up followed by an explicit terminal exchange in line 10 "see ye later". The nurse replies with "have a good holiday" and in turn the patient produces "bye" (line 12). This is followed by the nurse's "bye bye" in line 13. Hence applying an adjacency pair sequence to the terminal exchange.

Extract 5.40
(N: nurse, P: patient)

The patient has already accepted the closure and is gathering her belongings.

```
01   N:   nice to see you
02   P:   and you
03        (1.0) ((sorting some papers in her bag))
04   P:   ye mum all right
05   N:   yeah she's fine thank you she's off to India with a friend
06        she doesn't let the grass grown green >bless her she does
07        well> she's seventy seven tomorrow
08   P:   oh right good for her ((standing up))
09   N:   right↓ you take care
10   P:   ok
11   N:   all right see ye then
12   P:   thank you
13   N:   bye bye
14   P:   bye
15   N:   bye
```

The consultation has finalised and the patient is sorting her belongings in preparation to exit the consultation room. In line 4 the patient asks the nurse about her mother adopting a more colloquial conversation rather than talk as part of the medical consultation. The nurse replies in line 5 and offers information about her mother. The patient acknowledges this new information with the particle "oh" and proceeds to stand up indicating that she is ready to

leave. In line 11 the nurse introduces the terminal exchange with “see ye then” followed by “bye bye” in line 13. The patient replies with “bye” as well and the nurse reiterates her “bye” in line 15. In this interaction there is a clear exchange of ‘goodbyes’ by both participants.

In these routine consultations the difference between producing or not producing an exchange of ‘goodbyes’ can be due to the nurse’s instruction regarding the next activity the patient is required to perform. All patients are aware and have volunteered to perform a short semi-structured interview with the researcher immediately after their routine diabetic consultation with the nurse. However, in cases where the nurse has not instructed the patients to proceed next door during the closing phase, terminal exchanges are produced. Conversely, in cases where the terminal exchange is implied and noticeably absent, the nurse has given certain instructions to the patient during the closing of the visit i.e. “I’ll take you through to see Sarah next door”. The action of showing a patient to the next room could imply that the patients’ visit is somewhat extended and not completely finalised, hence the lack of ‘goodbyes’. Nonetheless, the absence of a terminal exchange does not appear troublesome for the interaction. Neither the patient nor the nurse is left waiting for a ‘goodbye’. There seems to be an understanding that the terminal exchange will not occur in these cases.

5.4 DISCUSSION

The data in this study suggests that closing type 2 diabetic routine consultations is achieved via multiple moves within an initiation and a reiteration of closure. The initiation of closure, always conducted by the nurse in this dataset, is where the patient has to identify the initiation and accept it. Once the patient has identified it and agreed on it, the closure has begun. At some point the nurse will reiterate the closure indicting that the closing she initiated is actually happening and the patient in turn will accept the final closure. This gives way to the terminal exchange.

However, there are cases as seen in section 5.3 (extracts 5.30-5.32) where the patient does not identify or accept the initiation of closure and either resists it by being silent or shifts to another topic setting his/her own agenda. Therefore, the closure is suspended and the nurse has to attempt a further initiation of closing. The patient eventually accepts this second initiation and the closure is successful. There are certain ways in which practitioners can indicate the initiation of closure. Some of these, as mentioned earlier, are: summarising the visit, making future arrangements, and clarifying next steps. In addition to these, this data set identified the use of "right" and the use of positive assessments as two specific closing resources (sections 5.2.1 and 5.2.2). However, using closing resources does not guarantee a closure. There are some closing resources such as the final concern sequence (e.g. 'anything else?') that instead of closing the conversation can do the exact opposite, it "opens up a closing" (Schegloff and Sacks 1973). The final concern sequence can create further questions and topic shifts (section 5.1.2). Nevertheless, the pattern of initiation and reiteration of closure still remains in these cases and is followed regardless of the patient's topic shifts or further information elicited by their responses to the final concern sequences.

It could be argued that initiating and reiterating closure is purely a reflection of one physician's (i.e. the nurse) personal deployment style when it comes to closings. However, it has been demonstrated that within all the interactions discussed in this chapter, patients make relevant the transition between the closing and the terminal exchange (i.e. the goodbyes) sequentially after the reiteration and not immediately after the initiation. I believe this is due to the turn taking machinery within the structure of the consultation.

As noted by Schegloff and Sacks (1973) the closing has been initiated and neither of the parties choose or care to carry on the conversation. Therefore, there is an acceptance and a "warrant" for the closing. I believe that after this warrant has been granted there is a need for a further exchange which reinforces the actual

closure. This reinforcement is necessary as between the warrant being granted and the actual closure topical shifts can occur. In addition, it is relevant for the nurse to reiterate the closing after the patient's initial acceptance in order to avoid any interactional trouble i.e. where the patient is not entirely sure that the consultation is actually over and stands up or gets ready to leave too soon. This is particularly important in UK consultations, as it is the patient who walks into a consultation room and thus physically has to stand up and exit the room at the end of the consultation. It would be troublesome for the interaction to stand up before the consultation is finalised. Equally, it would be troublesome for the interaction if the nurse suddenly stands up indicating the consultation is over. In this data set the nurse stands up after the patient, in order to accompany them to the door. More importantly, the evidence from the interactions shows that patients fully accept the closure, evidenced by either collecting their belongings or standing up, after the nurse's reiteration and not after the nurse's initiation. Demonstrating that the exchange within the initiation of closure via one adjacency pair is not sufficient for the patient to fully accept the closure, stand up or gather their possessions and proceed to the terminal exchange. This, I believe, is due to the turn taking machinery inherent within the consultation's structure. If the initiation of closing is done, for example, by mentioning a future arrangement, the patient will have to accept the future arrangement as well as accepting this as a closure initiation. Therefore, there is a need for the nurse to reinforce that the actual arrangement has been accepted in addition to the closing.

The findings in this particular data suggest that one adjacency pair is not sufficient to warrant the actual closing of the consultation as the closing resources used elicit a dual response. Therefore, the physician will have to restate the closing to achieve a successful transition to the terminal exchange. Closing the visit within multiple moves has the function of allowing patients to bring up any unmet concerns between the initiation and the reiteration. Hence, the importance of analysing closings in chronic visits. As shown in the data, patients can resist the closing initiation and mention any concerns or additional questions thereby suspending the closing. Once these concerns have been

addressed the nurse can proceed to reinstate the closing.

In terms of best practice, closing a consultation via an initiation and a reiteration appears to have a satisfactory effect for patients regarding their concerns during the visit. This is demonstrated by their responses in the post-visit semi-structured interviews. When asked, all patients stated that they felt they had opportunities to ask questions and mention concerns (see chapter 3, Methods and Methodological Discussion, section 3.2.2 patient post-visit interview, question number 6).

This type of closing provides some space between the initiation and the reiteration where patients can ask questions reducing the "by the way syndrome" (Rondondi et al 2009, White et al 1994) mentioned earlier and ultimately increasing patient satisfaction.

For practitioners, it is beneficial to be aware of multiple moves when closing a consultation, as it enables them to manage the closing successfully. Initiating and reiterating closure is efficient as it ensures that the patient accepts the closing without lengthening the overall consultation time.

In summary, chronic diabetes consultations seem to follow multiple moves for closing, whereby the closing environment is initiated by the nurse, accepted by the patient and then it is reiterated by the nurse with a further acceptance by the patient. This structure differs from the literature in terms of requiring more than 2 sets of adjacency pairs to close a chronic consultation. It appears that closing routine visits entails an initiation and a reiteration of closing, which sometimes includes several attempts before proceeding to the 'goodbyes'.

The next chapter will present how risk is talked about during chronic diabetes consultations.

6 Communicating risk via If-Conditionals

Although patients with type 2 diabetes have been informed about the potential risks of the illness when they are initially diagnosed, (heart and kidney disease, stroke, amputation and blindness) 8 out of the 10 patients in this data set stated when asked that having type 2 diabetes does not worry them. This could be due to not understanding the nature of the risks associated to the illness or lack of clarity during this communication, or both. It could also be due to the asymptomatic nature of some patients' diabetes. Alternatively, it could be that patients understand the risks, but are not overly concerned as per their responses during post consultation interviews.

6.1 IF-CONDITIONALS AND RISK TALK

The aim of this chapter is to present the way in which risk is talked about during patients' 6 monthly chronic check-up consultations. After analysing the talk between the patients and the nurse a pattern emerged. This pattern consisted of the use of a grammatical structure in order to talk about risk. The grammatical structure was the use of if-conditionals by the nurse when presenting risk or establishing potential risky behaviour. The use of if-conditionals was the only way risk was being presented or talked about during these visits. The data suggests that the function of if-conditionals within risk talk is to offer a recommendation.

The significance and contribution of this chapter to the field is to add to the knowledge base on if-conditionals and their use in medical discourse. If-conditionals have been previously established within three genres of written medical discourse (Ferguson 2001, Carter-Thomas et al 2008, Carter-Thomas et al 2014). However, little has been investigated in terms of their use in spoken

discourse within medical consultations. This chapter will focus on naturally occurring talk within diabetic check-up consultations and will demonstrate the use of if-conditionals as an advice giving resource when talking about risk. Analysing risk communication during chronic visits is essential for understanding how risk is talked about and whether or not it could have an effect on the patients' self-management of their illness.

In this data set the risks discussed during the check-up visits are related to acute and immediate risks to patients. Although the fundamental risk for type 2 diabetic patients is controlling their high blood glucose, one of the frequent risks mentioned in this data set is the exact opposite i.e. patients dropping their blood sugars too low and running the risk of having what is referred to as a "hypo" (Hypoglycaemia i.e. a low blood glucose episode). Risk talk in this particular data addresses hypos, feet care and diet recommendations to prevent any potential problems.

In this chapter I will start by describing how risk is communicated within type 2 diabetes check-up consultations, particularly through the use of if-conditionals. I will then provide examples that demonstrate this specific use of if-conditionals by the nurse in order to talk about risk. Finally, I will discuss its function within the interaction and how patients respond to if-conditionals as an expression of risk.

6.2 HOW IS RISK COMMUNICATED IN TYPE 2 DIABETES ROUTINE CHECK-UP CONSULTATIONS?

Risk talk is in this data is always initiated by the nurse and not by the patient and it is indicated by the introduction of a conditional clause marked by the use of the conjunction "if". In other words, risk talk in this data set is communicated via an if-conditional clause: *if p, q.* The literature on if-conditionals (Traugott et al 1986, Sanford 2003, Bennett 2003) suggests a logical relation of: *if p, q* consisting of a subordinate if-clause referred to as *p (protasis)* and the main clause or

matrix clause as *q (apodosis)*.

The if-conditionals in this data always refer to a future event that is conditional on another future event. The condition (p) is directly related to the situation in the matrix clause (q). The speaker intends the hearer to understand the condition of truth of the prediction: if p then q (Greenbaum & Quirk 1999). However, they leave the question of fulfilment or non-fulfilment of the condition unresolved, as this is dependent on the patient's action or non-action.
The aim of this chapter is to position conditionality within a framework of advice giving in consultations, particularly when related to risk prevention recommendations.

Conditionals can take the following forms (Greenbaum & Quirk 1999):
"If" + present tense (conditional clause) followed by:
will + inf/imperative/present tense (main clause)
Examples:
a) conditional clause + will and infinitive: *If you eat, you will get fat*
b) conditional clause + imperative: *If she eats that, tell her mother*
c) conditional clause + present tense: *If you smoke, you are irresponsible*

The if-conditionals mentioned above are grammatically correct and prototypical for the purpose of explaining the different formats if-conditionals can take. However, when is comes to naturally occurring talk these formats can change into more complex structures such as: "if you start to feel… then come back and see me" (extract 6.1 below), "if it's still high we're going to have to get you in the habit of having regular meals because…" (extract 6.8 below). These examples within natural occurring talk highlight the difference between a prototypical if-conditional and its actual use in spoken discourse.

The conditionals present in this data follow the forms "if" clause + imperative and "if" clause + present tense. There is lack of explicit if-conditional + will and infinitive. This could be due to that fact that the if-conditionals in this data are used to express risk and provide a recommendation. Therefore, the use of

another modal such as 'would' instead of 'will' might be deemed more appropriate and less demanding for a recommendation.

6.3 ON IF-CONDITIONALS

Conditionals have been of interest to philosophers, logicians, psychologists and linguists (Bennett 2003, Evans and Over 2004, Sanford 2003). However, their focus and perspectives on the matter have differed according to their research traditions and methods (Traugott et al 1986). Philosophers and logicians have provided an account of conditionals that identifies an *if-then* relationship. The literature on if-conditionals suggests a logical relation of: *if p (protasis), q (apodosis).* As stated by Ferguson (2001) conditionals are used to express options, evaluate the consequences of certain actions as well as the dependencies between certain circumstances. However, there is a wide range of typologies suggested by different disciplines.

Conditionals have been considered from a truth-value and probability of truth perspective (Lewis 1976). They have also been characterised from a semantic point of view, with a distinction between open and hypothetical conditionals (Greenbaum & Quirk 1999). This distinction lies on the degree of probability in terms of the realisation of the situation noted in the protasis (p). Comrie (1986) proposes a further distinction similar to open versus hypothetical based on the hypotheticality of the condition: "greater hypotheticality means lower probability" (pg. 88). Conditionals have also been viewed as topics (Haiman 1978). Haiman suggests that similar to topics, conditionals comprise a frame of reference concerning whether the main clause is true or not and is knowledge shared between the speaker and hearer. Notwithstanding, it is widely noted (Fillenbaum 1976, Comrie 1986, Ross 2004) that this logic (*if p, q*) does have a fallacy which is denoted by denying the antecedent. For instance, *if p, q* then *if not p, not q*. For example: if the car breaks down, we will be late. If the car doesn't break down, we won't be late. This is an invalid argument as we can still be late for another reason other than the car breaking down. Nonetheless, it appears that in conversation negating the antecedent is perfectly acceptable and when it

comes to promises, threats and warnings there is no fallacy at all (Fillenbaum 1976).

For the purpose of this study I will use Fillenbaum's approach (1975, 1976, and 1986) and discuss the use of if-conditionals from a perspective of their propositional content and linguistic structure. As the data in this study is based on naturally occurring talk it is more pertinent to conduct an analysis focused on the pragmatic function of the if-conditional structure.

Conditionals within natural language require some sort of relationship between the if-clause (p-protasis) and the consequent clause (q-apodosis). May it be a relationship of cause and effect, or one of enablement or inference (Ferguson 2001). Fillenbaum (1976) discusses the purposive use of if- conditionals in inducements specifically in threats, promises and warnings. Pragmatically, inducements have a logical form and a certain illocutionary force bound to the conversational context in which they occur. They attempt to change or control the hearer's behaviour in some way. Therefore, by taking the logical form of: *if p, q*, the purposive role can be viewed as: p is the cause of q and q is offered to get something done or not done regarding p. This is relevant to the study in hand, as the nurse, within the diabetic check-up conversational context, uses the structure *if p, q* in order to attempt a certain change in the patients' behaviour particularly around risk prevention. She uses an if-conditional form to warn the patients on how their behaviour could contribute to a potentially risky situation that could put their health at risk. I will demonstrate the use of this logical form *if p, q* by the nurse in conversation when presenting risk in the following 15 extracts (6.1-6.15)

Extract 6.1
(N: nurse, P: patient)

The nurse checks the patient's blood pressure since the patient was put on a new medication during her previous consultation. This is necessary as the new

medication could potentially produce a too larger drop in blood pressure which can cause a series of immediate problems.

```
01   N:   well↓ your blood pressure is fine ok(.) (.hhh) you were
02        doing all right on yu on yu last one really but I just
03        wanted to make sure that I didn't drop your blood
04        pressure too low it's all right us starting this medication
05        and then it dropping your blood pressure too low that
06        you've got ah ah a worry of fe feeling dizzy an an uh
07        falling over but your blood pressure is ok today (.hhh)
08        (1.0)(hhh)
09   N:   if you start to feel like that that when you stand up you
10        know that movement of bringing
11   P:   [yes
12   N:   [your head up
13   P:   um yes
14   N:   you feel light headed [and dizzy
15   P:                         [yes
16   N:   come back and see me because really after we've sort of
17        seen you these few uhhmm frequent visits we'll be leaving
18        you for six months so obviously we'll not be monitoring it
19        then
```

The nurse explains one of the risks i.e. feeling dizzy and falling over if her blood pressure were to drop too low (lines 6-7). The patient does not reply or overlap leaving the nurse to carry on. The nurse continues her talk by giving an account of a hypothetical situation the patient could face followed by a recommendation should it happen. The hypothetical risky situation is introduced by the conjunction 'if' (line 9). The account refers to how the patient could feel with very low blood pressure, specifically the light-headedness when bringing her head up. The patient agrees with this particular example and acknowledges the nurse's account (lines 13 and 15).

The if-conditional in line 9 "if you start to feel […]" is followed by an imperative in line 16, "come back and see me" indicating the recommendation. It is a directive from the nurse for the patient to do something i.e. come back and see her, if she feels light headed, which is the condition its dependent on. The

request in this interaction appears to be more of a telling than an asking, since there is little room for patient refusal. The nurse's use of the imperative form enables her to exhibit entitlement to direct the recipient's action (Craven and Potter 2010).

The risk mentioned by the nurse in lines 6-7 is explicit. She specifically says "feeling dizzy and falling over". It is possible for the patient to experience these symptoms since she is now taking an increased dose of her medication. This account is quickly followed by the importance of coming back to the surgery if the patient does feel lightheaded, as she will not be monitored for a while.
The risk of becoming dizzy and falling over is used as a means for the patient to take action in becoming more vigilant as she will not be monitored. This risk and recommendation is presented by using an if-conditional (line 9) in the format: if-conditional + recommendation.

Extract 6.2
(N: nurse, P: patient)

The extract below follows extract 6.1 chronologically. The nurse has previously explained symptoms to look out for in order to prevent the risk of falling over due to low blood pressure.

```
01   N:   […] so you know if you feel like that do come back an uhmm
02        we'll have a check of it all right(.)so you can pop that
03        sleeve back
04   P:   oh right(.)he he are we done
05   N:   yeh
```

In line 1 the nurse repeats the if-conditional ("if you feel like that") followed by the imperative ("do come back") and subsequently a further recommendation of checking everything is in order. She proposes a course of action in case the if-condition occurs. However, in this turn the nurse does seek some acceptance from the directive given to the patient in line 1 by saying "all right?" (line 2). It is not clear if the nurse is seeking acceptance to the recommendation "do come

back" or to the further recommendation "we'll have a check of it" or both. Nevertheless, the nurse's utterance "all right" does not allow for the possibility of acceptance or refusal as it is immediately followed by "so you can pop that sleeve back". There is no further pursuit from the nurse for an explicit response to her "all right" from the patient.

The risk mentioned is a potential low blood pressure moment that could cause the patient to fall over. The action intended by mentioning this risk is for the patient to be vigilant and to come back and see the nurse if she feels lightheaded. The risk and subsequent recommendation is introduced by an if-conditional in line 1 and takes the format: if-conditional + recommendation.

Extract 6.3
(N: nurse, P: patient)

The patient has previously mentioned a decline in his appetite and the nurse is informing him about the potential risk of not eating with the medication he is currently taking, as it could cause a 'hypo' (Hypoglycemic episode).

01	N:	but the Glimepiride that you're on it's important as I was
02		mentioning that you have your three meals a day cause that
03		will bring your blood sugars down(.) no matter what
04	P:	yeah
05	N:	so that will work so **if you're not putting any energy** back
06		in **you have that potential for your blood sugars to keep**
07		**carrying on going down** and down
08	P:	yeah
09	N:	an this is where we 'ave >ye heard of the term of a hypo<
10		when diabetics have a hypo that means that they're having a
11		low blood sugar (.hhh)
12	P:	yeah
13	N:	**so it's important that °you** uhhh (0.5)
14	P:	or sometimes you've got to eat chocolates haven't ye
15	N:	well this is what people have to have sometimes if their
16		blood sugars are low something that's quick acting hhh umm

In lines 1-3 the nurse starts to explain the importance of eating whilst on Glimepiride, as this medication will drop the patient's blood sugars unceasingly. The patient replies with a continuer "yeah" in line 4 and the nurse provides more information followed by a hypothetical scenario in lines 5-7. The risk is initiated by an if-conditional i.e. if the patient does not eat he has the potential to drop his blood sugars too low. The conditional is not followed by an imperative in this case, but by present tense. In line 9 the nurse introduces the concept of a "hypo" defining it briefly as a low blood sugar moment. The patient is still replying by a minimal acknowledgement "yeah" line 12. In line 13 the nurse provides her recommendation by reiterating the importance of having a meal, but does not grammatically complete her turn constructional unit. However, she lowers her pitch, hesitates with uhh (line 13) and a pause follows. The patient recognises the possible completion point and produces an account of what he thinks should be done when having a hypo in line 14 (eat chocolates) demonstrating that he is aware of what to do. His turn is completed by the use of "haven't ye" preferring a 'yes' response or agreement from the nurse.

In this extract the nurse offers a recommendation of having 3 meals a day before the if-conditional (lines 2-3). She then introduces the hypothetical risk of a hypo caused by the patient's lack of eating with an if-conditional in line 5. Following this she proceeds with a reiterated recommendation in line 13 resulting in the format: if-conditional + recommendation.

Extract 6.4
(N: nurse, P: patient)

The nurse is still discussing hypos with the patient. She has already pointed out the importance of eating when taking his medication in the previous extract (extract 3.3) in order to minimise the risk of a hypo.

```
01   N:   the best thing for you if you're ever out and about and
02        you've missed yer lunch and you're staring to feel a bit
03        strange a bit lightheaded some people start sweating ummm
04        they get a bit confused a bit unsteady always presume it's
```

05 **yer blood sugars** that's on the low side an' **if you c'n jst**
06 **stop at a café** and just get yer lunch **then do that**
07 P: yeah

In lines 1-6 the nurse mentions potential symptoms that could indicate and help identify a hypo. The risky symptoms of a hypo are introduced by an if-conditional in line 1-4 (if you are feeling strange, light headed, sweating, unsteady). The if-clause is followed by the action "always presume it's your blood sugars" in line 4 and then she gives a further recommendation of what to do in lines 5-6 also via an if-clause. This if-conditional uses a modal 'can', "if you can stop at a cafe…" (line 5) and then she produces the directive "do that" (line 6). By introducing a modal form, the suggestion is less direct and offers the patient choice in terms of stopping at a cafe if possible, acknowledging that it might not always be feasible. The patient responds with a continuer "yeah" in line 7. The risk is introduced by the nurse in line 1 with an if-conditional which is then followed by the nurse's recommendation (lines 4-6) following the format: if-conditional + recommendation.

Extract 6.5
(N: nurse, P: patient)

One of the routine checks within the patient's consultation is a foot check. The nurse is checking the patient's feet and she had previously mentioned that podiatry suggests filing toenails instead of cutting them. Feet should be checked for any sores, as well as monitoring their circulation in order to avoid any problems that could lead to potential amputation.

01 N: yes ai well **if you file 'em** just twice a week they say
02 that's all you need to do without cutting it cause **it's**
03 **less chance of you causing any** (0.4)
04 P: aah
05 N: **sort of trauma** to them
06 P: yeah

In line 1 the nurse is providing advice regarding the upkeep of the patient's feet, in particular how to manage his toenails. The recommendation is to file twice a week. She uses the if-conditional "if you file…" line 1, followed by the fulfilment of the condition: "it's less chance of you causing any trauma to them". This extract is slightly different in that it is phrased positively. The conditional is a desired action, as opposed to: if you don't file there is a chance of trauma. The patient offers a minimal acknowledgement token "yeah'' in line 6.
In this particular case the recommendation comes first as part of the if-clause and the risk prevention of causing any trauma is mentioned later taking the format: if-conditional as recommendation + explanation/ information.

Extract 6.6
(N: nurse, P: patient)

Extract 6.6 follows extract 6.5 chronologically.

01	N:	**if you notice any sort** of sores on em or anything that
02		you're concerned of Bob **let us (0.5) know straight away**
03		(0.5) the foot clinic at the Hallamshire the diabetic foot
04		clinic are keen that we refer anybody (0.5)
05	P:	yeah
06	N:	quite quickly

In line 1 the nurse introduces another if-conditional: "If you notice any sores on them", followed by the directive: "let us know straight away". There is a short pause in line 3, however, the patient does not take the turn and the nurse starts an account providing a further explanation justifying her directive (lines 3-4). There is another pause in line 4 at the end of nurse's turn, the patient identifies the transition relevance place and produces the token "yeah" (line 5).
The risk of potential sores is indicated by an if-conditional in line 1 and the recommendation of letting the practice know straight away follows in line 2 (if-conditional + recommendation).

Extract 6.7
(N: nurse, P: patient)

The patient in extract 6.7 has mentioned that she has lost her appetite and is not eating properly. The results from her HbA1c test, which measures the average blood sugar levels, have come back high and the nurse is discussing future options in terms of potential treatment to manage this rise.

01 N: we would normally at this stage now add in another tablet
02 from a different family basically
03 P: mm hum
04 N: now the worry with that other tablet is(.)it has the
05 potential as we mentioned earlier to drop your blood sugars
06 down(0.5)and cause what we call a hypo the low blood sugars
07 P: mm
08 N: now that worries me from my perspective is because **if you**
09 **take that tablet but then you don't have anything to eat**
10 that tablet is gonna work and work and work but it's not
11 getting any fuel back in an **we run a risk then of you**
12 P: yeah
13 N: **collapsing and going unconscious** really worse case scenario
14 (1.0)
15 N: (.hhhh) so it's really where do we go from here (0.5)
16 like ideally it's uhh it's deciding I guess whether part of
17 you feeling unwell an this lack of appetite an certainly
18 when people are unwell and they're poorly and even if
19 they're not eating it can tend to make your blood sugars go
20 up
22 P: yeah

In lines 1-2 the nurse starts explaining what generally would be done regarding treatment when patients' blood sugars are high. As the patient has high blood sugars this would call for a change in medication in order to manage this rise. In line 3 the patient produces a continuer and the nurse proceeds to explain the worry with using the standard treatment on her (lines 4-6).

The patient is not eating adequately so the nurse explains the potential risk of changing the medication while on her current eating habits. The new tablet will have an adverse effect on the patient if she takes it and does not eat i.e. she will be at risk of experiencing a hypoglycemic episode. In lines 8-9 the nurse explicitly mentions the risk and introduces it with an if-conditional: "if you take that tablet […] don't have anything to eat […] we run a risk then of you collapsing and going unconscious really worst case scenario". This risk is tailored specifically to the patient since the risk arises from the effect the patient's personal lifestyle would have on the new treatment. In other words, taking the new medication with the patient's inadequate eating habits at the moment would have an adverse effect on her health causing a high risk of hypos. In line 8 the nurse explains that she is concerned personally about this risk "[..] this worries me from my perspective [..]" she using the pronoun "me" (not 'us') as well as "my" (not 'our') noting that she would be personally worried.

The nurse carries on to mention the explicit risk of falling over and going unconscious and the patient is silent, there is no response instead there is a significant pause (line 14). This would be a transitional relevant place for the patient to initiate talk, but she does not. Her silence could demonstrate some resistance to the nurse's account or could function as a way of eliciting more information (Maynard 1997). Following the pause the nurse takes an in breath and changes the focus of the talk from the actual risk to next steps (line 15). The risk is introduced with an if-conditional in line 8, however unlike some of the previous examples the recommendation is implied within the if-clause (lines 8-9). The recommendation is that the patient needs to eat, if she changes her treatment. If she does not eat she will risk collapsing and going unconscious. Like in extract 6.5 the format is: if-conditional as recommendation + explanation/ information.

Extract 6.8
(N: nurse, P: patient)

The nurse has been discussing the risk of introducing a new medication to manage the patient's high blood sugars, in particular regarding the risk of a hypo in extract 6.7. The nurse is suggesting next steps or other ways to manage this raise.

01 N: […] maybe have another blood test done and then see if
02 things have settled back down
03 P: [yeah
04 N: [to where they were uhh and
05 then from there is umm **if it's still high** we're going to
06 have to **get yer in the habit of having regular meals**
07 because
08 P: yeah
09 N: I daren't increase your treatment until I know that you're
10 eating umm
11 P: um hum
12 N: eating eating adequately
13 P: yeah
14 N: how do you feel about that
15 P: yeah
16 N: yeah
17 P: I mean
18 (2.0)
19 P: it's not that I don't want to eat it's just (0.5) I don't
20 know what it is really

The nurse suggests a recommendation in line 1, "maybe have another blood test done […]". The use of "maybe" prior to the recommendation indicates less entitlement from the nurse minimising the recommendation to advice that could be refused. The patient agrees in overlap in line 3. In line 5 the nurse provides a further recommendation, but in this case it is not minimised and there is little space for patient refusal. The recommendation is initiated by an if-conditional. If the patient's blood sugars are still high after the blood test then the eating habits

will have to be changed. There is a directive for the patient to start having regular meals and the directive is followed by a reason for this change in line 9.

The nurse is building her case as to why she will ultimately not prescribe a new medication to treat the patient's high blood sugars until the patient is eating adequately. She is not willing to take the risk of prescribing the new treatment with the patient's current eating habits. This is evident in line 9 with nurse's utterance "I daren't" followed by her warning which takes a threat-like form: unless you start eating adequately, I will not change your medication. This face-threatening act is somewhat mediated by the nurse's use of plural "we're going" in line 5, suggesting that they are in this together and both nurse and patient will have to get her into the habit of changing her eating patterns. However, the patient interprets the turn as a threat-like utterance evidenced by her defensive response in line 19: "it's not that I don't want to eat". She justifies her current eating habit by suggesting that it is not a deliberate action and she is not sure what is causing this.

The risk of a hypo is used as a means to persuade the patient in changing her diet as well as a way of justifying a decision made by the nurse regarding on-going treatment. The risk of still having high blood sugars after the further test is introduced by an if-conditional (line 5) followed by the recommendation of changing the patient's eating habits (if-conditional + recommendation).

Extract 6.9
(N: nurse, P: patient)

The patient in the extract below has recorded a few low blood sugar episodes and the nurse is keen to alter his medication in order to manage this and prevent a potential hypo. The patient is resistant to changing his dosage as he says he feels fine.

```
01   N:   ye know and I'll I'll stress again with the importance of
02        ye going to your allotment with something to treat a low
```

03 blood sugar with even if you don't take your machine with
04 you **if you start to feel** funny ye presume that it's a low
05 blood sugar and **ye get something to eat**
06 P: ((nod))
07 N: so ye must always even if you leave some biscuits there ye
08 know

The nurse explains in lines 1-3 the importance of having something to treat a potential low blood sugar moment and in line 4 she introduces the risk of a hypo with an if-conditional. The conditional: "if you start to feel funny" is followed by the recommendation of presuming it is low blood sugar and ultimately followed by another recommendation in the form of an imperative "get something to eat". The patient provides a minimal response in the form of a nod in line 6 and the nurse carries on with her talk in line 7.

The nurse is using the risk of a hypo expressed via the if-conditional in line 4 as a way of persuading the patient in carrying something to eat to prevent a low blood sugar moment while he is working on his allotment. The risk is presented with an if-conditional followed by the recommendation of getting something to eat (if-conditional + recommendation)

Extract 6.10
(N: nurse, P: patient)

Extract 6.10 follows extract 6.9 chronologically. The nurse is trying to persuade the patient to change his medication i.e. reduce the dosage it in order to avoid potential risky hypos.

01 N: so it would be wise that **if you're starting feeling** a bit
02 like that because you're on yer gliclizide and it could ke'
03 ye know >that'll work and work and work no matter what<
04 whereas your metformin doesn't have the same effect so **it**
05 **would be advisable for you to umm ye know like I say have**
06 **some something to eat**
07 P: metformin doesn't have the same effect(.) what

```
08   N:   no(.)it's good for your diabetes control and it's got a lot
09        of good things about it but it doesn't have the potential
10        to have your blood sugars in yer boots(.)yer gliclazide and
11        insulin does
12        (1.0)
```

In line 1 the nurse reiterates the risk of a hypo with an if-conditional. She then provides an explanation as to why the patient could experience a low blood sugar moment i.e. taking Gliclizide, since this medication lowers blood sugars continuously. She compares Gliclizide to his other medication (Metformin). The if-conditional in line 1 is followed by a recommendation in lines 4-6, "it would be advisable for you to have something to eat". The nurse's entitlement to this recommendation is minimised by the use of the modal "would" in line 5. There is also some hesitation prior to the directive: "have something to eat". The patient replies with a question in line 7 which is not related to the recommendation given, instead it relates to the information provided by the nurse about the tablet's properties. The nurse replies to the question raised by the patient, however, there is a significant pause after her explanation (line 12) suggesting either a non-acceptance or resistance from the patient, or alternatively he did not fully understand the nurse's explanation.

The risk of a hypo is introduced with an if-conditional (line 1) and the recommendation of having something to eat follows in lines 5-6, maintaining the form: if-conditional + recommendation.

Extract 6.11
(N: nurse, P: patient, W: patient's wife)

Extract 6.11 follows extract 6.10 chronologically. The nurse is still trying to persuade the patient to change his medication. However, in this particular interaction she uses another kind of risk in order to achieve an acceptance from the patient. The risk is not potential hypos, but the potential of losing his driving license. Diabetics who take Gliclizide, as this patient does, have to self-test their blood sugars before driving and record their blood sugar readings every 3-4

hours as they should only drive with a reading of 5 millimols or above. The Driving and Vehicle Licensing Agency (DVLA) can ask for these records at any given time.

01 N: and do you drive as well
02 P: yeah
03 N: so yeah you could potentially be getting behind the wheel
04 of your car with a blood sugar under the five millimoles
05 which ye know ye the DVLA say that ye know ye shouldn't be
06 doing that and **if they say** ye know they might come to you
07 and say look ye know can you prove your blood sugars are
08 all above the five and that you're testing before ye drive
09 so **you could be in breach of ye ye driving license as well**
10 with that so
11 P: o::h
12 N: ok so there's a whole sort of
13 W: mm
14 N: a °ray of
15 P: so I'll do an eighty and a f'
16 N: all right and if you want to book for a month for us just
17 to run through 'em just to see what they're doing

In line 1 the nurse changes her strategy and shifts the conversation to another potential risk in order to persuade the patient to change his treatment as her previous attempts have not been successful. This new topic is introduced by the question: "do you drive as well?" The nurse starts building her case persuading the patient to changing his treatment as potential hypos could affect the retention of his driving license. This is further explained by the nurse in lines 3-5, specifically the fact that the patient should not drive with a reading of less than 5 millimols.

In line 6 the nurse introduces the risk via an if-conditional: "if they say" ("they" being the DVLA) she then self-repairs and carries on with "they might come to you […] can you prove your blood sugars are all above the five […]". The structure is slightly complex in that the nurse starts off with an if-conditional but then repairs her talk. She does however end the account with the matrix clause: "you could be in breech of your driving license" in line 9. The nurse has not

explicitly mentioned: if you cannot prove that your blood sugars are higher than five then you would be breech of your driving licence. Nevertheless, the implicit format is still if p then q: if they (the DVLA) come to you and you cannot prove that your blood sugars are all above five millimols, then q: you could be in breech of your driving license.

In line 9 she explicitly mentions the risk of being in "breach of ye driving license" and in line 11 the patient replies with an elongated "oh". This particle 'oh' is evidence of a change of state in knowledge or information. It registers a noticing, becoming aware of something (Heritage, 1998). Therefore, the patient has now understood that a hypo can be risky as it affects the preservation of his driving licence. He then proceeds in line 15 to mention the dosage previously noted by the nurse indicating that he has accepted the treatment decision and is willing to change the dosage.

By changing the focus of the risk from hypos that could affect the patient's wellbeing, to hypos that could affect his driving licence conditions, the nurse has managed to obtain an acceptance from the patient in lowering his dosage. The risk of breaching his driving license (line 9) by driving with low blood sugars is accepted and understood by the patient evidenced by his reply "oh" in line 11. Subsequently treatment change is accepted in line 15, as the patient says: "so I'll do an eighty and a f" repeating the dosage initially suggested by the nurse which was: "an eighty and a forty milligram".

The risk is introduced with an if-conditional (line 6) and the recommendation of lowering his dosage to an eighty ml and a forty ml is provided by the patient himself (if-conditional + recommendation offered by patient).

Extract 6.12
(N: nurse, P: patient)

The nurse is talking to the patient in the extract below about his eating habits. The patient has mentioned that he eats a particular honey coated cereal.

01 N: right(1.0)**if you could possibly switch those to a cornflake**
02 or uh like a wheatabix or something like that(.)do you like
03 any of the other cereals
04 P: ah uhh I've I've got them in 'ouse cornflakes and wheatabix
05 N: yeah it's just that they're coated in the honey and the
06 honey is sugar like you're doing all right with your
07 diabetes control
08 P: yeah ai ai
09 N: so really you're getting away with it at aren't ye at the
10 minute
11 P: yeah
11 N: but **if you could** if there's any sort of alternatives
12 without that sugar coating on it
13 P: yeah
14 N: **would be uhh better for you**
15 P: mm

This extract is slightly different to the other extracts analysed in that it does not deal with the risk of low blood sugars, but the risk of underlying high blood sugars due to a particular eating habit. The risk in this extract is implicit, however, it is still initiated with an if-conditional (lines 1 and 11).

Providing recommendations in these cases is a confirmation that the physician has interpreted the patient's lifestyle choice as problematic, hence the need for the advice (Sorjonen et al 2006). In line 1 the nurse advises the patient to switch his breakfast cereal. There is pause before she proceeds to advise the patient which would suggest a moment of thought on how to provide the recommendation indicating some difficulty when asking a patient to change a lifestyle habit. Linell and Bredmar (1996) note that talk on lifestyle changes threatens the patient's face hence being interactionally sensitive topics.

The nurse then uses the conditional with the modal 'could' (line 1), minimising her directive and her entitlement to provide the recommendation. The nurse not only uses the modal, she follows it with "possibly" making the directive more of a request that could be refused. The nurse is asking for a change in the patient's

lifestyle and she accompanies the request with a question in lines 2-3 “do you like any of the other cereals?” By asking this she is pre-empting the possibility of refusal due to not liking any of the other cereals. The patient replies in line 4 not only with a yes/no response, but with an account suggesting that he does have the alternatives in his house. The nurse justifies her advice in line 6 by informing the patient that the honey is sugar. She then justifies her position further by noting that the patient is doing “all right” (line 6) with his diabetes control, he’s “getting away with” having this extra bit of sugar (line 9). In line 11 she produces another if-conditional introducing her recommendation. If the patient could change to an alternative cereal, it would be better for him. The recommendation is provided with the modals ‘could’ and ‘would’. There is no imperative or directive. The patient produces a minimal response in line 15 that does not indicate whether he will take the advice or not.

Despite this extract being slightly different, in that it deals with diet choices and the impact they potentially have on raising the patient’s blood sugars, the underlying risk of eating a honey-coated cereal is introduced with an if-conditional (lines 1 and 11). The recommendation is embedded within the if-clause i.e. if you eat an alternative cereal it would be better for you, making the format: if-conditional as recommendation + explanation/information.

Extract 6.13
(N: nurse, P: patient)

The nurse has performed a foot check and is providing an account for the patient to check his feet too.

01 N: but certainly your feet are precious with diabetes so **if**
02 [**you**
03 P: [yeah
04 N: **ever get any sores or anything you come back and see us**
05 P: I’m quite aware if I feel a nick or anything ye know
06 N: yeah to come back and see us

In line 1 the nurse mentions how important and valuable feet are for a diabetic patient to which the patient agrees in line 3. In overlap the nurse proceeds with an if-conditional recommending the patient that if she sees any sores (if p) then to come back to the surgery (then q). The patient does not explicitly accept the recommendation, but provides an account also using an if-conditional: if she feels "a nick or anything" she will come back. The patient does not grammatically complete her turn, however, it is completed phonetically and the nurse pre-empts the patient's end of turn by competing it herself in line 6: "come back and see us".

The risk of sores on the patient's feet is introduced by an if-conditional, followed by the recommendation to come back if there are any problems (if-conditional + recommendation).

Extract 6.14
(N: nurse, P: patient)

The nurse has finalised the patient's foot check and is moving on to another test.

```
01   N:   so it's just you being vigilant just looking with your
02        eyes really isn't it
03   P:   yeah
04   N:   if you're not getting them signals naturally from your
05        foot to your brain telling you that they're hurting it
06        makes it even more vital that you have a good look round
07        and look after them
08   P:   yeah
```

The nurse is closing the foot check section of the consultation having performed the necessary checks. She gives some advice in lines 1-2 for the patient to be "vigilant" with her feet and ends her turn with "isn't it" preferring a yes response from the patient. The patient provides the preferred answer in line 3 and the nurse proceeds with an if-conditional highlighting the risk diabetics suffer in terms of their feet in lines 4-7, justifying her advice in the previous turn. She explains that if there is no signal from the foot to the brain, it is vital for the

patient to have a “good look round” and “look after them”. The patient provides a minimal token of acknowledgment in line 8.

The risk of no signal from the patient’s feet to her brain is introduced with an if-conditional (line 4) and the nurse’s recommendation of checking them follows in lines 6-7 (if-conditional + recommendation).

Extract 6.15
(N: nurse, P: patient)

The nurse is just finalising the patient’s foot check.

```
01   N:   so we always encourage ye ye know to be vigilant with your
02        feet we do this once a year but the rest obviously down to
03        you
04   P:   sure
05   N:   just to make sure everything is ok, any problems with them
06        you come straight back to us
07   P:   ok
```

The nurse has completed the check and provides some advice (lines 1-2) mainly for the patient to be vigilant and check their feet. The nurse mentions that this check within the consultation is performed once a year, so the patient has to check as well. She then introduces an if-conditional in line 5. In this extract the ‘if” particle is tacit but implied: “if you have any problems with them” followed by the imperative: “you come straight back to us”. This directive has very little room for refusal and the patient accepts the directive by using a token “ok” in line 7.

The risk of potential problems is introduced with a tacit if-conditional in line 5 and the recommendation of returning to the GP surgery follows in line 6 (tacit if-conditional +recommendation).

I have presented all the examples on explicit risk talk within the data collected for this study. The nurse uses an if-conditional structure in order to mention and talk about risk via the logical form *if p, q*. This form inevitably entails a

hypothetical situation whereby *if p* were to happen then *q* would occur. The nurse uses the presentation of this hypothetical to change patients' behaviours in order to prevent risk. For example in extract 5.5 the nurse provides a certain recommendation (filing toe nails instead of cutting) that in turn will prevent the patient from causing any potential trauma to his feet. In extract 5.4 she stresses the importance of eating regular meal to avoid hypos. In extract 5.12 she alters a particular eating habit to avoid high sugar content. The if-conditionals in this data set are positioned around a recommendation. In the next section I will explain the function of risk talk within the interaction.

6.4 FUNCTIONS OF RISK TALK

Risk talk in these routine consultations serves the function of either giving advice to the patient or requesting them to do something. Both of which are used to prevent a potentially risky situation that particular patient might face.

6.4.1 ADVICE GIVING

In the context of chronic diabetes check-up consultations risk can be regarded as the probability of harmful effects of action or non-action. The data suggests that in this particular context communication of risk serves the function of advice giving and encouraging patients to take certain action. The advice takes a hypothetical form, what Silverman et al (1992) refer to as 'hypothetical advice sequences'.

The nurse identifies a potentially risky situation for the patient, she expresses it via an if-conditional clause, together with explicit advice or recommendations. In terms of advice delivery and reception, the literature suggests that there are different types of advice giving. Nevertheless, the advice giving structure seen in this particular data is slightly different to the ones described in the literature. In Heritage and Sefi's research (1992) on delivery and reception of advice to first

time mothers they establish a five-step approach on how advice is constructed by the mother (M) and by the health visitor (HV).

1. HV: initial inquiry
2. M: problem indicative response
3. HV: focusing inquiry into a problem
4. M: responsive detailing
5. HV: advice giving

This approach is collaborative and it allows for the problem to emerge as a mutual construction. However, Health Visitors not always use the five steps as some steps might be skipped depending on the situation.

Maynard and Kinnell (1996) suggest other ways of advice giving, which they state are variations of Heritage and Sefi (1992). Advice giving after information; where the advice does not arise from a problem raised, instead it just follows certain information given by the practitioner. A certain piece of information comes with advice regardless of the patient's situation. Therefore, this advice tends to be assumptive in relation the patient's needs and the risk could be irrelevant. Advice giving after proposing a hypothetical situation; this advice is more ambiguous as it is not clear whether the advice is directed specifically to the patient or is just general advice that could be given to anyone. Due to this ambiguity this kind of advice is considered less challenging, since it is less confrontational, it can be received as advice or as information. However, it could also cause resistance if the hypothetical situation is not applicable to the patient. Finally, there is advice as information, which "packages" the advice as information from the very start. The use of "we" and "in general" provide an impersonal tone e.g. "we at the clinic strongly recommend that..." This kind of advice allows for less resistance.

I have mentioned 4 types of advice giving: five steps, advice after information, advice after a hypothetical situation and advice as information. In terms of the data presented in this study the advice giving structure observed is slightly

different. Advice giving in this data is embedded within a hypothetical if-conditional where risk is relevant.

The pattern emerging from the use of if-conditionals within risk talk when recommending tends to be in the form of: if-conditional + recommendation. The if-clause offers the information, explanation or description of circumstances and the matrix clause offers the recommendation, as seen in extracts 6.16-6.20.

Extract 6.16

(N: nurse, P: patient)

```
01   N:   if you start to feel like that that when you stand up you
02        know that movement of bringing
03   P:                          [yes
04   N:                          [your head up
05   P:   um yes
06   N:   you feel light headed [and dizzy
07   P:                          [yes
08   N:   come back and see me because really after we've sort of
```

If-conditional	Recommendation
If you start to feel […]	come back and see me

Extract 6.17

(N: nurse, P: patient)

```
01   N:   […] so you know if you feel like that do come back an uhmm
02        we'll have a check of it all right? So you can pop that
03        sleeve back
```

If-conditional (if p)	Recommendation (then q)
If you feel like that	Do come back

Extract 6.18

(N: nurse, P: patient)

01 N: the best thing for you **if you're ever out and about and**
02 **you've missed yer lunch and you're starting to feel a bit**
03 **strange a bit lightheaded** some people start sweating ummm
04 they get a bit confused a bit unsteady always presume it's
05 yer blood sugars that's on the low side an' **if you c'n just**
06 **stop at a café and just get yer lunch then do that**
07 P: yeah

If-conditional (If p)	Recommendation (then q)
If you're ever out and about […]	If you can just stop at a café… do that

Extract 6.19

(N: nurse, P: patient)

01 N: **if you notice any sort of sores** on em or anything that
02 you're concerned of Bob **let us (0.5) know straight away**

If-conditional (If p)	Recommendation (then q)
If you notice any sort of sores	Let us know straight away

Extract 6.20

(N: nurse, P: patient)

01 N: […] to where they were uhh and then from there is umm **if**
02 **it's still high we're going to**
03 **have to get yer in the habit of having regular meals**

If-conditional (If p)	Recommendation (then q)
If it's still high	We're going to have to get yer in the habit of having regular meals

Conversely to the examples above where the if-clause (p) offers the information or explanation and the matrix clause (q) presents the actual recommendation, in

extracts 6.21-6.23 the recommendation is presented in the if-clause and the information or explanation is presented in the matrix clause.

Extracts 6.21

(N: nurse, P: patient)

01 N: yes ai well **if you file 'em just twice a week** they say
02 that's all you need to do without cutting it cause **it's**
03 **less chance of you causing any** (0.4)
04 P: aah
05 N: **sort of trauma to them**
06 P: yeah

If-conditional (If p) + recommendation	Information/Explanation (then q)
If you file 'em just twice a week	Less chance of you causing any sort of trauma to them

The action of filing twice a week is desired and it is embedded in the if-conditional. The action will prevent risk in terms of causing any trauma to the feet explained in the matrix clause (q).

Extract 6.22

(N: nurse, P: patient)

01 N: now that worries me from my perspective is because **if you**
02 **take that tablet but then you don't have anything to eat**
03 that tablet is gonna work and work and work but it's not
04 getting any fuel back in an **we run a risk then of you**
05 P: yeah
06 N: **collapsing and going unconscious** really worst case scenario
07 (1.0)

If-conditional (If p) + implicit recommendation	Information/explanation (then q)
If you take that tablet but then you	We run a risk then of you collapsing

don't have anything to eat	and going unconscious

The recommendation to eat is implicit within the if-conditional. The outcome is a non-favourable one if the patient does not eat and is explained in the matrix clause (q).

Extract 6.23

(N: nurse, P: patient)

01 N: right(1.0)**if you could possibly switch those to a cornflake**
02 **or uhh like a wheatabix or something like that,** do you like
03 any of the other cereals?
04 P: ah uhh I've I've got them in 'ouse cornflakes and wheatabix
05 N: yeah it's just that they're coated in the honey and the
06 honey is sugar like you're doing all right with your
07 diabetes control
08 P: yeah ai ai
09 N: so really you're getting away with it at aren't ye at the
10 minute
11 P: yeah
11 N:→ but if you could if there's any sort of alternatives
12 without that sugar coating on it
13 P: yeah
14 N: **would be uhh better for you**
15 P: mm

If-conditional (If p) + recommendation	Information/ explanation (then q)
If you could possibly switch those to a cornflake […] if there's any sort of alternatives without the sugar coating	Would be uhh better for you

The recommendation is presented within the if-clause (p). If the action of switching cereal were done then the outcome would be favourable for the patient in term of his health.

6.4.1.1 SUMMARY

The data in this research indicates that if-conditionals are used to request actions from patients, to prevent them from potential risk, either as part of the condition or if-clause (p) or as part of the matrix clause (q).

When the action required is expressed in p, the clause q presents the information or explanation for the action in p. Conversely, when the information is presented in p, the clause q requests the action.

For instance:
"If you feel light headed" (p) "then come back and see me" (q).
P in this case is the information or explanation and q is the direct action.

"If you could switch to a cornflake" (p) "then it would be better for you" (q)
P is the action and q is the information.

The data suggests that the function of if-conditionals when it comes to risk talk is to offer a recommendation. This recommendation either arises due to the conditions of (p) being met, which would take the form: if p (information) then q (action), or as a way of reinforcing a recommendation that has been offered previously or that is part of the if-clause e.g. if p (action) then q (information).

6.4.2 IF-CONDITIONALS AS REQUESTS

One of the forms of risk talk via if-conditionals is that of requests. Despite these requests not being entirely beneficial for the speaker requesting i.e. the nurse, they still function as requests in that someone is asking someone else to do something. In that sense they are subject to the same sensitivity, relativeness directness and entitlement that underpin all requests (Curl and Drew 2008). As requests present a degree of imposition on their recipient, depending on the interactional context, they can take several different forms, from imperatives

('pass me x') to interrogative with modal verbs ('I was wondering if'). Speakers' entitlements will be reflected in their choice of how to request and its level of directness. The more entitled a speaker is to perform the request, the more direct that request will be.

6.4.2.1 REQUESTS VIA DIRECTIVES

During these particular nurse-patient interactions the nurse requests actions from the patients in order to prevent certain risks, generally taking the form of: if conditional + recommendation (imperative) as mentioned above. The actions requested are subject to the fulfilment of a certain condition. As noted by Vine (2009) this contingent varies depending on the recipient's willingness or capacity to perform the action requested. In this data set requests appear direct and are many times delivered using an imperative form. They take a form of telling rather than asking making the requests more of a directive as described by Craven and Potter (2010). There is a multiplicity of different ways in which directives have been formulated and Craven and Potter (2010) make a distinction between requests and directives that is relevant for this particular data analysis. They build on Curl and Drew's (2008) entitlement and contingency approach and suggest that:

a. the entitlement claimed in directives is 'to tell' rather than 'to ask'
b. directives do not orient to the recipients ability of desire to perform the relevant activity
c. directive contingencies are to be complied with not accepted and performed as with requests
d. directives do not project the possibility of refusal

The data in this research aligns itself to the notion of directives described by the characteristics above, as opposed to general requests, and this in itself has a direct impact on how patients respond to risk.

So far I have discussed how the nurse talks about risk specifically by her use of if-conditionals. These grammatical structures have the function of presenting a potential risk and recommending a certain course of action in order to avoid the risk. So how do patients respond to these recommendations and to the risk presented?

6.5 HOW DO PATIENTS RESPOND TO RISK PRESENTED VIA AN IF-CONDITIONAL?

In this section I will present 9 extracts (extracts 6.24-6.32) of the patient's responses to if-conditionals. In this data set the trend was for patients to provide minimal responses ("yeah, "uh hum") to the potential risk presented and to the recommendations offered. There was no indication that confirms that patients would follow the recommendations given by the nurse except for two cases.

6.5.1 PATIENT RESPONSES TO ADVICE

Kinnell and Maynard (1996) state that patients acknowledge advice in three different ways. Firstly through a marked acknowledgement ("oh right") after client-initiated advice, secondly through an unmarked acknowledgement ("mm", "yeh") using continuers avoiding the advice as informative and not overtly accepting it, and thirdly through an assertion of knowledge, indicating that the advice given was surplus.

Maynard and Kinnell's findings suggest that the most frequent responses were the unmarked acknowledgements. In these responses there is nothing that indicates that the patient will act on the recommendations given. There are no explicit markers of receipt of the advice given. Maynard states that delivering advice as information elicits minimal unmarked acknowledgments that function as continuers to keep the talk going, they do not indicate an acceptance of the advice. The function of risk talk in this data set has been identified as advice giving and the patient responses are aligned to Maynard's finding.

Patients produce minimal responses when they are given a recommendation to minimise any potential risk they might face. Responses consist of minimal tokens such as “right”, “mm”, or silence. Patients generally did not explicitly accept the advice or give any indication that they would act on the recommendation except for two cases.

Extract 6.24
(N: nurse, P: patient)

The recommendation of eating while on this particular medication is acknowledged by a minimal marker “yeah” in lines 8 and 12.

```
01   N:   but the Glimepiride that you're on it's important as I was
02        mentioning that you have your three meals a day cause that
03        will bring your blood sugars down no matter what
04   P:   yeah
05   N:   so that will work so if you're not putting any energy back
06        in you have that potential for your blood sugars to keep
07        carrying on going down and down
08   P:   yeah
09   N:   ah this is where we have ye heard of the term of a hypo
10        when diabetics have a hypo that means that they're having a
11        low blood sugar hhh
12   P:   yeah
```

Extract 6.25
(N: nurse, P: patient)

The recommendation of getting some lunch if the patient feels lightheaded and is having a low blood sugar moment is acknowledged with the minimal maker “yeah” in line 7.

```
01   N:   the best thing for you if you're ever out and about and
02        you've missed yer lunch and you're starting to feel a bit
03        strange a bit lightheaded some people start sweating ummm
```

they get a bit confused a bit unsteady always presume it's yer blood sugars that's on the low side an' if you c'n just stop at a café and just get yer lunch then do that

P: **yeah**

Extract 6.26

(N: nurse, P: patient)

The patient has been recommended to file his toenails instead of cutting them to avoid any trauma and potentially risky problems with his feet. His response is a minimal token: "yeah" in line 6.

N: yes ai well if you file 'em just twice a week they say that's all you need to do without cutting it cause it's less chance of you causing any (0.4)

P: aah

N: sort of trauma to them

P: **yeah**

Extract 6.27

(N: nurse, Patient: P)

The potential risk of a hypo is presented in line 6 and in line 7 there is a significant pause. The nurse carries on with an explanation on next steps and how to manage a change in treatment. The patient's response is a minimal token: "yeah" in line 14.

N: now that worries me from my perspective is because if you take that tablet but then you don't have anything to eat that tablet is gonna work and work and work but it's not getting any fuel back in an we run a risk then of you

P: yeah

N: collapsing and going unconscious really worst case scenario **(1.0)**

N: (. hhhh) so it's really where do we go from here like ideally it's hhh it's deciding I guess whether part of you feeling unwell an this lack of appetite an certainly

11 when people are unwell and they're poorly and even if
12 they're not eating it can tend to make your blood sugars go
13 up
14 P: **yeah**

Following this exchange the nurse carries on with more suggestions in extract 6.28.

Extract 6.28
(N: nurse, P: patient)

The nurse has provided her recommendation of getting the patient into a habit of eating regular meals if her blood sugars are still high after her next blood test. The patient replies with a token "yeah" in line 8 and responses thereafter are minimal as well (lines 11, 13 and 15).

01 N: […] maybe have another blood test done and then see if
02 things have settled back down
03 P: [yeah
04 N: [to where they were uhh and
05 then from there is umm if it's still high we're going to
06 have to get yer in the habit of having regular meals
07 because
08 P: **yeah**
09 N: I daren't increase your treatment until I know that you're
10 eating umm
11 P: **um hum**
12 N: eating eating adequately
13 P: **yeah**
14 N: how do you feel about that
15 P: **yeah**
16 N: yeah
17 P: I mean
18 (2.0)

Extract 6.29
(N: nurse, P: patient)

The nurse has recommended having something to eat to treat a potential hypo. The patient responds with a nod, which does not express sufficient acceptance of the nurse's recommendation. This is evidenced by the nurse's continuing talk in line 8 explaining her recommendation further.

```
01   N:   ye know and I'll I'll stress again with the importance of
02        ye going to your allotment with something to treat a low
03        blood sugar with even if you don't take your machine with
04        you if you start to feel funny ye presume that it's a low
05        blood sugar and ye get something to eat
06   P:   ((nod))
07   N:   so ye must always even if you leave some biscuits there ye
08        know
```

Extract 6.30
(N: nurse, P: patient)

The nurse has recommended switching to a non-sugar coated cereal. The patient responds to the suggestion by providing some information asserting his knowledge (line 4). However, having alternative cereals in the house does not ensure that action will be taken. In line 5 the nurse justifies her recommendation and the patient replied with a minimal token "yeah ai ai" (line 8). The nurse recommends an alternative cereal without the sugar and the patient again offers a minimal response (line 14). In line 15 the nurse explains that the alternative cereal would be better for him to which she receives another unmarked acknowledgment "mm" (line 16).

```
01   N:   right(1.0)if you could possibly switch those to a cornflake
02        or uhh like a wheatabix or something like that, do you like
03        any of the other cereals?
04   P:   ah uhh I've I've got them in 'ouse cornflakes and wheatabix
```

05 N: yeah it's just that they're coated in the honey and the
06 honey is sugar like you're doing all right with your
07 diabetes control
08 P: **yeah ai ai**
09 N: so really you're getting away with it at aren't ye at the
10 minute
11 P: yeah
12 N: but if you could if there's any sort of alternatives
13 without that sugar coating on it
14 P: **yeah**
15 N: would be uhh better for you
16 P: **mm**

In summary, regarding patients' responses to recommendations, most of the data in this study aligns itself with previous findings in so far as the regularity of unmarked acknowledgements to recommendations offered. However, there were two deviant cases, extract 6.31 and 6.32 below.

Extract 6.31
(N: nurse, P: patient)

The blood sugar results are back for this particular patient and they are high. The patient has accepted responsibility and admitted that he had been eating more sweet things lately, which is probably the cause for his high blood sugar count. The nurse agrees.

01 N: […] now we do I think it is probably attributed to the fact
02 that of what you've been doing
03 P: yeah
04 N: and the only way that we can see really is if ye hh not to
05 do it
06 P: yeah
07 N: and to 'ave it checked in three months time
08 P: **all right no worries**
09 N: saying that we do know that over time your diabetes does
10 get worse
11 P: mm

12 N: ye know it's a matter of uhh how they the course of the
13 diabetes really umm so but I would imagine if you just
14 watch what you're eating
15 P: yeah
16 N: we'll b' having a reading more like we got last time
17 P: **no I'll cut it out again**
18 N: yeah
19 ((both laugh))

The nurse provides an explanation as to why she thinks the patient's blood sugars are high. The reason for the high blood sugar is due to what the patient has been doing recently (lines 1-2). In this case the "doing" refers to the patient eating too many sweets. The patient agrees in line 3 and the nurse continues her talk by producing an account on how to verify if his eating is what is causing the increase. The nurse recommends the patient to stop "doing" what he is currently doing (lines 4-5) and have another blood test in three months' time (line 7). In line 8 the patient accepts the nurse's recommendation. In line 9 the nurse provides an account that challenges her previous recommendation, evidenced by her use of: "saying that" (line 9) as an expression of contrast. However, in line 13 she aligns her account with her previous suggestion (lines 1-2) and provides further advice via an if-conditional in the format: if p then q. The desired action is part of the if-clause (p) and the desired outcome is part of the matrix clause (q). If the patient watches what he is eating (p) the reading will probably be like last time i.e. lower and controlled (q). The if-conditional in this extract differs as it is positively framed and the future outcome (q) is something desired. In this case the patient does reply and accepts the recommendation by volunteering a certain action that he will be performing, which aligns with the nurse's advice in lines 13-14. The difference in this interaction compared to others in the data set is the patient's acceptance of the recommendation by offering an explicit action he will implement (line 17) as opposed to providing a minimal continuer. This difference is potentially due to the patient entering the consultation room already admitting certain risky behaviours on his part and taking responsibility for them. He takes 'the blame' for his raised blood sugar count and mentions cutting down on his sweets intake. This previous admission allows the nurse to

mention the risk, through an if-conditional like the others, but framing it positively.

In the majority of the cases the speaker preference is for the condition not to be met, for example: if you eat sweets your blood sugars will go up. In other words: if p, then q. P being an undesired behaviour or state of affairs that produces the negative effect q. In this deviant case the patient takes responsibility and action, and the nurse produces a positively framed if-conditional where p and q are desired. If you do p you will achieve q.

Extract 6.32 is the second deviant case.

Extract 6.32
(N: nurse, P: patient)

The nurse has recommended a change in dosage as the patient is having hypos. She mentions the risk of breaching his driving licence and the patient finally agrees to change the medication.

03 N: so yeah you could potentially be getting behind the wheel
04 of your car with a blood sugar under the five millimoles
05 which ye know ye the DVLA say that ye know ye shouldn't be
06 doing that and if they say ye know they might come to you
07 and say look ye know can you prove your blood sugars are
08 all above the five and that you're testing before ye drive
09 so you could be in breach of ye ye driving license as well
10 with that so
11 P: **o::h**
12 N: ok so there's a whole sort of
13 W: mm
14 N: a °ray of
15 P: **so I'll do an eighty and a f'**
16 N: all right and if you want to book for a month

This agreement is evidenced in line 15, where the patient repeats the dosage recommended by the nurse previously during the interaction. His repetition of

the actual recommendation dosage indicates the action he will be performing i.e. taking an eighty milligram and a forty milligram. Here we can see that the patient has offered the action as opposed to providing a minimal response. The risk of being in breach of his driving licence encourages him to accept the new treatment.

6.6 DISCUSSION

The literature mentioned earlier has suggested that requests receive minimal patient response, in particular if they are realised as directives. I believe that recommendations offered within the if-conditional structure function as directives. As per Curl and Drew's entitlement and contingency approach (2008) directives 'tell' rather than 'ask' e.g. "come back and see me", "let us know straight away", we're going to have to get you in the habit", "get something to eat", "you come straight back to us". They also do not adjust to the patients' desire or capacity to perform the said action. For instance, one of the patients has been told that her eating habits will have to change regardless of her ability. In turn, the patient produces a defensive account whereby she explains that her 'not eating adequately' is not purposeful.

In addition, directives do not project possible refusal. The exchange in extract 6.17 "if you start to feel […] come back and see me" offers little room for patient refusal. The patient would not be able to disagree with this directive. Finally, the fact that directives 'are to be complied with not accepted and performed as requests' could explain why the most frequent responses to these recommendations are unmarked acknowledgements.

Alternatively, patients' minimal responses provided to the nurse's recommendations could be interpreted as continuers, allowing the consultation's progression or waiting for further elaboration on the risk. This is similar to minimal responses from patients when hearing a diagnosis (Perakyla 2006). Some patients receive a diagnostic statement by providing acknowledgement

tokens like “yeah”, uhum” and as noted by Perakyla (2006) these are designed to encourage additional information on the diagnostic statement or the potential treatment.

Despite patients producing these unmarked acknowledgements, the grammatical structure of if-conditionals works well for presenting risks. This is because it does not focus on numerical values or percentages, which are often difficult for patients to interpret (Thomson et al 2005, Gigerenzer et al 2003, Eiser 1998, Anderson and Iltis 2008). Statistical numeracy many times presents difficulty due to the representation of information. Likewise percentages also present challenges in terms of the interpretation of probabilities.

If-conditionals in this data set do not rely on numeracy but present a hypothetical situation that could or could not happen if action were taken or not taken (*if p, q*). This risk presentation is based on experiential reasoning which patients typically rely on most (Collins et al 2009). When it comes to judging risk, physicians mostly rely on analytic reasoning as opposed to patients who rely on experiential reasoning. Therefore, risk in this data is presented differently from the majority of data on risk available in the literature. The main way risk is communicated in medical settings is through 3 basic formats: 1) numerical i.e. 1 in 5, or percentages, 2) verbal terms i.e. low or high risk of X, and 3) graphical representations. As mentioned above these ways of communicating risk can be difficult for lay audiences to understand and have an effect on the patients’ perception of risk (Rimmer and Harvey 2014, Misselbrook and Armstrong 2002). Risk models based on mathematics are designed for doctors and are not well suited for patients as they have a different way of perceiving risk. According to Ohnishi et al (2002) patients prefer words to numbers when it comes to communicating risk. However, a study which surveyed psychiatrists on their use of ‘colloquial’ verbal terms such as: “likely”, “rare”, “often”, suggested that not even they are in agreement on what these terms actually mean in practice (Hanmann et al 2011). Moreover, there was substantial variation regarding the psychiatrists’ view on what frequencies are entailed by these colloquial terms. Therefore, these verbal expressions are not deemed a reliable

and consistent way to communicate risk, despite the fact that they might be more amenable to patients' perception of risk.

The presentation of risk in this particular data set does not use numerical values or verbal terms as mentioned above. Instead, risk is presented via the use of a grammatical structure. Risk talk is indicated by the introduction of a conditional clause marked by the use of the conjunction "if". The use of if-conditionals relies on the proposition: *if p, q*. Therefore, referring to a future event that is conditional on another future event, for example: if you take this tablet and do not eat you will experience a hypo. The recommendation provided in order to avoid risk is individual and tailored to the patient. It is not only informing the patient of a potential risk, it is also attempting to control or change the patient's behaviour. Due to this attempt, the risk presented has to be individual to the particular patient and to his or her own risky behaviour. This is beneficial since including individual risk on a one-to-one basis is considered a more effective way of communicating risk (Edwards et al 2000) as opposed to estimating a more general risk for the larger population. In this study, it is exactly the individual risk that the nurse relies on in order to persuade the patient in changing certain behaviours.

The individuality of the risk talk in this data and the directives produced by the nurse via if-conditionals can be explained in terms of the routine nature of these consultations. Hence, the importance of analysing chronic visits.

Firstly, the data in this study are based on type 2 diabetic routine check-up consultations. Patients have already been diagnosed and are aware of the major risks of diabetes i.e. heart and kidney disease, stroke, amputation and blindness. These major risks have been previously addressed and therefore constitute shared knowledge between the patients and the nurse. Both speakers are aware of the risk context they are engaged in (Adelswärd et al 2002). Patients are attending the routine check-up consultation because they suffer from a chronic illness, which has an impact on their overall health, hence requiring regular checks. Therefore, the risks mentioned in these particular check-up visits are

pertaining 'minor' risks of a more immediate nature, as the speakers are already aware of the major risks. These minor risks could potentially become major, consequently, these consultations review the patients' current wellbeing and address any potential risks brought on by their own behaviour and/or management of their illness. Due to the routineness of the visits, the nurse can concentrate on the individual and immediate risks to the patient. In this context the nurse does not deem necessary the use of percentages and statistics, hence her use of hypothetical future events via an if-conditional structure. The nurse is dealing with individual risks specific to the patient which are dependent on his/her behaviour. The way this is executed by the nurse is by offering a direct recommendation dependent on the action or non-action of the conditional.

Secondly, the directness of the nurse's recommendations can also be explained by the routine nature of these consultations. As these are regular 6 monthly check-ups, in all cases but one, the patients have already meet the nurse and therefore have built a relationship prior to these recorded visits. Moran et al (2008) suggest that the familiarity between the practitioner and the patient in diabetes consultations has a bearing on the level of directness in the practitioner's recommendations. Therefore, in consultations where the patient and the doctor know each other, recommendations and advice from the doctor appear more direct and more frequent. This could account for the directives produced by the nurse when giving advice. The familiarity the nurse has with the patients could explain why she produces more directives as well as making relevant her entitlement for the directives (Curl and Drew 2008). Her choice of expressing a directive reflects her stance in terms of the "grant-ability" of the request. The request in form of a directive e.g. "if X, come back and see me", displays an urgency in the request that needs to be granted should X occur. It demonstrates an understanding that the request not only can be granted by the recipient, but should be granted if X were to happen.

However, it appears that when it comes to patient responses, if-conditionals do not elicit extensive replies from patients, instead they offer minimal tokens of acknowledgement as mentioned above. Patients' minimal responses to risk via

if-conditionals are not necessarily an indication of a lack of a patient centred approach within the visit or a lack of patient satisfaction. This is confirmed by the patient post-consultation interviews, where all the patients stated to be satisfied with the visit, understood everything that was discussed and felt they could ask questions. Patients' minimal responses could be due again to the routineness of the consultation and the familiarity with the nurse. Howie et al (1999) talk about "enablement" as a measure related to patient satisfaction and state that patients reported increased enablement when they knew the doctor well.

On the other hand, patients' minimal responses could be due to the compliance nature of the directives within the if-conditional clause, which are to be followed and not accepted. It could be argued that the two deviant cases in extracts 6.8 and 6.9 prove that some patients do accept directives. However, I believe this is due to other factors. In extract 6.8 the patient has already taken responsibility for the high blood sugar results showing in his test. Action needs to be taken in order to reduce these, making the risks less hypothetical. The patient had already offered his own recommendation of reducing his 'sweet' intake previously in the consultation making the request from the nurse less of a directive. This could explain the positive framing of the if-conditional by the nurse, as there is no need to point out the risk within the if-clause since the patient is already aware of it, evidenced by his own offering of action.

Extract 6.32 is different to the other extracts because in this case there is specific pursuit for an acceptance from the patient. The nurse is pursuing an explicit acceptance from the patient to change his medication. She is using risk in order to persuade him to accept this treatment change. Therefore, she resorts to the risk of breaching his driving licence as a way of encouraging him to accept the new dose. The patient finally accepts this treatment change evidenced by his receipt and repetition of the new dosage.

The research in this chapter builds on the knowledge base of if-conditionals and their use within medical discourse in particular within spoken discourse. Its

original contribution arises from findings where if-conditionals have been identified as a resource for the presentation of risk talk and advice giving within chronic diabetic routine consultations.

The literature on if-conditionals within medical discourse have previously addressed its use within three specific medical genres: research articles, conference presentations and editorials (Carter-Thomas and Rowley-Jolivet 2008, 2014, Ferguson 2001). These studies on if-conditionals rely on large corpus based data and little has been done on if-conditionals and naturally occurring talk (Ferguson 2001). It appears that if-conditionals have different functions and serve different purposes depending on the genre they are used in.

For example, Ferguson (2001) suggests that within medical research articles if-conditionals are used to provide definitions, however in spoken consultations they are resources for managing the interaction with sensitivity and politeness. Moreover, if-conditionals were more frequently found in editorials compared to articles and presentations. Ferguson (2001) proposes that this is due to the editorials' purpose, as some aim to provide a more authoritative perspective on present knowledge and therefore use assertive if-conditionals in order to achieve this. He also presents within this genre a pattern of "advice-offering sentences" where the advice or recommendations are presented followed by specific circumstances relevant to the advice. However, when it comes to if-conditionals in spoken consultations he presents politeness as one of the most salient functions and uses of if-conditionals. Nevertheless, this was not the function of if-conditionals when presenting risk in chronic diabetic consultations. In fact, similarly to the functions described in editorials, if-conditionals in this chapter displayed a pattern of: advice (if-conditional) followed by information/ circumstances of advice. Likewise, it aligns to the notion of a more authoritative voice and the conception that if-conditionals have levels of directness realised via their grammatical structure i.e. use of modals or imperatives as mentioned previously. Therefore, if-conditionals in this data set serve the purpose of presenting risk and providing recommendations. They are not only used as politeness resources for managing consultations in this context.

Furthermore, if-conditionals are used to present specific risk tailored to each patient and their circumstance. The level of directness within the recommendations offered by the nurse in order to avoid risk is potentially linked to the routine nature of these consultations. Interestingly, patients did not disagree with any of the recommendations provided via the if-conditional structure. This could be due to the hypothetical nature of these when presenting risks. Nevertheless, patients often disagree with practitioners and one of the ways this is displayed is by offering resistance. This is demonstrated in the following chapter.

7 Disagreeing by resisting

Doctor-patient communication studies consistently depict an asymmetry of knowledge and authority between physicians and patients (Maynard 1991, Ariss 2009, Lindstrom and Weatherall 2015). Arguably, doctors appear more dominant or more 'powerful' in terms of their position within the doctor-patient interaction due to the asymmetry of knowledge between doctor and patient which characterised the medical encounter. Undoubtedly, physicians' epistemics have a direct bearing on the doctor-patient interaction particularly in terms of providing treatment recommendations. Physicians hold the knowledge and therefore, are the advice givers, making the patients the advice receivers. This relationship is based on the asymmetry between participants regarding certain topics (Ekberg and LeCouteur 2015). The advice giver is generally considered the knowledgeable and competent party on the given topic, whereas the advice receiver is less competent on the topic and therefore requires the advice.

This intrinsic asymmetry within the doctor-patient interaction is part of the context and is procedurally consequential to the talk (Schegloff 1992). It is displayed during turn taking and influences the interaction's trajectory. This is particularly significant when it comes to advice giving, as physicians will index a higher epistemic authority during the interaction when providing advice and recommending treatment.

Prior research has demonstrated that advice giving can be considered a potentially problematic activity (Kinnell and Maynard 1996, Waring 2007). Advice giving entails an epistemic disparity between participants, as one is the advice giver and the other is the advice receiver. This is particularly troublesome when the advice is not solicited. However, it can still cause resistance even when it is expected. In medical consultations the patient has already accepted the role of 'less competent' (Waring 2007) nevertheless, patients can still resist the physician's recommendation, resist the less competent status or resist both.

7.1 HOW IS PATIENT RESISTANCE DISPLAYED?

Several studies have identified patients' resistance to physician's advice in the form of silence or minimal acknowledgements such as: "mm," "yeh" (Kinnell and Maynard 1996, Koenig 2011, Stivers 2006). Kinnell and Maynard (1996) noted very few acknowledged responses from patients in their study on advice giving in HIV clinics. Moreover, during some of these exchanges patients did not even offer minimal acknowledgments and declined the opportunity to talk.

Resistance in this chapter is more explicit as it is not expressed through minimal acknowledgements or withholding responses, instead it involves offering additional information or explanations that are discrepant to the nurses' suggestions.

This chapter will examine ways in which patients resist a diagnosis, a treatment change and a diet recommendation during chronic type 2 diabetic check-up consultations. This chapter will present and analyse 12 extracts (7.1-7.12) which correspond to the 12 examples of active resistance found in this data set. Active resistance in this study refers to resistance whereby the patient offers more than just a minimal acknowledgement or silence as per Stivers (2006) passive resistance. Instead, patients display more of an active role through talk and express their resistance via resources such as providing additional experiential information discrepant to the nurse's suggestions.

Resistance occurred within three different contexts: diagnosis (section 7.1.), treatment change (section 7.2) and diet (section 7.3). It will be shown that one of the ways in which patients actively express their resistance is by providing evidence from their own experience that is inconsistent or discrepant with the medical evidence or nurse's view. This is the preferred organisation in order to maximize the social solidarity and minimize disaffiliation within this potentially troublesome course of action (Heritage 1984, Muntigl 2014). Patients demonstrate resistance to the nurse's recommendation instead of explicit disagreement to the recommendation. This resistance tends to be expressed via

patients' additional accounts that contradict the nurse's reasoning behind the advice given. That way, patients can demonstrate resistance and exert agency, whilst maintaining a certain degree of alignment with the nurse's views, conducive to the consultation's progression. Stivers (2008) suggests that alignment occurs when the hearer acknowledges information and supports the progress of the telling. Patient resistance in this data is a way for patients to demonstrate their own stance in a non-confrontational manner, hence allowing the consultation's progression.

The chapter builds on previous research (Stivers 2005, 2006, Perakyla 2006, Koenig 2011) regarding patient resistance by presenting forms used by patients to actively resist recommendations.

Koening (2011) notes that patient resistance is a significant interactional resource for patients to assert agency, enabling a space for negotiations between physicians and patients. Stivers (2005, 2006) suggests that patients passively resist treatment by offering minimal acknowledgements and not fully accepting the diagnosis. By not accepting the diagnosis the trajectory of the consultation is sequentially suspended, as the doctor cannot proceed to the closing phase of the consultation without a treatment acceptance. Likewise the findings presented in this study, Perakyla (2006) states that patients disagree with a diagnosis by offering a symptom description that is discrepant with the doctor's diagnosis.

The originality of this work lies on the fact that the data analysed is from chronic check-up consultations. Therefore, resistance is displayed in terms of the patients' on-going diagnosis, on-going treatment and on-going diet monitoring. This chapter provides instances on how diabetic patients typically display active resistance to their diagnosis, to their on-going treatment and to a diet change.

7.2 RESISTANCE OVER DIAGNOSIS

Although patients have already been diagnosed with type 2 diabetes when attending these check-ups the patient in the extract below, is still resisting her diagnosis.

She has been recently diagnosed and her blood sugar is slightly higher than normal which has tipped her into the diabetes threshold. This is her first follow-up check-up with the nurse.

Extract 7.1
(N: nurse, P: patient)

```
01   N:   right↓ any problems since I last saw ye
02   P:   no, not really
03   N:   ((coughs)) excuse me
04   P:   well yu' know I'm in delai denial
05        ((both laugh))
06   N:   I know (1.0) >I ws going t' say< that have you come [uh
07   P:                                                      [yeah]
08   N:   yeh come to terms with uh the diagnosis
09   P:   not really
10   N:   no no
11   P:   I don't feel no different
12   N:   no which is good but that sort [of
13   P:                                  [yeah]
14   N:   from our perspective the scary bit about it is that you
15        feel all right but we know potentially what c'd 'appen sort
16        of long term with it which is why it's important that we do
17        what we do really but uh we've taking your last blood test
18        today this will determine what we're gonna to do after this
19        really you're not keen to medica[tion
20   P:                                    [not taking I'm not taking
21        owt
22   N:   I know even though we've discussed haven't we
23        [the complications
23   P:   [no not taking]
```

24 N: why we advise you to but at the end of the
25 day it's you know you're [decision
26 P: [well I'll live till I die]
27 N: you're important

The nurse starts the consultation by asking the patient if she has had any problems since the last visit (line 1). The use of "any" by the nurse in line 1 prefers a 'no' response which the patient offers in line 2 aligning with the nurse's talk. Following the patient's "no, not really" response in line 2, the patient explicitly notes in line 4 that she is in denial. This denial could be either with the diagnosis, the illness itself or both.

The patient starts her utterance with a prefacing "well". The function of this turn-initial "well" is to shift to another topic and introduce a new relevant agenda point in the talk. Heritage (2015) states that "well" prefaced turns function as a way of introducing a new topic. The new topic introduced by the patient is her denial and she makes evident that the nurse knows about her denial. The patient's utterance "yu' know I'm in denial" (line 4) establishes the patient's denial as common ground they both share. Immediately after the common ground is noted there is laughter from both parties in line 5, demonstrating further solidarity from both speakers (Haakana 2002). In this case laughter is reciprocated which entails a level of bonding which is reflected by both the nurse and the patient aligning to a shared sense of humour. In line 6 the nurse admits knowledge of the patient's denial and in line 8 she asks the patient if she has come to terms with the diagnosis. The nurse does not explicitly mention 'diabetes', but 'diagnosis', potentially minimising the effect of the question by avoiding the term the patient is in denial with. The patient's reply in line 9 "not really" displays some resistance in that she has been given a medical diagnosis which she does not fully accept and has "not really" comes to terms with it. The "really" has a minimising effect within the patient's no-response.

In line 11 the patient resists the diagnosis further by offering contradictory evidence to the diagnosis that only she can provide "I don't feel no different". This is the patient's personal evidence that cannot be contested by the nurse as it

stems from her own personal experience regarding how she feels with the current diagnosed illness. The patient is providing a symptom description that she considers is discrepant with the diagnosis. This is what Perakyla (2006) refers to as patient resistance. The nurse acknowledges the patient's resistance, evidenced by her response in line 12 where she offers an account which justifies her actions as to why it is important for 'them' (the medical professionals) to do what they do. They know that despite the patient "feeling no different" there is an underlying illness which potentially could develop further health problems long term.

The patient resists the diagnosis by offering information on her health that could contradict her actual diagnosis i.e. she "feels no different" than before she was diagnosed.

Extract 7.2
(N: nurse, P: patient)

The consultation carries on and after further talk about the patient's views on life and death, the nurse brings the conversation back on track and mentions the blood test.

01 N: so even if your blood test today comes back the same as
02 that hopefully better because if we've changed things and
03 put things in place (0.6) you know from from a perspective
04 of high blood sugars it maybe that we don't we wouldn't
05 have to start ye know sort of not insist to you [but
06 P: [**no what**
07 **gets [me**
08 N: [encourage you to go on a tablet
09 P: **I don't take sugar**
10 N: no but it's not about that is it
11 P: no: I know it's fat as well
12 N: it's it's just what's not happening within your body really
13 P: yeah

In this extract we can find resistance in the form of implicit disagreement (Peraklya 2006). The patient has previously stated in extract 7.1 that she will not

take medication for her illness. The nurse then mentions her blood sugar test results in line 1 with a focus of potentially changing her diet and the patient provides further evidence in line 6 stating that she does not take sugar (line 9). This personal evidence reinforces her position of denial regarding her diagnosis and provides an account that contradicts her high blood sugar test result. Again this is the kind of evidence which cannot be refuted by the nurse, since it refers to the patient's personal eating habits.

In line 10 the nurse accepts the patient's evidence, but also suggests that it is more than not taking sugar asserting her epistemic authority as the medical expert with the medical knowledge regarding the illness. In line 11 the patient retreats to her realm of knowledge (Ariss 2009), agrees with the nurse and provides a further account of what she thinks also affects the illness in terms of diet.

Patient resistance is not only present when dealing with diagnosis. Patients can also resist a change in treatment as demonstrated in the following section.

7.3 RESISTING CHANGE IN MEDICATION

This section will focus on the patient's interaction with the nurse regarding the change in dosage of one of his on-going medications. Extracts 7.3-7.7 are all negotiations between the patient and the practice nurse presented in chronological order. The reason for presenting extracts from the same interaction is because the patient resists several attempts from the nurse to change his on-going treatment. Therefore, the nurse has to build her case for this change and increase her efforts in order to persuade the patient for an acceptance.

Even though the examples in this section occurred in the same consultation with the same speakers, they are still significant in terms of generalizability. In extracts 7.3-7.6 the patient displays his resistance by providing experiential

information that is discrepant with the nurse's views. Therefore, in these examples that patient uses the same resources to exert his agency and resist the change like the other patients do in sections 7.2 and 7.4.

The patient in the extracts below has had diabetes for a few years and due to its severity he has to take two types of medication in order to control it. One of the medications requires the patient to self-test his blood sugars a few times a day, and if driving report these figures back to the UK Driver Vehicle and Licensing Agency (DVLA) when asked. The DVLA mandates that diabetic patients on this particular medication should not drive with a glycaemic reading below 5 millimols. Hence, the need for the patient to self-test every few hours when driving.

In addition, the main effect of this medication is that it lowers blood sugars constantly regardless of diet. Therefore, it is important to have three meals a day in order to avoid hypoglycemia (low blood sugar episodes). The patient has attended this particular consultation with his wife (W).

Extract 7.3
(N: nurse, P: patient, W: patient's wife)

01	N:	yer blood test result that we've just done now has gone
02		back down and a little bit under the threshold so my
03		question to you was were you having some low blood sugars
04		and you are aren't ye (.) so that's reflected in that ye
05		having really hypos which is the the low blood sugars that
06		we sort of talk about
07	P:	**yeah but**
08	N:	yeah
09	P:	**this is what's baffled me uhhh**
10	N:	mm
11	P:	**I feel ok**
12	N:	yeah
13	P:	**no dizziness or anything like that ye know it's uhh**

In lines 1-6 the nurse explains that the patient's blood sugar test shows he is running a little bit under the desired blood sugar threshold and is experiencing hypoglycaemia (low blood sugar episodes). The nurse's account (lines 1-6) prefers a 'yes' response, in particular due to her use of "aren't ye" in line 4. However, the patient produces a dispreferred response in line 7 using an agreement + disagreement format "yeah but" (Schegloff 2007). In this format the agreeing response "yeah" delays the disagreeing or dispreferred one "but'. In line 9 the patient expands his dispreferred response by adding that something has "baffled" him and in line 11 he mentions that what has baffled him is the fact that he feels "ok". Similarly to extract 7.1 in the previous section (7.2) the patient provides an account where he "feels ok" (line 11) implying that no change is needed. This account of him "feeling ok," challenges the nurse's previous account regarding him experiencing hypos, hence being baffled. There is a discrepancy between how the patient is feeling and how he should be feeling if he is indeed experiencing hypos. In line 13 the patient gives further evidence to support his view by stating that he has had "no dizziness or anything like that", demonstrating his knowledge about the illness and also his ability to identify whether he is actually experiencing a low blood sugar moment. Dizziness is a symptom he should have if he is experiencing hypos. Therefore, not feeling dizzy disputes the fact that his blood sugars levels are too low.

This evidence offered by the patient in line 11 ("I feel ok") and in line 13 (no dizziness or anything…') is based on his own experience, thus being irrefutable by the nurse.

Extract 7.4
(N: nurse, P: patient)

This extract follows extract 7.3 chronologically.

```
01   N:   how do you feel ye know when you're low how did ye feel
02        when these were
03        (1.0)
04   N:   w' °low
```

05 P: **jst' I woke up feeling 'ungry that was all**
06 N: yeah just the hungry feeling not [anything else
07 P: [**uhhh but like I said**
08 **there's no dizziness**
09 N: no
10 P: anything else it's just that
11 (1.0)
12 P: **which I do do normally sometimes ye know when I have to go**
13 **t' toilet ye know**
14 N: mm
15 P: which is a BIND
16 ((both laugh))

The nurse asks the patient how he felt when he was experiencing low blood sugar moments (lines 1-2). In line 5 the patient starts his turn with the adverb "jst" (just) serving as 'merely' or 'only'. He then says "I woke up feeling 'ungry that was all". Again minimising the effects of the hypo, as he was only feeling hungry. The nurse reiterates "just the hungry feeling" in line 6 and the patient overlaps in line 7 repeating what he had said in the previous extract "no dizziness" asserting his knowledge about hypos and in particular his ability to identify potential hypo symptoms.

There is a silence in line 11 and the patient then gives more evidence in line 12 supporting his claim that waking up feeling hungry is not unusual for him. He says "which I do do normally sometimes ye know when I have to go t' toilet ye know". The patient's use of both adverbs: "normally sometimes" in succession suggests some repair in his talk. First he mentions that he normally gets up, indicating that this is frequent, however he then says "sometimes" suggesting that it happens on some occasions, not always. He then proceeds with a complaint in line 15 about getting up, "which is a bind". This complaint serves the function of a joke which makes relevant the recipients' laughter in line 16. After a joke, laughter is conventionally expected (Jefferson 1979). The patient is normalising his situation i.e. having low blood sugars. This is evidenced with his use of "just" in lines 5 and 10, indicating a no problem situation. In addition, in line 12 he refers to getting up at night and feeling hungry, and how this is not

unusual for him. Thus normalising the situation, making it appear less serious, to the extent of commenting in line 15 how annoying it is to have to get up for the toilet.

The patient is resisting the idea that his blood sugars are too low. He provides evidence that contradicts the fact that he is running low on blood sugars. Namely, he is not experiencing the symptoms that reflect low blood sugars.

Extract 7.5
(N: nurse, P: patient)

Extract 7.5 follows extract 7.4 chronologically. The nurse suggests dropping the dose on one of the patient's tablets as a way of managing these low blood sugar moments.

01	N:	we work on fifty to sixty as ye know so an you've normally
02		sort of run about fifty five whereas you're sort of forty
03		nine now so you've just sort of tipped under that threshold
04	P:	mm
05	N:	so that's why
06	P:	**oh eh they're only one offs and as I said**
07	N:	mm
08	P:	**I've taken your advice thoroughly** if you want to look but
09		**I'm I'm mainly fives and sixes that there is**
10	N:	yeah
11	P:	**I have had some really HIGH ones like that one**
12	N:	mmm

The nurse starts in line 1 by giving the patient the figures on what an ideal blood sugar reading should be ("we work on fifty to sixty as ye know"); the patient is aware of this margin, as it has been mentioned before. The nurse then carries on mentioning his "normal" test result, ("you've normally sort of run about fifty-five"). She then contrasts fifty-five with the new test result of forty-nine (line 2), and evaluates the current result as "just sort of tipped under the threshold" (lines 2-3), minimising the test results and suggesting it is somewhat borderline.

With these contrasting results the nurse is building her case for the patient to accept her recommendation of reducing his medication.

In line 6 the patient responds that the low blood sugar instances he has had are only "one offs". This account resists the nurse's recommendation regarding lowering his medication. This new evidence he provides of "one offs" demonstrates that the nurse's recommendation is not warranted because the low blood sugars he is experiencing are not constant, but only one offs.

The patient tries to strengthen his argument in line 8 by noting that he has taken the nurse's advice thoroughly and mentions some self-testing figures of his own. These figures mentioned, fives and sixes in lines 8-9, generally suggest accurate blood sugar control for type 2 diabetes patients (Diabetes UK). Therefore, he implies that he has taken her advice thoroughly and the figures from his self-testing (fives and sixes) reflect this. Furthermore, he adds in line 11 that he has had some really high blood sugar readings, which is the exact opposite to what the nurse is trying to prove.

The patient makes use of his own experience and knowledge about his self-testing in order to resist the nurse's recommendation. He resists the recommendation of changing his on-going treatment by providing contradictory accounts to the nurse's advice.

Extract 7.6
(N: nurse, P: patient, W: patient's wife)

The nurse reviews the patient's recorded figures from his self-testing and repeats her recommendation of changing the medication dosage.

```
01   N:   yeah just do but just drop that one gliclizide off in the
02        morning shall we do that do ye think that's
03        (1.0)
04   N:   all right
05   P:   I can try it [but
```

06 N: [n' I'll see ye in mid September
07 P: **as I said uhh I just feel normal irrespective to what**
08 N: I know
09 W: yeah but [what
10 N: [but we've got to be guided
11 W: yeah your blood sugars' saying
12 N: that's it ye know the test works for ye know they control
13 both ways ye know it's when it's not controlled and we need
14 to step up treatment but likewise ye know for making sure
15 we're not over treating ye ye know we have the potential to
16 put you at risk then

In line 1 the nurse is recommending decreasing the dose of one of the medications (Gliclizide). There is a 1 second silence in line 3 where the nurse pauses and then completes her turn in line 4 overtly asking for agreement from the patient ("all right"). The nurse's utterance is phrased in such a way that it prefers a 'yes' response. In line 5 the patient responds "I can try it but" reluctantly accepting the recommendation. The patient aligns his initial reply "I can try it" to the 'yes' preferred response however, this is followed by a dispreferred answer using "but". The patient uses the agreement + disagreement format "yeah but" (Schegloff 2007) in order to express his resistance.

The nurse overlaps in line 6 and is already mentioning a potential date for their next visit, indicating some closure. However, the patient carries on from his "but" in line 6. In line 7 he notes that as he has said before he feels "normal" regardless of what tests are showing. The nurse acknowledges the patient's disagreement in line 8 evidenced by her explanation that although the he might feel normal now they "have to be guided" (line 10). Moreover, in line 12 she provides a further detailed explanation of the importance of the test result in terms of monitoring his blood sugars and explicitly mentions the potential risk of over treating (lines 15-16).

The patient provides his account of him feeling "normal" irrespective of the tests as evidence that the medication does not need changing.

Extract 7.7

(N: nurse, P: patient, W: patient's wife)

The patient has finally accepted the treatment change recommended by the nurse. As mentioned previously the patient has attended this consultation with his wife.

01 P: so I'll see you in a month's time
02 N: I'll not know the outcome for another three months till
03 we've got rid of ye know these blood cells that carry the
04 sugar that
05 W: yeah
06 N: until they're out of the way we've got a clean slate yeah
07 it's three months before I can do another one
08 P: ohh
09 N: ok(.)but I jst want to see how you're going with your blood
10 sugar readings
11 (1.0)
12 N: ok
13 P: yeah
14 N: all right
15 P: **if I'm not happy I'm going back to-** ((starts laughing))
16 ((all laugh))
17 N: yeah I know we'll do what yeah
18 ((all laugh))
19 N: well it'll be down there on screen [th'
20 P: [sorry
21 N: I recommended it so
22 ((all laugh))
23 N: what you do with it when you walk out of that door
24 P: so it's jst one single ((gazes towards wife and stands up))
25 W: [yeah
26 N: [yeah

In line 1 the patient reiterates a future arrangement mentioned previously by the nurse. The nurse explains in lines 6-7 that the next blood test would be in three months' time. The patient acknowledges the information by an "ohh" in line 8. The nurse seeks acceptance in line 9 but the patient does not produce an explicit acceptance. After a pause in line 11 the nurse pursues an acceptance again in line

12 and 14. The patient does not fully accept the recommendation, instead he asserts his own recommendation noting that if he's not happy he will go back to what he was doing before (line 15). This utterance using an if conditional format takes the form of a warning or threat and due to the potential conflict that threats can bring to the interaction the utterance is balanced by producing it as a joke. The patient's laughter at the end of his turn invites laughter from the other parties (nurse and wife) and in turn his laughter is reciprocated in line 18. The laughter together serves the purpose of social bonding and indicates a level of intimacy between speakers (Jefferson et al 1987). Following the laughter the nurse responds by noting that everything is documented and after the patient's repair in line 20 the nurse carries on with her talk taking responsibility for her recommendation.

There is simultaneous laughter once again in line 22 and the patient finally accepts the nurse's recommendation in line 24. This is evidenced by his repetition of the prescription dosage regarding his treatment ("so it's just one single"). Up to now the patient has provided his evidence and built his case for his medication not to be altered. However, by repeating the actual dosage change in line 24 he is confirming this change recommended by the nurse and is making sure he knows exactly how much to take from now on. Nevertheless, despite accepting the recommendation there is still some resistance as the patient warns in a joke like threat that he will go back to what he was on before if he is not happy with this change (line 15).

Another area where active patient resistance is displayed is concerning lifestyle change, in particular advice on changes in diet in order to lower blood sugars.

7.4 RESISTANCE ON DIET CHANGE

Equally in the extracts above, patients do not explicitly disagree, but instead offer an account that suggests the nurse's assessment is mistaken.

This section will present and analyse two patients' resistance to the implication that their lifestyle is conducive to their recent elevated blood sugar test results. Extracts 7.8-7.11 are all negotiations between the first patient and the practice nurse presented in chronological order. Extract 7.12 corresponds to the second patient's negotiation with the nurse on her inadequate eating habits.

The patient in extracts 7.8-7.11 has had a high blood sugar reading in his latest test. It was agreed that he was going to alter his diet in order to help lower these levels. However, his last test result came back higher.

The nurse goes through his current daily eating routine and mentions the fact that he is eating too many carbohydrates. Following this, the patient starts providing evidence regarding his cooking methods, implying a degree of resistance to the fact that his diet is indeed affecting and even causing his high blood sugars.

Extract 7.8
(N: nurse, P: patient)

01 N: ok right ok ummm I think we might've got too much sugar in
02 carbohydrates in there of certain degree of which convert
03 carbohydrates convert to sugar
04 P: **oh well I don't know**(.)that's just(.)that's a normal d'
05 N: I don't know whether these ye know adjustments will bring
06 [yer HbA1c
07 P: **[I don't have I don't have**
08 N: down totally or whether we need
09 to increase your treatment
10 P: **I 'av I 'av a fair amount of fish**
11 N: mm
12 P: **bake it**
13 (1.0)
14 P: **boil it or I don't fry anything anymore**
15 N: no
16 P: very rarely

The nurse states that she thinks there is too much sugar in the carbohydrates the patient is eating, as carbohydrates convert to sugar (lines 1-3). The patient responds in line 4 with "Oh well" and acknowledges this as new information, he follows this up by saying, "he doesn't know", and he is merely mentioning what he has to eat during his daily routine. There is overlap in lines 6 and 7 where the patient is trying to state what he does not have to eat instead of what he does. However, he repairs his talk in line 10 and mentions food that he does eat which are not carbohydrates i.e. fish. He then proceeds to cooking methods noting that he rarely fries his food. He starts building a case with evidence from his eating habits that contradict his current high blood sugar results.

Extract 7.9
(N: nurse, P: patient)

01	P:	if I do fry something it's **only like a stir fry** cook me
02		vegetables
03	N:	mm
04	P:	and I only do **use that one cal spray** anyway
05	N:	yes so that's good
06	P:	so I don't if I had iffff some days we'll 'av probably a
07		baked sandwich with some mushrooms **but they're grilled**
08	N:	mm
09	P:	**it's all grilled**
10	N:	yeah
11	P:	**nothing is ever fried** so
12	N:	no
13		(1.0)
14	N:	well just on what you've told me I'll just say show you
15		where we can like make it where we can improve
16	P:	[yeh
17	N:	[things really
18	P:	I don't know where it how it's shot up because ((laughs))
19	N:	yeah yeah ai
20	P:	ye know

In line 1 the patient justifies his action of frying food by firstly stating that he only stir-fries his vegetables. This is followed by his use of a 1 calorie spray (line

4) to which the nurse replies with a positive assessment in line 5. The patient carries on explaining that he grills his mushrooms (line 7) and never fries his food (line 11) despite him admitting that he does fry vegetables.

In line 14 the nurse initiates her recommendation in terms of changes to be made which can improve the patient's diet. In line 14 the use of "just" in "I'll just say" minimises the nurse's recommendation. There is also substantial repair: "I'll just say, show you" and "we can like make it, where we can improve", indicating the nurse's difficulty when trying to phrase a recommendation that involves a lifestyle change. The patient's lifestyle has been interpreted as problematic hence the need to change his diet. Sorjonen et al (2006) suggest that when physicians ask about the patient's lifestyle, this in itself indicates that their life choices might have an impact on their health. Advice-giving within the patient's lifestyle choices involves more epistemic authority from the patient than advice giving on non-lifestyle discussions, as it provides a space for the patient to bring their own lifestyle account into the interaction (Barton et al 2016). Thus allowing more room for the patient to resist the advice.

In line 18 the patient overtly states that he does not know why or how his blood sugars have gone up. He has provided evidence that suggests he is maintaining a healthy diet and therefore contradicts the fact that his diet is causing his high blood sugar.

Extract 7.10
(N: nurse, P: patient)

Extract 7.10 follows extract 7.9 chronologically.

```
01   N:   but just on what you've told me with just what you've ate
02        like the day uhhmm we can just make some adjustments there
03        (1.0)
```

04 N: hhhh the sugar on the cornflakes we need to loose umm so
05 whether ye uhhmm chop some fruit up or yer banana and put
06 that on for yer element of sweet to go with it
07 P: right
08 N: as one of yer portions of fruit of the day
09 P: yeh
10 N: or you're gonna have to get an artificial sweetener to
11 sprinkle there
12 P: well I
13 (1.0)
14 P: **I used t' I never I don't have sugar in teas and coffees I**
15 **have sweeteners**
16 N: no yeah that's good
17 P: I have a sweet click things I 'av one of them
18 N: mm yeah I know it sort of sounds like just a little bit of
19 a sprinkling but with there as I chat with ye the other
20 bits you're getting sugars
21 P: yeah

The patient is still resisting the idea that his lifestyle, in particular his eating habits, are contributing to his high blood sugars. In lines 1-2 the nurse reiterates that some adjustments can be made to his diet. There is no response from the patient and following a pause the nurse proceeds to suggest specifically what can be changed (lines 4-6). The sugar in the cornflakes needs to be stopped (line 4) or replaced by an artificial sweetener (line 10). In line 14 the patient repairs his talk ("I used to, I never, I don't") before providing his life world evidence that he does not have sugar in tea or coffee and he takes sweeteners already. The nurse provides a positive assessment in line 16, to which the patient responds with more evidence in that he has a "sweet click things". In line 18 the nurse pre-empts the patient's account as implicit disagreement as she proceeds to explain that even if it is a little sprinkling of sugar it still has an adverse effect, as it all adds up.

In this extract the nurse has implicitly suggested that the patients' eating habits are problematic and asks the patient to list what he eats during a normal day. The patient resists this implication and he does so by providing the nurse with

evidence within his eating habits which contradict her suggestion that his eating routine is causing the recent raise in his blood sugars.

Extract 7.11
(N: nurse, P: patient)

The nurse is still discussing the patient's eating habits and their impact on his high blood sugar test result.

```
01   N:   an' ye know you're having quite a lot of carbohydrates it
02        sounds or more than ye should do so ye know over the course
03        of the day
04   P:   ws gonna say it must be
05   N:   it sort of like mounts up doesn't it
06   P:   it must be two months since I bought a bag of sugar
07   N:   yeah yeah so you're not having much
08   P:   ye know I'm just
```

In this extract the patient shows his resistance again by providing empirical evidence regarding his sugar consumption. In line 6 he indicates that he has not bought a bag of sugar in two months, building his case towards his lack of sugar intake. This account demonstrates how little sugar he is consuming and in turn reflects how this lack of sugar intake cannot be causing the high blood sugars. The nurse qualifies this evidence as 'not having much' (line 7).

Extract 7.12
(N: nurse, P: patient)

The patient in the extract below has received her test results. These are showing that her blood sugars are higher than average. In addition, the patient reported earlier during the consultation that she is not feeling well in general and admits that she has not been eating adequately.

```
01   P:   I find I'm eating more crisps
02        (2.0)
```

N: mm
P: than maybe a solid meal
N: yeah
P: ye know so I seem to be going through three packs of crisps a day
N: REALLY wow
P: umm fair enough my husband's cooking and he's trying to
N: mm
(1.0)
N: is that part of why you're feeling a bit rubbish is that
P: [**I don't know**
N: [an element of it
P: what that is
N: yeah
P: it's I've been bad all weekend in bed umm with a right bad chest and uhh <really sore throat>
N: mm
P: and constantly coughing
(1.0)
P: but I stopped smoking a year ago
N: well done
P: **but I'm just wondering if it's maybe the electronic**
(2.5)
P: cause it's toxin in them (0.5) that liquid apparently
N: in what sorry I didn't get what
P: you know in the e
(2.0)
P: the e cigarettes
N: right <yes sorry>
P: well the liquid apparently has got toxin in it
N: mm
(1.0)
P: and sometimes you can get that in your mouth when you're
(1.0)
N: mm
(1.0)
P: so I don't know if it's that that's
N: yeah you'll have to maybe stop and just see if you're better for not using those
P: yeah

In line 1 the patient notes that she has been eating more crisps than a solid meal (line 4). The nurse's utterance in line 12 is a yes/no question and prefers a 'yes' response. The nurse is strongly suggesting that it could be her inadequate eating habits that are causing her to feel unwell in line 12. The nurse is offering a hypothesis on why the patient is feeling unwell based on previous information provided by the patient on her eating habits. Hence phrasing her question as a hypothesis, thus providing an opportunity for the patient to admit that her eating habits have affected her overall health. However, the patient does not agree and replies: "I don't know" in line 13. The patient proceeds to present her evidence that aligns with her "not feeling well"; bad chest, sore throat and constantly coughing in lines 17, 18, 20. She then produces a candidate diagnosis (Ijäs-Kallio et al 2010) in line 24 whereby she proposes that the electronic cigarette might be the cause of her feeling unwell as it has toxins (line 26) and not her diet as suggested by the nurse in line 12.

The patient produces evidence that she is not feeling well and this evidence of a bad chest, sore throat and coughing aligns with her candidate diagnosis, as opposed to with her current inadequate eating. She is resistant to the nurse's suggestion that her diet might be having an adverse effect on her health. This resistance is displayed by the patient's use of additional information, in particular her candidate diagnosis, which cannot be refuted by the nurse.

7.5 DISCUSSION

The data from the extracts presented above suggests that patient resistance during chronic diabetic check-ups is realised by the production of an account on the part of the patient that contradicts or is discrepant with the recommendations offered by the nurse on their medical diagnosis, treatment or diet change.

Examples:

Evidence that contradicts the type 2 diabetes diagnosis:

P: I don't feel no different
P: I don't take sugar

Evidence that contradicts having hypos and blood sugars are too low:

P: I feel ok
P: no dizziness or anything like that ye know it's uhh
P: jst' I woke up feeling 'ungry that was all
P: uhhh but like I said there's no dizziness
P: oh eh they're only one offs and as I said
P: I've taken your advice thoroughly if you want to look but I'm I'm mainly fives and sixes that there is
P: I have had some really HIGH ones like that one
P: as I said uhh I just feel normal irrespective to what

Evidence that contradicts the fact that the patient's diet is problematic:

P: I 'av I 'av a fair amount of fish
P: bake it
P: boil it or I don't fry anything anymore
P: if I do fry something it's only like a stir fry cook me vegetables
P: and I only do use that one cal spray anyway
P: baked sandwich with some mushrooms but they're grilled
P: it's all grilled
P: nothing is ever fried so
P: I used t' I never I don't have sugar in teas and coffees I have sweeteners
P: I have a sweet click things I 'av one of them
P: it must be two months since I bought a bag of sugar

Evidence that contradicts the implication that the patient's inadequate eating habits are causing her to feel unwell:

P: it's I've been bad all weekend in bed umm with a right bad chest and uhh <really sore throat>
P: and constantly coughing
P: but I stopped smoking a year ago
P: but I'm just wondering if it's maybe the electronic
P: cause it's toxin in them (0.5) that liquid apparently

In all three settings: diagnosis, treatment change and diet, patients resist by offering contradictory evidence from their 'life world' experience (Barton et al 2016, Barry et al 2001) to the nurse's recommendations.

The patient resisting diagnosis did this by negatively phrasing her contradictory evidence with "I don't feel no different". The patient resisting treatment change focuses on physical evidence and repeats that he feels no dizziness and feels normal. He also mentions that he has followed the nurse's previous advice and he has even had very high readings highlighting the exact opposite to what the nurse is trying to suggest.

One of the ways in which patients resist diagnosis and treatment change is by providing physical evidence that contradicts what is expected. Both patients emphasize 'feeling fine'. In fact, the patient in section 7.3 repeats it and specifically notes that he has not felt how he should (dizziness) if he were experiencing hypos.

In terms of resisting diet change, the patient in section 7.4 (extracts 7.8-7.11) resists by justifying his eating habits, in particular by balancing the food he eats with cooking methods. Food which he pre-empts could be viewed as unhealthy is combined with what is considered healthy cooking methods. Resistance here does not focus on how he feels but on how he manages his lifestyle choices around his diet. For example, he refers to eating fish, which is considered healthy, he then mentions frying, which is probably considered an unhealthy cooking method. Furthermore, he justifies the frying by noting that he only uses "1 Cal", which is a low calorie fry spray considered to be a healthier option when frying. He mentions eating a sandwich, however, he notes that the mushrooms

are grilled not fried. Again, justifying his eating by a cooking method which is viewed as a healthier option.

Finally, the patient in extract 7.12 resists the nurse's implication that it is her diet which is affecting her overall health. The patient resists the nurse's implication by mentioning candidate symptoms corresponding to another illness, which she attributes, is due to the toxins in e-cigarettes.

Likewise Perakyla's (2006) findings on communicating and responding to diagnosis, patients can resist a diagnosis by presenting a symptom description that is discrepant with the doctor's diagnosis. However, the originality of this study lies on the fact that the patient has already been diagnosed and the data is extracted from routine check-up consultations. Therefore, the diagnosis is known to both the nurse and the patient, which makes the resistance a known issue for both parties as well.

In terms of resisting treatment, Stivers (2006) suggests that patients withhold acceptance of treatment as a way of displaying passive resistance. However, it appears that resisting a change in on-going treatment is performed differently. Patients in these routine consultations are already following a certain treatment so a change in this treatment is responded to by more than withholding and producing passive resistance. The patient in this study offered additional experiential information in order to resist a change in his treatment.

Finally, when it comes to resisting diet recommendations, it is inevitable to look into research on general lifestyle recommendations. As noted by Johanson et al (1995) lifestyle questions and recommendations within medical consultations are focused on the patients' risk factors and their individual diseases. Furthermore, findings in their study suggest that lifestyle habits are an important part of the discourse in general primary health consultations. Nevertheless, primary care nurses struggle with lifestyle advice when it requires a change as opposed to promoting healthy lifestyle behaviour in general (Jansink et al 2010). In diabetes consultations nurses have to change their approach to a

more counselling manner, as they are not only offering simple advice on lifestyle, but are trying to change the patient's behaviour. Undoubtedly due to this, nurses encounter significant barriers to lifestyle counselling. Some of which were reported to be due to lack of time and specific training, while others are patient related. Nurses reported that patients have a lack of knowledge on healthy behaviours and are not fully aware of their own behaviour regarding health options. Nurses also reported that patients lack the motivation and discipline to change their behaviour. These barriers provide some understanding regarding the difficulty in recommending lifestyle changes, however Jansink et al's study (2010) was based on interviews with nurses reporting their observations and impressions rather than observing first-hand what actually happens during the visits. Nevertheless, the findings align themselves to other studies like Lambe and Collins' (2010) research on lifestyle counselling in general practice, where patient resistance to lifestyle advice is identified as a significant barrier. However, there is no detail on how patients' resistance actually manifests itself during the consultations. This resistance is left to the practitioner's interpretation. Nonetheless, it is clear that lifestyle issues, including diet, have an impact on patients' health (Sorjonen 2006.) Promoting healthy life choices is a significant task for healthcare practitioners. This is particularly important for type 2 diabetic patients whose illness is directly linked to their diet, specifically to their sugar consumption and glycaemic control.

In this data set of diabetic check-up consultations diet is discussed if:
a) the patient's test results indicate hyperglycaemia (high blood glucose)
b) the patient's test results indicate hypoglycaemia (very low blood glucose)
c) if the patient presents symptoms of hypoglycaemia
d) if the patient has been given new medication that could potentially produce hypoglycaemia

As mentioned previously these are routine diabetic check-ups, therefore the nurse is providing dietary recommendations to avoid potential risks. The aim is for the patient to change any habit that could lead to further health problems. Patients resist the dietary recommendation by providing evidence from their

own experience which contradicts the nurse's implication that diet is an issue and is causing problems. The resource patients use to resist is to provide an additional account with evidence that is irrefutable by the nurse in order to exert their agency.

The epistemic gradient between the nurse and the patient is steep in so far as the information imbalance that exists between them (Heritage 2012). Doctors and nurses are experts in their fields and as experts they are entitled to have more knowledge than their patients (Drew 1991). However, by presenting life world experiences patients are able to open a space for discussion where the gradient's steepness is reduced. The resistance displayed is based on the patients' experience and this is their own knowledge which cannot be contested by the nurse. Hence patients being able to implicitly disagree by expressing resistance without it leading to interactional difficulties.

Resistance is valuable communicative resource for patients to use when wanting to express disagreement as it enables them to safely object to the practitioner's recommendation. In addition, it creates a space for potential negotiation, which can allow the practitioner to understand why the patient is objecting and it also enables the patient to assert their agency and set their own agenda. Practitioner and patient communicative resources are discussed further in the next chapter.

8 Discussing risk, closing and resistance

CA has established itself as a robust methodology to use when analysing communication between practitioners and patients during medical consultations.

In this chapter I will discuss the study's findings in terms of their relevance and significance within the aggregated review of conversation analysis findings in medical interaction presented in chapter 2.

The systematic review of the literature in chapter 2 provides an extensive overview on how CA has contributed to the field of doctor-patient communication. The aggregative findings from the review were categorised into 5 categories:

1. Communicative resources available to clinicians, and their consequences for the interaction
2. Communicative resources available to patients, and their consequences for the interaction
3. Clinician-patient asymmetries
4. Diagnosis and diagnostic delivery
5. Treatment decisions

For the purpose of this discussion I will focus on the first 3 categories: 1) communicative resources available to clinicians, 2) communicative resources available to patients, and 3) clinician-patient asymmetries). These categories were chosen as they are the most relevant to the findings analysed in this study. Category 4 (diagnosis and diagnostic delivery) and category 5 (treatment decisions) are not included in this discussion since diabetic patients have already been diagnosed and are already following treatment. However, these categories will be considered in the subsequent section (8.5) Diagnosis and Treatment.

In the next section I will discuss this study's findings in terms of the literature presented, specifically within the first 3 categories mentioned above, established by the aggregative findings from the systematic review in chapter 2.

8.1 USE OF IF-CONDITIONALS WHEN PRESENTING RISK: COMMUNICATIVE RESOURCE AVAILABLE TO CLINICIANS

Risk talk in this data set is always initiated by the nurse and it is done by the introduction of a conditional clause marked by the use of the conjunction "if". The nurse presents a hypothetical situation conditional on a future event in the format: if p, then q. The pattern emerging from the findings consist of an if-conditional followed by a recommendation. For example, "if you start to feel X, then come back and see us", or "if you take that tablet and have nothing to eat, you run the risk of collapsing". The if-clause offers the information, explanation or description of the circumstances and the matrix clause offers the recommendation.

Using an if-conditional to present risk is a particular linguistic resource used by the nurse in order to mention a potentially risky situation the patient might experience, making it relevant to category 1: Communicative resources available to clinicians, and their consequences for the interaction. Using an if-conditional to present potential risks allows the nurse to tailor the risk to the specific patient, as opposed to stating a generalised percentage related to most diabetic patients. Presenting risk with an if-conditional forces the nurse to produce an individual risk assessment taking into consideration the patient's circumstances and in turn providing relevant recommendations to that particular patient and their risks in terms of how they manage their illness. In addition, presenting risks via an if-conditional avoids the use of percentages and figures, which can be difficult to interpret. It also avoids the use of verbal descriptors such as: likely, common, and rare, which according to the literature (Marteau et al 2000, Büchter et al 2014) are even more difficult to interpret than numbers. Risk is presented through a potential scenario and this is individual depending on the

patients' circumstances. However, despite the individual nature of the risk presented, patients generally produce minimal responses such as "right", "mm", or silence. Arguably, this could be due to the advice giving function within these if-conditionals. Since delivering advice as information elicits minimal unmarked acknowledgments that function as continuers (Kinnell and Maynard 1996). Alternatively, minimal responses to this kind of risk and advice could be explained due to the hypothetical nature of the risk and the recommendation mentioned.

The if-conditionals in this data always refer to a future event that is conditional on another future event i.e. *if p, q*. The condition (p) is directly related to the situation in the matrix clause (q). The recommendation, generally expressed in (q), is only made relevant if (p) occurs. Therefore, the risk is not guaranteed as (p) might never happen. This hypothetical situation, that could or could not occur, might account for the patients' lack of explicit acceptance on the advice given. Since the advice is not to be followed immediately, but is dependent on the occurrence of another circumstance. Alternatively, minimal responses could indicate the patients' encouragement for further elaboration on the nurse's risk statement, similar to the minimal responses provided after presenting a diagnosis. Nevertheless, minimal acknowledgement tokens produced as a response to recommendations being offering reveal a degree of resistance. When the nurse offers a certain course of action, either within the patient's treatment or regarding their diet, this offering requires a response may it be an acceptance or a refusal. Therefore, minimal acknowledgments such as: "mm" "ahem" after a recommendation are treated as non-acceptance and demonstrate some resistance from the patient to the recommendation offered. However, there are other contexts within medical consultations in which minimal acknowledgement tokens do not display this resistance and have a different interactional function. Perakyla (2006) states that one of the ways patients receive a diagnosis is by providing minimal acknowledgement tokens such as "yeah", "ahem", "yes" (pp234) and in many cases these are intended to encourage elaboration on the diagnosis. In this particular context minimal acknowledgement tokens act

differently, since the practitioner is providing new information and not a course of action that needs to be accepted or not.

There could be a similarity between patients' responses to risk and to diagnosis, since both statements made (risk and diagnosis) are potentially new information for the patient. Moreover, to a certain extent, the new information given will generally include a problem that needs treating. So, for example, the nurse expresses the risk of potentially collapsing to a patient suffering hypoglycaemia. Therefore, a certain dosage of medication needs prescribing in order to treat this hypoglycaemia. Equally within the diagnosing phase, a patient is diagnosed with X, and therefore will be given a certain treatment course to deal with X. It could be argued that because diabetic consultations are routine the information is not new to the patient. Nevertheless, if the information is already known to the patient the nurse will note this through utterances such as "as I have mentioned before", as I said earlier", "as we've seen before" used previous to mentioning the risk. Consequently, it could be assumed that the risk presented by the nurse via a hypothetical situation (If-conditional) is new to the patient unless stated otherwise.

However, more data analysis on the use of if-conditionals to present risk would be needed to prove whether the lack of patients' explicit responses display space for further elaboration, are due to the advice giving function of this grammatical structure, or are due to the if-conditional's hypothetical nature.

Patients' minimal responses do serve a purpose within the interaction, and this will be discussed in the section 8.3. However, before presenting patients' communicative resources, I will discuss another recourse used by physicians when it comes to closing the consultation in the section below.

8.2 CLOSING DIABETIC ROUTINE CONSULTATIONS: COMMUNICATIVE RESOURCE AVAILABLE TO CLINICIANS

Physicians can use certain communicative resources in order to indicate the initiation of the closing phase of the consultation. This closure has to be indicated somehow within the interaction and it would be sequentially insufficient to just stop talking (Schegloff and Sacks 1973). The silence would not necessarily mean that the consultation is over or that is it closing down. Instead it could be heard as a pause part of the turn taking machinery whereby producing a transitional relevant place for the other speaker to initiate further talk. Therefore, the physician has to indicate that the closing of the visit has begun.

Research suggests (White et al 1997, Robinson 2001, West 2006) that summarising the visit, shifting to the future and making future plans, can indicate the initiation of closing. However, using these resources does not guarantee a successful closure. The initiation of closing has to be accepted in order to proceed to the terminal exchange (the goodbyes). The findings from the data on chronic diabetic routine consultation show that the nurse initiates the closing and at some point reiterates the closing in order to shut down the consultation.

In these routine consultations there seems to be multiple moves and a need for a reiteration of the closing. It could be argued that this is merely the nurse's style when it comes to initiating the closing phase of the visit. However, patients make relevant the transition between the closing and the terminal exchange after the reiteration of closure and not after its initiation. Patients start collecting their belongings preparing themselves to exit the room after the nurse as reiterated the closure. In the UK it is generally the patient who walks into the consultation room at the start of the visit and has to then physically stand up and leave the room at the end of the visit. Therefore, it is important for the patient to realise when the consultation is finalised and when he/she can stand up and leave the room. Standing up prematurely could potentially cause interactional difficulties, as the consultation is not over yet. The nurse would have to point out the

misunderstanding causing some embarrassment.

Initiating and reiterating closure is an effective way of closing routine diabetic consultations and is a useful resource for practitioners to use when wanting to close a consultation successfully. It provides a clear warrant of the closing, avoiding any ambiguity about whether the visit is being terminated or not. It also gives patients space to ask questions or raise unmet concerns between the initiation and the reiteration. Once the closing has been accepted participants can proceed with the terminal exchange. However, the data shows that in some of these consultations the terminal exchange is noticeably absent as per discussed in chapter 5.

8.3 PATIENT RESISTANCE: COMMUNICATIVE RESOURCES AVAILABLE TO PATIENTS

Patients also resort to certain communicative resources in order to exert their agency and introduce their own agenda. Despite the consultation's rigidness in terms of its overall structure, there are ways patients can express their views. The main resource used by patients in this study is patient resistance. In diabetic check-up consultations patient express their disagreement by resisting. This generally takes the form of silence or by offering additional information that is discrepant with the nurse's information or recommendation. For example, when the nurse mentions to a particular patient that his blood glucose is low and therefore can experience hypoglycaemic episodes, the patient resists this notion by stating that he is "feeling fine" and has had no hypoglycaemic symptoms. Thus providing a contradictory account to the nurse's previous assessment. Other studies (Peräkylä et al 2010, Koenig 2011, Monzoni et al 2011) mention resistance as a way of disagreement. In particular offering candidate illnesses, or additional information provided by other physicians mainly in the diagnosis phase. In routine diabetic consultations patient offer experiential information that is discrepant with the nurse's account and it is information that cannot be

refuted by the nurse i.e. “I’m feeling ok”, “I don’t take sugar”. This kind of additional information cannot be contested by the nurse, unlike candidate illnesses, where the nurse could provide an account supported by her medical knowledge that contradicts the patient’s candidate illness offered. However, like other findings (Koenig 2011, Monzoni et al 2011) patients’ resistance provides a space for negotiation with the physician where both parties can express their views and agree on a course of action. In this data set patient resistance displays a way of disagreeing with the nurse.

It is important to clarify the difference between resistance as disagreement and explicit disagreement due to misunderstandings in the talk between speakers. For example, there was one case where disagreement was explicit and did not take the form of resistance. However, in this instance, the disagreement was about when the patient should call to book the next appointment. The nurse misunderstood what the patient had previously mentioned in terms of when to call to book his appointment, so the patient initiates the nurse’s repair. Repair in conversation is when a speaker attends to a potential problem in the interaction, either expressed in their own talk (‘wrong’ word choice or misarticulation) or in hearing or understanding the talk of others (Kitzinger 2013). Speakers can self-repair their talk or they can repair another speaker’s talk. In the example below, the patient repairs the nurse’s talk as she mistook what he had said regarding booking his next appointment.

Extract 8.7
(N: nurse, P: patient)

The consultation is being finalised by arranging next steps.

```
01   P:   I’ll put it on me calendar to ring down for an appointment
02        in mid October
03   N:   oke dokie
04   P:   we’ll we’ll we’ll see what happens
05   N:   yeah yeah more late really just cause we don’t we want to
06        get rid of these
```

07 P: **NO: I'll RING in mid October**
08 N: yeah ring in mid October
09 P: so cause by the time I ring in mid October >it'll be a week
10 before I can an appointment anyway< so
11 N: yeah it's true that though cause we don't want any of these
12 high blood sugars being on that

The patient suggests that he will call for another appointment in mid-October (lines 1-2). The nurse indicates that he should call later for this appointment (line 5). The patient produces an other-initiated repair in line 7, stating with "NO" his clear disagreement with the nurse's statement in lines 5-6. The patient clarifies that he will be ringing in mid-October, not booking the appointment for mid-October. He proceeds to explain this difference in line 9. In this case the disagreement is produced by a misunderstanding which needs rectifying, hence the other-initiated repair by the patient. This is interactionally dissimilar to disagreement over a treatment change or a diet recommendation. The disagreement in this case lies on a misinterpretation or mishearing by the nurse, therefore the patient repairs her talk to allow the progression of the conversation. The explicit elongated "no" at the start of the patient's turn in line 7 indicates his need to clarify the misunderstanding. Repair will be evidenced in the talk in cases where the conversation has hit some trouble around mishearing or misarticulation. Repair of this kind will not be displayed in cases where disagreement takes the form of patient resistance.

8.4 CLINICIAN-PATIENT ASYMMETRIES

The nurse-patient interaction within diabetic routine check-ups is bound by an asymmetry of knowledge between the practitioner and the patient like in any other primary care consultation. The practitioner is the one holding the knowledge and giving the advice and the patient is the one requiring the knowledge and needing the advice. The asymmetry of knowledge is an intrinsic part of medical consultations, as patients are attending a consultation because they require expert advice on how to manage a potential problem, which they do not possess. Nevertheless, this difference in epistemic authority between the

doctor and the patient has consequences for the interaction. Robinson (2001) notes that doctors tend to initiate all the actions and solicit responses and patients are the ones responding to the doctor's questions. This is particularly the case for chronic routine diabetic consultations where the nurse is the one performing all the tests and checking all the results.

Regarding the presentation of risk, despite the patient being aware of the major risks entailed in living with type 2 diabetes, when the nurse provides advice on how to avoid potential risks, patients' responses tend to be minimal. This could be due to the difference in claims of knowledge both participants possess. As noted by Ariss (2009) patients will demonstrate inferior knowledge about a diagnosis or treatment, allowing the practitioner to proceed with the consultation. This could be applicable to routine consultations as well. If the patient were to explicitly disagree with the physician, Ariss (2009) claims that this is resolved quickly by both parties "retreating" to their boundaries of epistemic authority. In this data set disagreement is less explicit and takes the form of resistance. Due to the asymmetric nurse-patient interaction patients tend to resist as opposed to overtly disagree and they do this by offering additional experiential information that contradicts the nurse's suggestions or recommendations. Other research has similar findings insofar as patient resisting a diagnosis or treatment by presenting candidate illnesses, withholding acceptance or providing additional information from other physicians (Ijas-Kallio et al 2010, Perakyla 2006, Stivers 2006). However, resistance in chronic routine consultations occurs towards known issues already shared by the nurse and the patient in previous visits. For instance, patients can resist their initial diagnosis, which was delivered some time ago. They can resist a change in their on-going treatment or a change in their diet. In these cases resistance appears more active than a silence or withholding acceptance. Patients have had time to get to grips with their illness and treatment. They also have become more knowledgeable about living with their illness and how to manage it. In addition, they have developed a relationship with the nurse due to attending regular check-up consultations. Therefore, they can claim more entitlement when resisting, as they too have knowledge from an experiential point of view

regarding their diabetes. The nurse acknowledges the patients' epistemic authority, which is evidenced in her responses to their resistance. She tries to justify her recommendations and attempts a more collaborative talk including them in the decision-making process as a way of persuading the patients to follow her suggestions.

Extracts 8.8-8.10 demonstrate how the nurse involves the patient in the decision-making process regarding altering his medication.

Extract 8.8
(N: nurse, P: patient)

```
01          (1.0)
02    N:    I don't know how you feel about dropping your treatment
03          again and seeing how we go cause I'm just a bit worried
04          that you're running a bit on the the low side of things and
05          with it being summer and being on your allotment an ye
06          could be there on your own and potentially yer blood sugars
07          (1.0)
08    N:    drop
09    P:    oh: well that's ok when weather's fine
10    N:    mm
11    P:    but obviously when it's been raining
```

The nurse is asking the patient how he feels about changing his medication acknowledging the fact that the patient has a voice in this decision. She then proceeds to explain why she is suggesting the change (lines 3-6).

Extract 8.9
(N: nurse, P: patient)

```
01    N:    […] so I'm just wondering whether we just drop a a
02          gliclazide back off again I know we've uped ye and >now
03          we're coming back down again< but we've just got to respond
04          to what we're seeing ye know to what you're doing and what
05          our results are showing uhhhmm
06          (2.0)
```

07 N: **I don't know how you feel about that**

The nurse suggests a change in medication and introduces it with "I was wondering whether" (line 1). This minimises her epistemic authority and places them in a similar position to make the decision on his treatment. The patient does not reply so the nurse asks the patient how he feels about this suggested change (line 7).

Extract 8.10
(N: nurse, P: patient)

01 N: yeah just do but just drop that one gliclizide off in the
02 morning **shall we do that do ye think that's**
03 (1.0)
04 N: **all right**

The nurse asks the patient if her suggestion is acceptable including him in the decision.

Extracts 8.11-8.13 display the nurse's attempt at a collaborative approach when suggesting a lifestyle change by using the plural and including herself in the suggested dietary change.

Extract 8.11
(N: nurse, P: patient)

01 N: ok right ok ummm I think **we** might've got too much sugar in
02 carbohydrates in there

Extract 8.12
(N: nurse, P: patient)

01 N: well just on what you've told me I'll just say show you
02 where **we** can like make it where **we** can improve
03 P: [yeh
04 N: [things really

Extract 8.13

(N: nurse, P: patient)

```
01   N:   but just on what you've told me with just what you've ate
02        like the day uhhmm we can just make some adjustments there
03        (1.0)
04   N:   hhhh the sugar on the cornflakes we need to loose umm so
05        whether ye uhhmm chop some fruit up
```

Extracts 8.11-8.13 demonstrate a more collaborative approach in terms of the nurse involving the patient in the decisions and recommendations being made. She does this by asking the patient if he agrees on the suggested treatment change and also by including herself in the lifestyle changes.

This collaborative approach can be due to the routineness of the consultations. The fact that patients attend these visits regularly and have first-hand knowledge with the illness entitles them to more of a two-way consultation with the nurse. This is possibly one of the main differences between chronic routine consultation and acute primary care consultations as discussed in chapter 4.

8.5 DIAGNOSIS AND TREATMENT

As established in chapter 4, routine chronic consultations bypass this diagnostic and treatment phase of the visit, since patients already have a diagnosis and are already following treatment.

In chapter 4, I established that diabetic chronic consultations in this study comprises 4 phases: 1) opening phase, 2) examination and test results phase, 3) treatment review phase, and 4) closing phase. However, it could be argued that there still is potential room for diagnosis within the examination and tests results phase. For instance, if a patient's urine sample comes back positive for protein, the nurse could diagnose potential kidney damage and this could lead to further treatment. This would be an instance of diagnosis within the routine

check-up. Nevertheless, as this diagnosis stems from a regular test, patients have already been warned about the potential problem should the test come back positive. If this did occur, it would make the diagnosis expected, to a certain extent, rather than new as in acute primary care consultations.

Diagnosis and delivery in these visits is replaced by the examination and tests results phase. Equally with the treatment phase, this is replaced by the treatment review phase, since chronic diabetic visits review the on-going treatment, rather than offering new treatment depending on a previous diagnosis. However, there are some similarities in so far as the actual treatment delivery is concerned. In both, acute and chronic consultations, patients need to accept the treatment in order to proceed to the closing phase. This can be either accepting new treatment for acute visits and for chronic visits accepting a change to the on-going treatment or accepting a no change in the current treatment. Only then will the consultation proceed to the closing phase of the visit.

Notwithstanding, the overall structure of chronic visits lacks a diagnosis and treatment phase and I believe this structure could potentially be generalizable to other chronic routine visits. It would have been valuable to have more than one GP practice involved in the analysis in order to establish this, however, no study is without its limitations. The main limitation for this study is the use of only one GP surgery and only one practitioner. As much as there are a variety of patients in this study it would have been beneficial to have data from another practice and another practitioner. This could have provided a broader picture, firstly in terms of the routineness of the consultations and its overall structure. It could have substantiated the theory of a 4-phase visit as opposed to a 6-phase visit, seen in acute primary care consultations. Secondly, it might have delivered more evidence regarding the communication of risk and how this was conducted during the chronic visits. It would have been interesting to see if risk talk in other diabetic consultations is initiated differently i.e. not using if-conditionals but other linguistic structures. Thirdly, it could have demonstrated a similar or different way of closing diabetic chronic consultations and finally, it could have corroborated what elements of talk were indeed proper to the nurse's style.

Nevertheless, as mentioned throughout, regardless of the nurse's style, she does make use of certain linguistic resources, which have an effective way of dealing with closure and presenting risk. In addition, more data specifically on the use of if-conditionals when presenting risk would have been advantageous in identifying whether the hypothetical nature of if-conditionals is what elicits minimal responses from patients, or whether it is due to encouraging further elaboration of the risk statement.

Moreover, it might have been valuable to collect data from diabetic consultations delivered by a GP and compare that data to the consultations delivered by the nurse. However, I believe this to be one of the future areas of research in this field. How do patients interact with GPs as opposed to nurses during chronic routine consultations? Likewise, the findings from this study could be relevant to future research on other chronic consultations dealing with long term conditions such as arthritis, obstructive pulmonary disease, hypertension and even dementia.

9 Conclusion and Implications

The overall contribution of this study to the field of research in medical consultations is its focus on chronic routine visits. To the best of my knowledge there appears to be a gap when it comes to researching talk in routine check-ups. However, when managing serious long-term conditions successfully, analysing these type of consultations is particularly important. Furthermore, with long-term illnesses such as type 2 diabetes, which are directly affected by patients' lifestyle choices, it is key to observe how they self- manage their condition and the main way of doing so is by looking at their routine check-up consultations.

It is in these routine visits that the progression of the illness is monitored and talked about. By analysing the talk within these consultations it is possible to demonstrate that these chronic diabetic visits entail a slightly different structure to acute primary care visits, which could be generalizable to other routine visits and have practical applications.

As mentioned in chapter 4, the overall structure of chronic routine diabetic consultations in this data set consists of 4 phases and not 6 as per acute primary care consultations. The 4 phases are: 1) opening phase 2) examination and test results 3) treatment review 4) closing. The apparent absence of a clear presenting complaints phase could be considered characteristic of these consultations, as their routine nature implies a follow up to a problem that has already been diagnosed. This can prevent patients from easily raising new concerns, as there appears to be sequentially no phase within routine consultation to do this. Nevertheless, the nurse's opening questions could function as problem solicitations taking a boundary position between the opening phase and the problem presentation phase. Therefore, the problem presentation phase would sit within the opening phase. That said most patients in this study did not treat opening questions as problem solicitations. Alternatively, the tacit problem presentation phase could be seen as beneficial

towards the progression of the consultation in terms of its checklist type format. The lack of a clear delineated space where to present new concerns focuses the visit on conducting all necessary routine checks. Furthermore, if new concerns are raised and these are not related directly to the patient's diabetes, patients will be swiftly directed to other specialists, clearly delineating the remits of these visits.

Nevertheless, according to the findings in this data set, if new concerns are raised, these are done within the examination or treatment phase. Informing practitioners of this could increase their awareness and, if they deem it necessary, could allow them to explicitly provide a space for new diabetic concerns. Arguably, using a final concern sequence i.e. asking, "anything else I can do for you?" could be viewed as a way of eliciting new concerns. However, this would not suffice, as demonstrated in chapter 5, since this sequence is generally associated with the initiation of closure and not always effective in eliciting new concerns.

The final concern sequence is one of the resources used to initiate closing of the consultation. As mentioned in chapter 5, shifting to the future, summarising the visit and making plans are all closing resources. Nonetheless, they do not always guarantee a successful closure. Closing in this data set involves multiple moves, whereby the nurse indicates the initiation of closure, using particular resources, and then reiterates the closure also using closing resources. It could be argued that initiating and reiterating closure is this particular nurse's way of closing the visit. Nevertheless, regardless of this argument, this process is effective, as patients start gathering their belongings getting ready to leave only after the reiteration of closure. Indicating that only at this point were they sure the visit was over. In some cases the closure was 'suspended' following the nurse's initiation. The patient did not accept the closure and shifted to another topic. However, after the nurse's reiteration the patients accepted the closure, which lead to the terminal exchange.

Informing practitioners of multiple moves within initiation and reiteration of

closing could assist in terms of ensuring a relatively quick and successful closure. In addition, other closing resources from the findings suggest that the use of "right" is shown to be a useful resource for closing. It displays a sequential end of one topic and a start of a new one, hence proving a useful resource when shutting down a conversation. Furthermore, providing positive or encouraging assessments about the visit or indeed about the patient's illness management are also demonstrated in this data set to serve the purpose of a successful closing resource. Again, it could be argued that this merely reflects the nurse's style of talk. However, patients were seen using these two resources ("right" and positive assessments) for closure as well. Indicating that they are not only a reflection the nurse's style of talk.

It is always a limitation to have only one practitioner, and this is addressed in chapter 8, section 8.5. However, it can be useful when looking at patient resistance, since the focus is on the patients' talk and having the same nurse will establish a similar environment for all patients.

In chapter 7 I presented examples of patient resistance within chronic type 2 diabetes routine consultations, in particular when resisting a diagnosis, a treatment alteration and a diet change. Patients display resistance by providing evidence from their own experience that contradicts the medical issue being presented by the nurse. Patients use this resource to resist the nurse's recommendation and exert their agency. It reduces the nurse-patient epistemic gradient creating some space for negotiation, which can ultimately help the nurse understand the patient's reservations towards her recommendations (Koenig 2011, Reuber 2011). In terms of practical applications, practitioners would benefit in knowing how patients disagree by resisting during their visits. Being aware of patient resistance and managing it could have an effect on patients' adherence to treatment. Particularly when it comes to an alteration on their on-going treatment, where diabetic patients have some knowledge and potentially can strongly resist a change, as seen in chapter 7, section 7.3. Patients in this data set resist by providing experiential evidence that is irrefutable by the nurse, hence building their case against a recommendation

given. If practitioners identify this evidence provided by the patients as resistance and ultimately disagreement, it could allow for practitioners to negotiate differently with the patient in order to reach an agreement. Patients' experiential evidence cannot be contested by the practitioner, hence the need to focus on other type of evidence.

The function of diabetes chronic routine consultations is to assess and review the patient's illness management. This is conducted via the performance of a series of tests and checks. Due to this structure, risk is mentioned when it is relevant to the examinations being completed. For instance, if a patient's test result reveals very low blood glucose, the nurse will mention the risk of hypoglycaemia and will recommend an appropriate course of action. As a result risk is not talked about in all consultations, it is mentioned in relation to problematic test results. When risk is mentioned it is presented via an if-conditional clause, conveying a hypothetical risky situation dependent on the patients' action or non-action. This displays the nature of the illness as a health condition that is affected by patients' choices and can be managed accordingly. Despite patients producing minimal responses to the risk presented, it is still an effective way to communicate risk as it is individual to the patient and avoids generalizable percentages. Interpreting percentages can be challenging, particularly if patients have low numeracy skills. Even with high numeracy skills what does it actually mean when, for example, a practitioner says: "you have a 30% chance to feel nauseous with this medication". How does this help the patient decide whether or not to take the medication? Uncertainty on the meaning of generalizable percentages and figures could affect the patient's decision-making. Practitioners could benefit from another form of presenting risk, should they need to express risk in a more individualised manner.

Overall, chronic diabetic routine consultations in this data set appear more collaborative than primary care ones insofar as the patient-practitioner relationship is concerned. There is a familiarity between the parties as they generally have meet before during other routine visits and the nurse acknowledges the patients' own experiential understanding of their illness.

However, the structure and routineness of these visits does produce a checklist type approach which might not be conducive to patient elicitation. Furthermore, the lack of a clear delineated complaints presenting phase could leave patients with unmet concerns that could be serious if not addressed. These findings could potentially be generalizable and applicable to other chronic routine consultations. Nonetheless, as seen in this study, opening questions by the nurse can also be designed to solicit patient problem presentation. However, most patients were not treating the opening questions in this way. Therefore, is there a need for the practitioner to emphasise opening questions as problem solicitations? What happens during other chronic routine visits? How do patients elicit their new concerns regarding their already known long-term condition? Building on the work and findings conducted in this study, questions like these would be relevant for future research on long–term conditions and their management.

References

Adams, R. 2010. Improving better health outcomes with better patient understanding and education. Risk Management and Health Care Policy, 3, 61-72.

Adelswärd, V., Linell, P., Sachs, L., Bredmar, M., and Lindstedt, U. 2002. Expert talk in medical contexts: Explicit and implicit orientation to risks. Research in Language and Social Interaction, 35, 195-218.

Allen, S., Petrisek. A., and Laliberte, L. 2001. Problems in doctor-patient communication: the case of younger women with breast cancer. Critical Public Health, 11, (1) 39-58

Anderson, E., and Iltis, A. 2008. Assessing and improving research participants'' understanding of risk: potential lessons from the literature on physician-patient risk communication. Journal of Empirical Research on Human Research Ethics, 27-37.

Antaki, C. 2008. Discourse analysis and conversation analysis. In Alasuutari, P., Bickman, L., and Brannan, J. (eds). *The SAGE Handbook of Social Research Methods, London*, Sage, 431-446.

Antaki, C. 2002. "Lovely": turn-initial high-grade assessments in telephone closings. Discourse Studies, 4 (1), 5-23.

Antaki, C., Houtkoop-Steenstra, H., and Rapley, M. 2000. "Brilliant. Next question…": High-Grade Assessment Sequences in the Completion of Interactional Units. Research on Language and Social Interaction, 33 (3), 235-262.

Ariss, S. 2009. Asymmetrical knowledge claims in general practice consultations with frequently attending patients: Limitations and opportunities for patient participation, Social Science and Medicine, 69, 908-919.

Barnett-Page, E and Thomas, J. 2009. Methods for synthesis of qualitative research: a critical review. BMC Medical Research Methodology, 11 (9), 59.

Barton, J., Dew, K., Dowell, A., Sheridan, N., Kenealy, T., Macdonals, L., Docherty, B., Tester, R., Raphael, D., Gray, L., and Stubbe, M. 2016. Patient resistance as a resource: candidate obstacles in diabetes consultations. Sociology of Health and Illness 38 (7), 1151-1166.

Bennett, J. 2003. *A Philosophical Guide to Conditionals*. Oxford: Oxford University Press.

Blommaert, J., and Bulcaen, C. 2000. Critical Discourse Analysis. Annual Review of Antropology, 29, 447-466.

Bolden, G., and Angell, B. 2017. The organization of the treatment recommendation phase in routine psychiatric visits. Research on Language and Social Interaction. doi: 10.1080/08351813.2017.1301299

Borreani, C., Miccinesi, G., Brunelli, C., and Lina, M. 2004. An increasing number of qualitative research papers in oncology and palliative care: does it mean a thorough development of the methodology of research? Health and Quality of Life Outcomes, 2 (7) doi:10.1186/1477-7525-2-7.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., and Pill, R. 2002. Using Meta Ethnography to Synthesise Qualitative Research: A Worked Example, J Health Services Research Po, 7, 209-215.

Büchter, R., Fechtelpeter, D.,Knelangen, M.,Ehrlich, M., and Waltering, A. 2014. Words or numbers? Communicating risk of adverse effects in written consumer health information: a systemtic review and meta-anlysis. BMC Medical Informatics and Decision Making 14, 76.

Byrne, P., and Long, B. 1976. *Doctors Talking to Patients*. HMSO, London.

Carter-Thomas, S. and Rowley-Jolivet, E. 2008. *If*-conditionals in medical discourse: From theory to disciplinary practice. Journal of English for Academic Purposes 7, 191-205.

Carter-Thomas, S. and Rowley-Jolivet, E. 2010. If-conditionals in medical discourse: from theory to disciplinary practice. Journal of English for Academic Purposes, 7, 191-205.

Carter-Thomas, S. and Rowley-Jolivet, E. 2014. A syntactic perspective on rhetorical purpose: the example of if-conditionals in medical editorials. Iberica 28, 59-82.

Chatwin, J., Kennedy, A., Firth, A., Povey, A., Rogers, A., and Sanders, C. 2014. How potentially serious symptom changes are talked about and managed in COPD clinical review consultations: A micro-analysis. Social Science and Medicine, 113, 120-136.

Collins, D., and Street, R. 2009. A dialogic model of conversations about risk: coordinating perceptions and achieving quality decisions in cancer care. Social Science and Medicine 68, 1506–1512

Collins, S. 2005. Explanations in consultations: the combined effectiveness of doctors' and nurses' communication with patients. Medical Education, 39, 785-796.

Collins, S., Drew. P, Watt, I., and Entwistle, V. 2005. 'Unilateral' and 'bilateral' practitioner approaches in decision-making about treatment. Social Science and

Medicine, 1, 2611-2627.

Craven, A. and Potter, J. 2010 Directives: Entitlement and contingency in action. Discourse Studies, 12 (4), 419-442.

Critical Appraisal Skills Programme (CASP) Systematic Review Checklist 31.05.13. www.casp-uk.net

Comrie, B. 1986. Conditionals: A typology. In E. C. Traugott, A. Meulen, J. S. Reilly, & C. A. Ferguson (Eds.), *On conditionals*. Cambridge: Cambridge University Press.

Curl, T. and Drew, P. 2008. Contingency and action: A comparison of two forms of requesting. Research on Language and Social Interaction, 41(2), 129-153.

Depperman, A., and Spranz-Fogazy, T. 2011. Doctors' questions as displays of understanding. Communication and Medicine, 8, 111-122.

Dixon-Woods, M., Shaw, R., Agarwal, S., and Smith, J.A. 2004. The Problem of Appraising Qualitative Research. Quality Safety Health Care, 13, 223-225.

Dixon-Woods, M., Bonas, S., Booth, A. Jones, D., Miller, T., Sutton, A., Shaw, R., Smith, J., and Young, B. 2006. How can Systematic Reviews Incorporate Qualitative Research? A Critical Perspective. Qualitative Research Journal, 6, 27-44.

Drew, P. 1991. Asymmetries of knowledge in conversational interactions. In I. Markova and K. Foppa, (Eds.) *Asymmetries in dialogue.* Hemel Hempstead, England: Harvester Wheatsheaf.

Drew, P., Chatwin, J., Collins, S. 2001. Conversation Analysis: A Method for Research into Interactions between Patients and Health-care Professionals. Health Expectations, 4, 58-70.

Drew, P. and Heritage, J. 1992. Analysing talk at work: an introduction. In P. Drew and J. Heritage (eds), *Talk at work: interaction in institutional settings*. Cambridge: Cambridge University Press.

Diabetes UK. www.diabetes.org.uk

Diabetes National Service Framework 2001
www.gov.uk/government/publications

Edley, N. 2001. Analysing Masculinity: Interpretative Repertoires, Ideological Dilemmas and Subject Positions. In Wetherell et al. *Discourse as Data*. Milton Keynes: The Open University, 189-228.

Edwards, A., Hood, K., Matthews, E., Russell, D., Russell, I., Barker, J., Bloor, M., Burnard, P., Covey, J., Pill, R., Wilkinson, C., and Stott, N. 2000. The effectiveness of one-to-one risk-communication interventions in healthcare: a systematic review. Medical Decision Making, 20 (3), 290-297.

Eiser, R. 1998. Communication and interpretation of risk. British Medical Bulletin, 54: 4. 779-790.

Ekerg, K., and LeCouteur, A. 2015. Clients' resistance to therapists' proposals: Managing epistemic and deontic status. Journal of Pragmatics, 90, 12-25.

Estabrooks, C.A., Field, P.A., and Morse, J.M. 1994. Aggregating Qualitative Findings: An Approach to Theory Development. Qualitative Health Research 4 (4), 503-511.

Evans-Agnew, R., Johnson, S., Liu, F., and Boutain, D. 2016. Applying Critical Discourse Analysis in Health Policy Research: Case Studies in Regional, Organizational, and Global Health. Policy, Politics & Nursing Practice, 17 (3), 136-146.

Evans, J. and Over, D. 2004. *If: Supposition, Pragmatics, and Dual Processes*. Oxford: Oxford University Press.

Fairclough, N. 2013. *Critical discourse analysis: the critical study of language*. New York: Routledge

Fairclough, N., and Wodak, R. 1997. Critical Discourse Analysis. In Van Dijk, T (ed) *Discourse Studies A Multidisciplinary Introduction, Volume 2: Discourse as Social Interaction*. London: Sage. 357-378.

Feijoo-Cid, M., Moriña, D., Gomez-Ibanez, R., and Leyva-Moral, J. 2017. Expert Patient illness narratives as a teaching methodology: a mixed method study of student nurses satisfaction. Nurse Education Today, 50, 1-7.

Ferguson, G. 2001. If you pop over there: a corpus-based study of conditionals in medical discourse. English for Specific Purposes 20, 61-82.

Fillenbaum, S. 1975. If: some uses. Psychological Research 37, 245-260.

Fillenbaum, S.1976. Inducements: On the Phrasing and Logic of Conditional Promises, Threats, and Warnings. Psychological Research 38, 231-250.

Fillenbaum, S. 1986. The use of conditionals in inducements and deterrents. In E. C. Traugott, A. Meulen, J. S. Reilly, & C. A Ferguson (Eds) *On conditionals*. Cambridge: Cambridge University Press, 179-195.

Fraser, B. 1999. What are discourse markers? Journal of Pragmatics 31, pp 931-952.

Gigerenzer, G. and Edwards, A. 2003. Simple tools for understanding risks: from innumeracy to insight. British Medical Journal, 327: 741.

Gill, V.T. 1998. Doing attributions in medical interaction: Patients' explanations for illness and doctors' responses. Social Psychology Quarterly, 61 (4), 342-360.

Gill, V.T., and Maynard, D. 2006. Explaining illness: patients' proposals and physicians' responses. In J. Heritage and D. Maynard (eds) *Communication in Medical Care.* Cambridge University Press, Cambridge.

Goldberg, J. 2004. The amplitude shift mechanism in conversational closing sequences. In G.H. Lerner (ed) *Conversation analysis: studies from the first generation.* Amsterdam: John Benjamins.

Goodwin, C., and Heritage, J. 1990. Conversation Analysis, Annual Review of Anthropology, 19, 283-307.

Greenbaum, S. and Quirk, R. 1990. *A student's grammar of the English language*. Pearson, India.

Gumperz, J. 1982. *Discourse Strategies*. Cambridge: Cambridge University Press.

Gulich, E. 2003. Conversational Techniques Used in Transferring Knowledge between Medical Experts and Non-experts. Discourse Studies, vol 5, (2), 235-263.

Haakana, M, 2002. Laughter in medical interaction: From quantification to analysis, and back. Journal of Sociolinguistics 6/2, 2002: 207-235

Haiman, J. 1978. Conditionals are topics. Language, 54, 3, 564-589.

Hamann, J., Mendel, R., Buhner, M., Leucht, S., and Kissling, W. 2011. Drowning in numbers-what psychiatrists mean when talking to patients about probabilities of risks and benefits of medication. European Psychiatry, 26, 130-131.

Hayano, K. 2013. Question design in conversation. In J. Sidnell and T. Stivers (eds) *The Handbook of Conversation Analysis.* Wiley-Blackwell, Chichester.

Heritage, J. 1984. *Garfinkel and Ethnomethodology*. Cambridge: Polity.

Heritage, J. 1998. Oh-prefaced responses to inquiry. Language and Society 27, 291-334.

Heritage, J. 2011. The interaction order and clinical practice: some observations on dysfunctions and action steps, Patient Education and Counseling, 84, 338-343.

Heritage, J. 2012. The Epistemic Engine: Sequence Organisation and Territories of Knowledge. Research on Language and Social Interaction, 45 (1), 30-52.

Heritage, J, 2015. Well-prefaced turns in English conversation: A conversation analytic perspective. Journal of Pragmatics 88 (2015) 88—104.

Heritage, J., and Maynard, D. 2006a. Introduction: Analysing interaction between doctors and patients in primary care encounters. In J. Heritage and D. Maynard (eds) *Communication in Medical Care.* Cambridge University Press, Cambridge.

Heritage, J., and Maynard, D. 2006b. Accounting for visit: giving reasons for seeking medical care. In J. Heritage and D. Maynard (eds) *Communication in Medical Care.* Cambridge University Press, Cambridge.

Heritage, J., and Robinson, J. 2005. The structure of patients' presenting concerns: the completion relevance of current symptoms, Social Science and Medicine, 61, 481-493.

Heritage, J., and Robinson, J. 2006. Physicians' opening questions and patients' satisfaction, Patient Education and Counseling, 60, 279-285.

Heritage, J. and Robinson, J. 2006a. The structure of patients' presenting concerns: physicians opening questions. Health Communication, 19 (2), 89-102.

Heritage, J., Robinson J., Elliot, M., Beckett, M., and Wilkes, M. 2007. Reducing patients' unmet concerns in primary care: the difference one work can make. Journal of General Internal Medicine, 22 (10), 1429-1433.

Heritage, J., and Robinson, J. 2015. How patients understand physicians' solicitations of additional concerns: implications for up-front agenda setting in primary care. Health Communication, 31 (4)

Heritage, J., and Stivers, T. 1999. Online commentary in acute medical visits: of method of shaping patient expectations, Social Science and Medicine, 49, 1501-1517.

Heritage, J., and Sefi, S. 1992. Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first time mothers. In *Talk at Work*, (eds) Drew, P and Heritage, J. Cambridge: Cambridge University Press, 359-417.

Heritage, J., and Stivers, T. 2001. Breaking the sequential mold: Answering "more than the question" during comprehensive history taking, Text 21, 151-185.

Howie, J., Heaney, D., Maxwell, M., Walker, J., Freeman, G., and Rai, H. 1999. Quality at general practice consultations: cross sectional survey. British Medical Journal, 319 (7212), 738-743.

Ijäs-Kallio, T., Ruusuvuori, J., and Perakyla, A. 2010a. Patient involvement in problem presentation and diagnosis delivery in primary care, Communication Medicine, 7, 131-141.

Ijas-Kallio, T., Ruusuvuori, J. and Perakyla, A. 2010b. Patient resistance towards diagnosis in primary care: implications for concordance. Health, 14 (2010), 505-522.

Jackson, C., Land, V., and Holmes, E. 2017. Healthcare professionals' assertions and women's responses during labour: A conversation analytic study of data from One born every minute. Patient Education and Counseling, 100, 465-472.

Jansink, R., Braspenning, J., Van der Weijden, T., Elwyn, G., and Grol R. 2010.

Primary care nurses struggle with lifestyle counseling in diabetes care: a qualitative analysis. BMC Family Practice, 11 (41).

Jefferson, G, 1979. A technique for inviting laughter and its subsequent acceptance declination. In G. Psathas (ed.) Everyday Language. Studies in Ethnomethodology. New York: Irvington Publishers. 79-96.

Jefferson, G. 1984 Transcription Notation, In J. Atkinson and J. Heritage (eds), *Structures of Social Interaction*, New York, Cambridge University Press.

Jefferson, G. 1983. Notes on a systematic deployment of the acknowledgement tokens "yeah" and "mm hm." In G. Jefferson (Ed.), *Two papers on transitory recipientship*. Tilburg University: Tilburg Papers in Language and Literature 30, 1-18.

Jefferson, G. 2004. Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed). Conversation Analysis: Studies from the First Generation. Amsterdam: John Benjamins. 13-31.

Jefferson, G., Harvey, S., and Schegloff, E. 1987. Notes on laughter in the pursuit of intimacy. In Graham Button and John R. E. Lee (eds.) Talk and Social Organization. Clevedon, Philadelphia: Multilingual Matters Ltd. 152-205.

Johanson, M., Larsson, U., Saljo, R., and Svardsudd, K. 1995. Lifestyle in Primary Health Care Discourse. Social Science and Medicine, 40 (3), 339-348.

Jones, A. 2003. Nurses talking to patients: exploring conversation analysis as a means of researching nurse–patient communication, International Journal of Nursing Studies, 40, 609-618.

Kinnell, A., and Maynard, D. 1996. The delivery and receipt of safer sex advice in pretest counselling sessions for HIV and AIDS. Journal of Contemporary Ethnography, 24 (4), 405-437.

Kitzinger, C. 2013. Repair. In J. Sidnell and T. Stivers (eds) *The Handbook of Conversation Analysis.* Wiley-Blackwell, Chichester.

Koenig, C. 2011. Patient resistance as agency in treatment decisions, Social Science and Medicine, 72, 1105-1114.

Lambe, C., and Collins, C. 2010. A qualitative study of lifestyle counselling in general practice in Ireland. Family Practice, 27, 219-223.

Lewis, D. 1976. Probabilities of conditionals and conditional probabilities. Philosophical Review, 85, 297-315.

Lindgren, B., Oster, I., Astrom, S. and Graneheim, H. 2011. "They don't understand… you cut yourself in order to live" Interpretative repertoires jointly constructing interaction between adult women who self-harm and professional caregivers. International Journal of Qualitative Studies on Health and Well-being, 6, (3) 7254.

Lindstrom, A., and Weatherall, A. 2015. Orientations to epistemics and deontics in treatment discussions. Journal of Pragmatics, 78, 30-53.

Linell, P., and Bredmar, M. 1996. Reconstructing topical sensitivity: Aspects of face-work in talks between midwives and expectant mothers. Research on Language and Social Interaction, *29,* 347–379.

Lutfey, K. 2004. Assessment, Objectivity, and Interaction: The Case of Patient Compliance with Medical Treatment Regimes. Social Psychology Quarterley, vol 67, (4), 343-368.

Marteau, T. M., Saidi, G., Goodburn, S., Lawton, J., Michie, S. and Bobrow, M. 2000. Numbers or words? A randomized controlled trial of presenting screen negative results to pregnant women. Prenatal Diagnosis, 20, 714–718.

Maynard, D, 1991. Interaction and Asymmetry in Clinical Discourse. American Journal of Sociology, 97 (2), 448-495.

Maynard, D. 1997. The New Delivery Sequence: Bad News and Good News in Conversational Interaction. Research on Language and Social Interaction, 30 (2), 93-130.

Maynard, D. 2006. "Does it mean I'm gonna die?": On meaning assessment in the delivery of diagnostic news. Social Science Medicine, 62, 1902-1916.

Maynard, D., and Kinnell, A. 1996. The Delivery and receipt of safer sex advice in pretest councelling sessions for HIV and AIDS. Journal of Contemporary Ethnography, vol 24, No 4, 405-437. Sage Publications.

McCabe, R., Heath, C., Burn, S., and Priebe, S. 2002. Engagement of patients with psychosis in the consultation: conversation analytic study. British Medical Journal, 325, 1148-1151.

Meryn, S. 1998. Improving doctor-patient communication. Not an option, but a necessity. British Medical Journal, 27, 316 (7149), 1922-1930.

Misselbrook, D., and Armstrong, D. 2002. Thinking about risk. Can doctors and patients talk the same language? Family Practice, 19 (1), 1-2.

Mohanna K, and Chambers R. 2001. Risk: what's that all about then? In: Mohanna K, Chambers R, eds. *Risk matters in health care: communicating, explaining and managing risk*. 1st ed. Abingdon, Oxon: RadcliVe Medical Press, 3–14.

Monzoni, C., Duncan, R., Grunewald, R., and Reuber, M. 2011. Are there interactional reasons why doctors may find it hard to tell patients that their physical symptoms may have emotional causes? A conversation analytic study in neurology outpatients, Patient Education and Counselling, 85, e189-e200.

Moran, J., Bekker, H., and Latchford, G. 2008. Everyday use of patient-centred motivational techniques in routine consultations between doctors and patients

with diabetes. Patient Education and Counseling 73, 224-231.

Muntigl, P. 2014. The therapeutic relationship in action: How therapists and clients co-manage relational disaffiliation. Psychotherapy Research, 24 (3), 327-345.

Murtagh, G. M., Furber, L., and Thomas, A.L. 2013. Patient-initiated questions: How can doctors encourage them and improve the consultation process? A qualitative study. British Medical Journal Open, 3, e003112.

National Institute for Health and Care Excellence
www.nice.org.uk

National Service Framework for Diabetes: Delivery Strategy 2003
www.yearofcare.co.uk

Nowak, P. 2011. Synthesis of Qualitative Linguistic Research-A Pilot Review Integrating and Generalizing Findings on Doctor-patient Interaction, Patient Education and Counseling, 82, 429-441.

Ohnishi, M., Fukui, T., Matsui, K., Hira, K., Shinozuka, M., Ezaki, H., Otaki, J., Kurokawa, W., Imura, M., Loyama, H., and Shimbo, T. 2002. Interpretation of and preference for probability expressions among Japanese patients and physicians. Family Practice, 19 (1), 7-11.

Parry, R., and Land, V. 2013. Systematically Reviewing and Synthesizing Evidence from Conversation Analytic and Related Discursive Research to Inform Healthcare Communication Practice and Policy: An Illustrated Guide. BMC Medical Research Methodology, 13, 69.

Perakyla, A. 1997. Conversation Analysis: a new model of research in doctor-patient communication. Journal of the Royal Society of Medicine, 90, 205-208.

Perakyla, A. 2002. Agency and Authority: Extended Responses to Diagnostic Statements in Primary Care Encounters. Research in Language and Social Interaction, 35, 219-247.

Perakyla, A. 2006. Communicating and responding to diagnosis, In J. Heritage, D, Maynard, *Communication in Medical Care Interaction between primary care physicians and patients*. Cambridge University Press, 214-247.

Potter, J., and Wiggins, S. 2008. Discursive psychology. In Willig, C., and Staiton-Rogers, W *The SAGE Handbook of Qualitative Research in Psychology*. London: Sage, 73-90.

Reuber, M., Plug, L., and Sharrack, B. 2009a. Seizure, Fit or Attack? The Use of Diagnostic labels by Patients with Epileptic or non-epileptic Seizures. Applied Linguistics, 31, 94-114.

Reuber, M., Monzoni, C., Sharrack, B. and Plug, L. 2009b. Using interactional and

linguistic analysis to distinguish between epileptic and psychogenic nonepileptic seizures: A prospective, blinded multirater study. Epilepsy Behaviour, 16, 139-144.

Reuber, M. Toerien, M., Shaw, R., Duncan, R. 2015. Delivering Patient Choice in Clinical Practice: A Conversation Analytic Study of Communication Practices used in Neurology Clinics to Involve Patients in Decision-making. Health Services & Delivery Research 3:7.

Ricci-Cabello, I., Olry de Labry-Lima, A., Bolivar-Munoz, J., Pastor-Moreno, G., Bermudez-Tamayo, C., Ruiz-Perez, I., Quezada-Jimenez, F., Moratalla-Lopez, E., Dominguez-Martin, S., De los Rios, A., Cruz-Vela, P., Prados-Quel, M., and Lopez-De Hierro, J. 2013. Effectiveness of two interventions based on improving patient-practitioner communication on diabetes self-management in patients with low educational level: study protocol of a clustered randomized trail in primary care. BMS Health Services Research, 13:433

Rimmer, C., and Harvey C. 2014. Consent: assessing and communicating risk. Surgery, 32, (2), 69-72.

Robinson, J. 2001a. Closing medical encounters: two physician practices and their implications for the expression of patients' unstated concerns. Social Science and Medicine, 53, 639-656.

Robinson, J. 2001b. Asymmetry in action: Sequential resources in the negotiation of a prescription request, Text, 21, 19-54.

Robinson, J. 2006. Soliciting patients' presenting concerns, In J. Heritage, D, Maynard. *Communication in Medical Care Interaction between primary care physicians and patients*. Cambridge University Press, 22-47.

Rodondi, P., Maillefer, J., Suardi, F., Rodondi, N., Cornuz, J., and Vannotti, M. 2009. Physician Response to "By-the-way" Syndrome in Primary Care. Journal of Internal Medicine 24, (6), 739-41.

Ross, H. B. 2004. *The Psychology of Learning and Motivation*. Vol 44, Elsevier Academic Press.

Sanford, D. 2003. *If P, Then Q: Conditionals and the foundations of reasoning.* New York: Routledge.

Schegloff, E. 1982. Discourse as interactional achievement: Some uses of "uh-huh" and other things that come between sentences. In Georgetown University Round-table on Language and Linguistics, (ed) D. Tannen. Washington DC: Georgetown University Press, 71-93.

Schegloff, E. 1992. On talk and its institutional occasions. In P. Drew and J. Heritage (eds), *Talk at work: interaction in institutional settings*. Cambridge: Cambridge University Press.

Schegloff, E, 2007. *Sequence Organisation in Interaction: A Primer on Conversation*

Analysis. vol 1. Cambridge University Press.

Schegloff, E. and Sacks, H. 1973. Opening up closings. Semiotica, 8, pp 289-327.

Shaw, C., Chrysilou, V., Davis, S., Gessler, S., Rodin, G., and Lanceley A. 2017. Inviting end-of-life talk in initial CALM therapy sessions: A conversation analytic study. Patient Education and Conseling, 100, 259-266.

Silverman, D., Perakyla, A. and Bor, R. 1992. Discussing safer sex in HIV counseling: assessing three communication formats. AIDS CARE: 4/1, 69-82.

Sorjonen, M., Raevaara, L., Haakana, M., Tammi, T. and Perakyla, A. Lifestyle discussions in medical interviews. 2006. In J. Heritage, D. Maynard, *Communication in Medical Care. Interaction between primary care physicians and patients*. Cambridge University Press, 340-378.

Stenner, K., Courtenay, M., and Carey, N. 2011. Consultations between nurse prescribers and patients with diabetes in primary care: A qualitative study of patient views. International Journal of Nursing Studies, 48, 37-46.

Stivers, T. 2006. Treatment decisions: negotiations between doctors and parents in acute care encounters, In J. Heritage, D, Maynard, *Communication in Medical Care Interaction between primary care physicians and patients*. Cambridge University Press, 279-312.

Stivers, T. 2008. Stance, alignment and affiliation during storytelling: When nodding is a token of affiliation. Research on Language and Social Interaction, 41 (1), 31-57.

Teas Gill, V. P. 2005. Patient "Demand" for Medical Interventions: Exerting Pressure for an Offer in a Primary Care Clinic Visit. Research in Language and Social Interaction, 38, 451-479.

Teas Gill, V., Pomerantz, A., and Denvir, P. 2010. Pre-emptive resistance: Patients' participation in diagnostic sense-making activities, Sociology of Health and Illness, 32, 1-20.

Teas Gill, V., Maynard, D. 2006. Explaining Illness: patients' proposals and physicians' responses, In J. Heritage, D. Maynard, *Communication in Medical Care Interaction between primary care physicians and patients*. Cambridge University Press, 115-150.

Teas Gill, V., and Roberts, F. 2013. In J. Sidnell and T. Stivers (eds) *The Handbook of Conversation Analysis.* Wiley-Blackwell, Chichester.

Ten Have, P. 2006. Conversation Analysis versus other approaches to discourse. Forum: Qualitative Social Research, 7 (2), 100-109.

Taylor, J., and Siddiqi, N. 2016. Improving health outcomes for adults with severe mental illness and comorbid diabetes: is supporting diabetes self-management

the right approach? Journal of Psychiatric and Mental Health Nursing, 23, 322-330.

Thomson, R., Edwards, A., and Grey, J. 2005. Risk communication in the clinical consultations. Clinical Medicine, 5 (5), 465-469.

Toerien, M., Shaw, R., and Reuber, M. 2013. Initiating decision-making in neurology consultations: 'recommending' versus 'option-listing' and the implications for medical authority. Sociology of Health and Illness, 35, 873-890.

Traugott, E., Closs, E., Ter Meullen, A., Reilly, J., and Ferguson, C. 1986. *On conditionals*. Cambridge: Cambridge University Press.

Van Dijk, T. 1995. Aims of Critical Discourse Analysis. Japanese Discourse, 1, 17-27.

Vine, B. 2009. Directives at work: Exploring the contextual complexity of workplace directives. Journal of Pragmatics 41, 1395-1405.

Waring, H.Z. 2007. Complex advice acceptance as a resource for managing asymmetries. Text Talk, 27 (1), 107-137.

West, C. 2006. Coordinating closings in primary care visits: producing continuity of care, In J. Heritage, D, Maynard, *Communication in Medical Care Interaction between primary care physicians and patients*. Cambridge University Press, 379-415.

West, C. and Garcia, A. 1988. Conversational shift work: a study of topical transitions between women and men. Social Problems, 35, 551-573.

Wetherall, M., and Potter, J. 1988. Discourse analysis and the identification of interpretative repertoires. In Antaki, C. (ed), *Analysing everyday explanation: a casebook of methods*. Newbury Park, CA: Sage, 168-183.

White, J., Levinson, W., and Roter, D. 1994. 'Oh by the way…': the closing moments of the medical visit. Journal of General Internal Medicine, 9, January, 24-8.

White, J. C., Rosson, C., Christensen, J., Hart, R. and Levinson, W. 1997. Wrapping things up: A qualitative analysis of the closing moments of the medical visit. Patient Education and Counseling 30, pp 155-165.

Wright, M. 2001. The phonetics-interaction interface in the initiation of closings in everyday English telephone calls. Journal of Pragmatics, 43, 1080-1099.