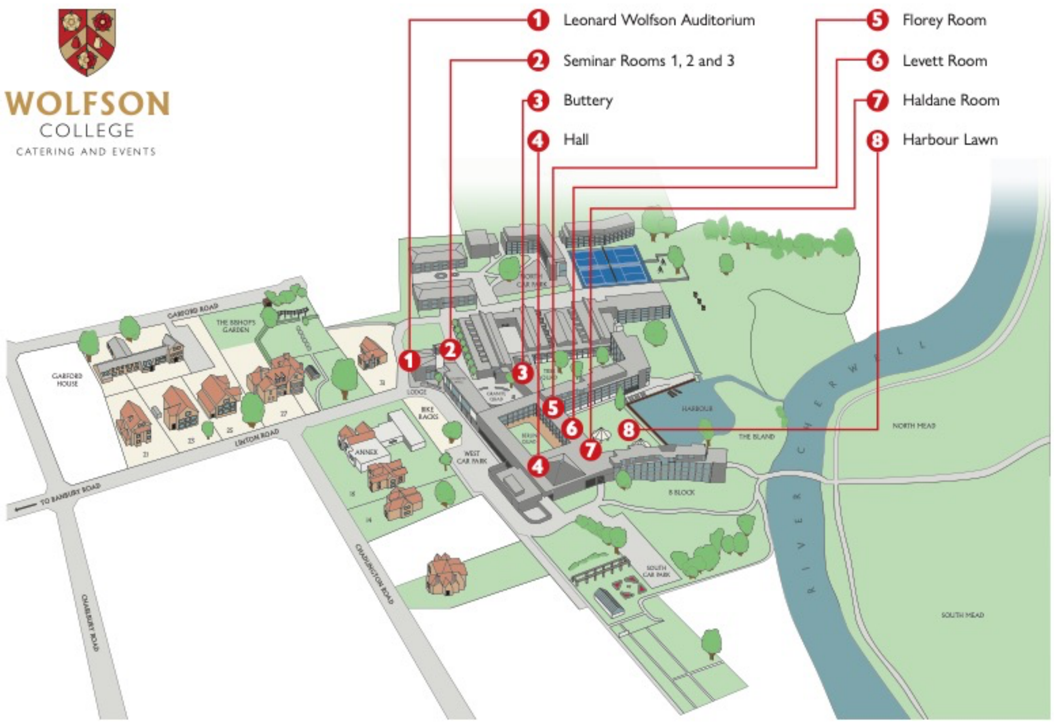
8th INTERNATIONAL MEETING
on Conversation Analysis and Clinical Encounters (#CACE2024)
Monday 1st – Wednesday 3rd July 2024 --- Wolfson College, Oxford

GENERAL INFORMATION



Registration

Enter the venue via the lodge and the CA&CE 2024 registration desk will be signposted. It will be open during the following times:

Sunday, June 30th – 5.00-7.30pm
Monday, July 1st – 8.00-9.00am
Wednesday, July 3rd – 8.00-8.45am

Please sign in to collect your conference badge. There will be a limited number of printed programmes available. Sign up sheets will also be available for the data sessions. Because places are limited for these sessions it is wise to sign up early. Please ensure that your name badge is worn at all times during the conference.

Wi-Fi is available via Eduroam. There is also a BT wifi and the password is ‘leonard’ all lower case.

Refreshments

Refreshments will be available in the Haldane Room during the morning and afternoon breaks, including teas, coffee, water and fresh fruit. You are very welcome to use the college gardens to get some fresh air.

Outside of these breaks, the Wolfson Café serves hot and cold drinks and snacks from 08.00-17.00 Monday-Friday – card payments only. There is a water station here to refill bottles.

Lunches

Sandwich-style lunches will be provided in the Haldane Room each day with cake, fresh fruit, teas, coffee, chilled juice and water. You are very welcome to eat outside and walk in the college gardens.

Social Activities

See here for information on things to do and see in the City of Oxford including our Colleges.

Sunday 30th June

If you arrive in the city early, you may wish to try your hand at punting – a quintessentially Oxford leisure activity - on the River Cherwell over at the nearby Cherwell Boathouse (a restaurant and teahut). Please send us your photos! For those seeking somewhere to gather informally on Sunday evening, you may wish to head to the Rose & Crown on North Parade Avenue (approximately 15 minutes walk from Wolfson, also serves food), the historic Lamb and Flag on St Giles, approx. 26 minutes walk from Wolfson) or the Turf Tavern (approx. 32 minutes walk from Wolfson, also serves food) if you can find it!

Monday 1st July

Monday evening will be spent at leisure. There are many cafes, pubs, bars and restaurants to eat in and around Oxford.

For local fare, we recommend North Parade Avenue, for breakfast try the small but lovely Barefoot café or visit the Rose & Crown pub an early evening drink.

Towards the city centre we recommend the Tree Artisan Café on Little Clarendon Street for coffee, and Ramen Kulture on Woodstock Road for noodles.

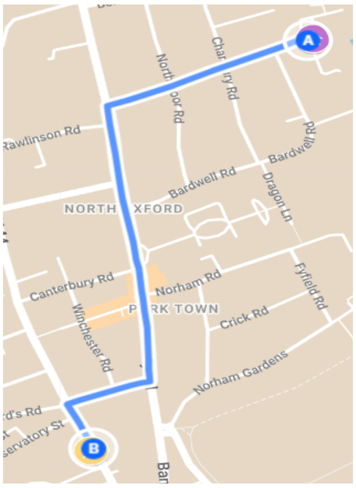
Walton Street in the Jericho area (approximately 25 minutes' walk toward Oxford), has a number of lovely independent coffee houses and casual dining eateries, including Branca and Mama Mia and drinkeries such as The Old Book Binders (also serves food) on Victor Street.

The Summertown area (approximately 20 minutes' walk north) also has a few restaurants including another Mama Mia, cafes such as Columbia Coffee Roasters and bars. It is advisable to book a table in Oxford restaurants ahead of time.

Tuesday 2nd July – Celebratory meeting dinner

For those with dinner bookings, on Tuesday evening there will be a celebratory three course meal with wine in the historic Radcliffe Observatory at Green Templeton College, 43 Woodstock Rd, Oxford OX2 6HG, see here for information about access provisions.

Please arrive at Green Templeton College by 7.15pm as dinner will be served at 7.30pm. We will be asked to vacate the venue by 10pm. The College is a 20-minute walk from Wolfson College or a short taxi ride from the venue (Royal Car Taxis 01865 777 333). See the walking map from the venue (A) to Green Templeton College (B):

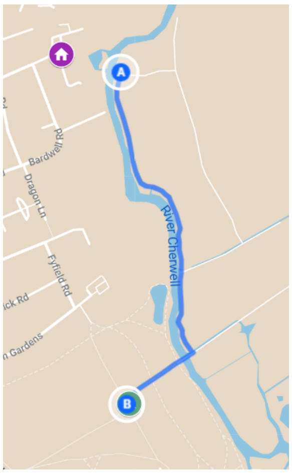


Local walks

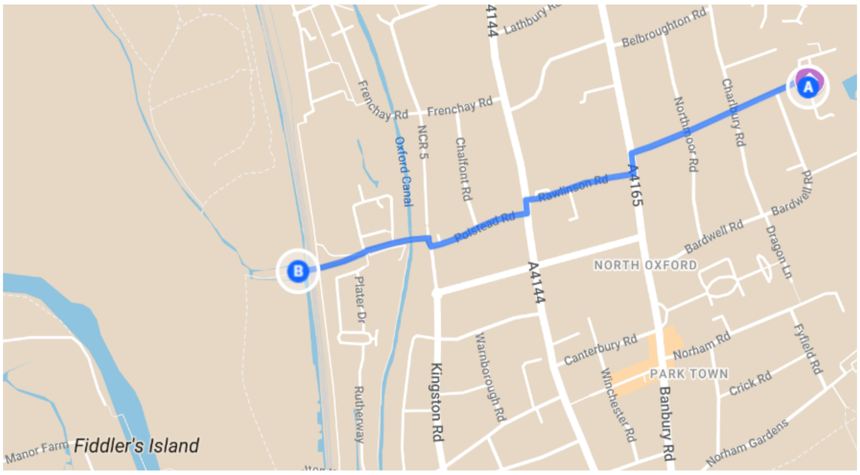
Wolfson College has two garden areas to walk in. Behind the college adjacent to the River Cherwell features their Formal Garden, Winter Garden and Damp Garden. Next to the college (accessed via a signposted passage) is Bishop's Garden, an Edwardian-style Garden with seating.

There is a bridge across the River Cherwell behind the college that will take you into the college meadows. Walking trails follow the river south to University Parks (a large green park) and into the city centre. Two things to look out for: (1) the very rare brown hairstreak butterfly lives in the hedges along this trail, and (2) students/tourists often fall into the river along here while punting!

To the west of college, you'll find Port Meadow adjacent to the River Thames. This is a wide-open green space grazed by livestock. You can pick up one of the walking trails (well signposted) south into Jericho or into the city centre.



South into University Parks



West toward Port Meadow

Organisers contact

During the meeting, the general contact for the organisers is cace2024@phc.ox.ac.uk

Emergency contacts

The emergency services in England are reached by dialling 999. You will be asked if you want Fire, Police or Ambulance. For urgent health advice go to NHS 111 online or dial 111. For other NHS services nearby such as pharmacies and walk-in clinics etc., please go to https://www.nhs.uk/

FINAL PROGRAMME

DAY 1: **Monday 1st July 2024**

08:00-09.00	Registration	
09.15-09.30	OPENING Leonard Wolfson Auditorium **Catherine Pope, Professor of Medical Sociology, University of Oxford** – Welcome to Oxford! **Rebecca Barnes & the Organising Committee** – Introducing CA&CE 2024	
09.30-10.30	**KEYNOTE 1 Rose McCabe, Professor of Clinical Communication, City, University of London** **Communication in mental health assessments with people presenting to the Emergency Department in a mental health crisis** Leonard Wolfson Auditorium	
10.30-11.00	MORNING BREAK – Haldane Room	
11.00-12.30	PARALLEL SESSION 1A – Leonard Wolfson Auditorium ***Mental health care***	PARALLEL SESSION 1B – Buttery ***Remote & digital health care***
11.00-11.15	1A.1 **Rose McCabe** et al. Communication in mental health care: A state-of-the-art review of conversation-analytic research	1B.1 **Ayeshah Syed** Opening teleconsultations during check-up visits for patients with Type 2 Diabetes guided by a teleconsultation checklist
11.15-11.30	1A.2 **Catherine Woods** Remote discussion of emotional concerns in telephone versus face-to-face primary care consultations (REMOTION): A pilot study	1B.2 **Evi Dalmaijer** et al. Advice-giving and authority in a digital paediatric rehabilitation treatment
11.30-11.45	1A.3 **Iris van der Scheer** The discussion of common mental health concerns in GP-patient interactions	1B.3 **Sara Keel** Solving a problem with an app in physiotherapy consultations as an opportunity for situated learning
11.45-12.00	1A.4 **Clara Iversen** et al. Accomplishing (anti)racism in the context of unconditional support: Examining responses to callers' racialised talk in suicide preventive helplines	1B.4 **Fiona Stevenson** Negotiations around the implementation of a digital health intervention (DHI) for management of long covid into secondary and community care
12.00-12.30	**Adam Brandt** & Spencer Hazel Automating clinical encounters – developing AI voice assistants for routine healthcare calls to patients Leonard Wolfson Auditorium	
12.30-13.30	LUNCH – Haldane Room	

13.30-15.00	DATA SESSIONS					
	Leonard Wolfson Auditorium **Maria Stubbe** ‘For young people like you’: Negotiating age categories in primary care consultations	Buttery **Anca-Cristina Sterie** Introducing & managing end-of-life topics in discussions between spiritual counsellors & hospitalised older adults	Seminar Room 1 **Valeria Barbieri** Miscommunication in medical interaction: problems of understanding in doctor-patient consultation	Seminar Room 2 **Heidi Kevoe-Feldman & Galina Bolden** ‘I don’t wanna die’: Managing caller panic in high-stakes emergency calls	Seminar Room 3 **Virginia Calabria et al.** Not being able to exercise: how GPs treat patients’ accounts based on mental vs physical health co-morbidities with diabetes	The Levett Room **Rebecca Barnes & Adaku Agwunobi** Identifying problems for action in pharmacist-led structured medication reviews

15.00-15.30	AFTERNOON BREAK – Haldane Room	
15.30-17.00	PARALLEL SESSION 2A – Leonard Wolfson Auditorium ***Managing practical problems in health care***	PARALLEL SESSION 2B – Buttery ***Identity work***
15.30-15.45	2A.1 **Marit Nygård Halvorsen** Midwives' approaches in thematizing violence in antenatal care	2B.1 **Blair Ying Jin** ‘I am here again’: Display of patient loyalty in routine chronic visits
15.45-16.00	2A.2 **Bregje de Kok** et al. Persuasion and shared decision-making in antenatal care in Ghana	2B.2 **Ruiyu Tang** ‘You think I’m an augur?’ Sequential consequences of invoking categories beyond Doctor-Patient collection in clinical interaction
16.00-16.15	2A.3 **Eniola Boluwaduro** 'What you'll help me do is x’: Securing patients’ adherence in Nigerian HIV consultations	2B.3 **Caroline Tietbohl** et al. Physician self-disclosures in the context of discussions about diagnosis and treatment
16.15-16.30	2A.4 **Daniele Urlotti** The epistemic upgrading of questions as a confirmation seeking device in mediator-interpreted clinical encounters with migrants	2B.4 **Madeleine Tremblett**, Tim Auburn & Cordet Smart Identity in multiprofessional teams: The negotiation of tasks
16.30-16.45	2A.5 **Magdalena Solarek-Gliniewicz** Strategies to establish common understanding under medical consultations in a second language	2B.5 **Marine Riou** & Nirukshi Perera Accentism, intersubjectivity, and disaffiliation in French emergency calls
16.45-17.00	**Annesofie Ishøy Nielsen & Catherine E. Brouwer** Interaction with minimally conscious patients: Dealing with lack of response Leonard Wolfson Auditorium	

DAY 2: Tuesday 2nd July 2024

09.00-10.00	**KEYNOTE 2 Johanna Ruusuvuori, Professor of Social Psychology, University of Tampere, Finland** **Touch and Affect in Healthcare** Leonard Wolfson Auditorium	
10.00-10.30	MORNING BREAK – Haldane Room	
10.30-12.00	PARALLEL SESSION 3A – Leonard Wolfson Auditorium ***Palliative care & end of life talk***	PARALLEL SESSION 3B – Buttery ***Individual presentations***
10.30-10.45	3A.1 **Ruth Parry** Communication in palliative care and about end of life: A state-of-the-art review of conversation-analytic research	3B.1 **Kleopatra Sideridou** Mouth opening sequences in dental appointments: a collaborative interplay
10.45-11.00	3A.2 **Marco Pino** et al. Moving towards (and away from) possible discussions about disease progression and end of life: Some emergent outcomes of companions' actions in palliative care interactions	3B.2 **Irene Kelder** 'Normally I always ask briefly…': How patients and healthcare professionals in oncology construct sexuality as a delicate topic
11.00-11.15	3A.3 **Andrea Bruun** et al. Questions during funeral planning sessions with support staff and people with intellectual disabilities	3B.3 **Xinxin Yang** & Ray Wilkinson Known Answer Question Sequences: A Comparative Analysis of Persons with Aphasia-Therapist and Persons with Aphasia-Spouse Interactions
11.15-11.30	3A.4 **Ana Cristina Ostermann** & Paola Konrad 'I don't have good news to give you': Communicating death over the phone to families of patients in COVID-19 intensive care	3B.4 **Anna Sowerbutts** 'What does obey mean?': Interactions between a young offender with language disorder and his youth offending team worker
11.30-12.00	**Ruth Parry** et al. Translating conversation-analytic perspectives and evidence into existing communication training: The RealTalk approach Leonard Wolfson Auditorium	
12.00-13.00	LUNCH – Haldane Room	

13.00-14.30	DATA SESSIONS					
	Leonard Wolfson Auditorium **Gilian Noord** Interactional	Buttery **Heidi Meyer** & **Sjaan Gomersall** 'We don't use that	Seminar Room 1 **Yicen Guo** Interactional benefits &	Seminar Room 2 **Joanna Lindell** Evidentials and epistemic humility in	Seminar Room 3 **Lieve van Hengel** Categorization work	The Levett Room **Caroline Tietbohl & Anne White** Exploring

<table>
<tr><td></td><td>difficulties in GP-patient telephone consultations in UK primary care</td><td>language here!’ – Clinical dietetics and how dietary health behaviour change talk occurs in Type 2 Diabetes community healthcare</td><td>challenges of adult patient companions' participation in Chinese medical consultations</td><td>assessment consultations</td><td>in group discussions on child vaccination</td><td>encouragement across clinical settings</td></tr>
<tr><td>14.30-15.00</td><td colspan="6">AFTERNOON BREAK – Haldane Room</td></tr>
<tr><td>15.00-16.30</td><td colspan="3">PARALLEL SESSION 4A – Leonard Wolfson Auditorium
Paediatric care</td><td colspan="3">PARALLEL SESSION 4B – Buttery
Designing, delivering & implementing interventions</td></tr>
<tr><td>15.00-15.15</td><td colspan="3">4A.1 Laura Jenkins et al.
Communication in paediatric care: A state-of-the-art review of conversation-analytic research</td><td colspan="3">4B.1 Jack Joyce et al.
Using CA to design and refine a communication-intervention in a clinical trial: How health coaches provide weight loss support</td></tr>
<tr><td>15.15-15.30</td><td colspan="3">4A.2 Clare Jackson
Doing risk surveillance and management during labour</td><td colspan="3">4B.2 Liliia Bespala et al.
Balancing epistemics: A study of self-repairs in opportunistic weight loss advice interactions</td></tr>
<tr><td>15.30-15.45</td><td colspan="3">4A.3 Chloe Shaw et al.
Informing parents about their child’s condition in neonatal critical care</td><td colspan="3">4B.3 B.B. Stinensen, Petra Sneijder et al.
Analysing and evaluating patient–practitioner interaction about chronic pain: A workshop for pain rehabilitation practitioners</td></tr>
<tr><td>15.45-16.00</td><td colspan="3">4A.4 Bogdana Humă et al.
Formulating ‘doubt’ about child vaccination</td><td colspan="3">4B.4 Geraldine Leydon on behalf of the REDUCE Team
‘God you’re going to have to remind me of the scoring options as we go along’: The telephone administration of the PHQ9 depression questionnaire in the REDUCE Trial.</td></tr>
<tr><td>16.00-16.15</td><td colspan="6">Nan Wang
Fail to respond or fail to recognize: Caregivers’ unsolicited expression of concerns and doctors’ responses in Chinese paediatric primary care encounters
Leonard Wolfson Auditorium</td></tr>
<tr><td>16.15-16.45</td><td colspan="6">On (in)dispensability: Remembering Manny Schegloff
Leonard Wolfson Auditorium</td></tr>
</table>

DAY 3: Wednesday 3rd July 2024

08:00-08.45	Registration	
09.00-10.00	**KEYNOTE 3 Alison Pilnick, Professor of Language, Health & Society, Manchester Metropolitan University** **Understanding the 'failure' of patient-centred care: A conversation-analytic perspective** Leonard Wolfson Auditorium	
10.00-10.30	MORNING BREAK – Haldane Room	
10.30-12.00	PARALLEL SESSION 5A – Leonard Wolfson Auditorium ***Medical decision-making***	PARALLEL SESSION 5B – Buttery ***Patients' perspectives***
10.30-10.45	5A.1 **Merran Toerien** Invoking the patient's right to accept or refuse treatment: the deviant cases that reveal two norms for medical decision-making	5B.1 Sakari Ilomäki & **Aija Logren** Epistemic, deontic, and affective relevance of patients' ideas and integration of knowledge in neurological outpatient clinics
10.45-11.00	5A.2 Anikó de Geest et al. Respecifying 'vaccine hesitancy' as an interactional accomplishment	5B.2 **Piera Margutti** & Vittoria Colla Patients' overlapping talk: conveying concerns in oncology treatment visits by withholding the progressivity of interaction
11.00-11.15	5A.3 **Chloe Shaw** et al. When 'option-listing' provides patients with the interactional opportunity to positively engage with a conservative treatment option	5B.3 **Amanda McArthur** et al. Responding to patient disclosures of medication nonadherence: Contexts and consequences
11.15-11.30	5A.4 **Aija Logren** & Sakari Ilomäki Categorization of information sources and information users as pre-empting potential disalignment in stance and preference	5B.4 **Marine Riou** et al. The epistemic phrase 'I (don't) think' in emergency calls: A mismatch of callers' practices and call-takers' orientation
11.30-11.45	5A.5 **Laura Jenkins** et al. Interactional insights into risk communication in paediatric allergy	5B.5 **Rachael Drewery** et al. Compassion, patient tellings and the design of healthcare professionals' responses
11.45-12.00	**Bethan Benwell** & Catrin Rhys Comprehending complainability: Achieving empathy while maintaining professional neutrality in healthcare complaints Leonard Wolfson Auditorium	
12.00-13.00	LUNCH – Haldane Room	

13.00-14.30	PARALLEL SESSION 6A – Leonard Wolfson Auditorium ***Primary care***	PARALLEL SESSION 6B – Buttery ***Dementia care***
13.00-13.15	6A.1 **Rebecca K. Barnes** & Catherine Woods Communication in primary health care: A state-of-the-art review of conversation-analytic research	6B.1 **Danielle Jones** et al. Negotiating risk in memory clinic interactions: Risk identification and the role of third-party involvement
13.15-13.30	6A.2 **Timothy Halkowski** Metric shifts in doctor-patient discussions of alcohol & tobacco use	6B.2 **Suzanne Beeke** et al. 'It's okay you're not gonna fall': Accounting for care in acute healthcare settings with patients with dementia to avoid, de-escalate or resolve episodes of distress
13.30-13.45	6A.3 **Anna Lindström** & Rebecca K. Barnes Asking about allergies: Implementing safe prescribing of antibiotics in primary care	6B.3 **Isabel Windeatt-Harrison** et al. The first step in triadic decision-making involving people with dementia: determining who talks when
13.45-14:00	6A.4 **Chase Wesley Raymond** et al. Conversations about cost in primary care: notes on 'opportunity spaces'	6B.4 **Rebecca O'Brien** et al. 'I want to get out… I've got a child at home': Intersubjectivity and reality disjunctures in the care of people living with dementia.
14:00-14:15	6A.5 **Caroline Tietbohl** Gender differences in empathic validation provided during geriatric medicine consultations communication	6B.5 **Felicity Slocombe** et al. Reminiscence respecified: A conversation-analytic examination of practice in a specialist dementia care home
14:15-14:30	6A.6 **Christopher Koenig** How can treatment recommendation formulations help patients feel included in primary care encounters?	6B.6 **Lauren Bridgstock** et al. 'Wonderful Wonderful': Use of praise in the care of people living with dementia
14.30-15.00	AFTERNOON BREAK – Haldane Room	
15.00-16.00	**KEYNOTE 4 Steven Bloch, Professor of Communication & Social Interaction, University College London** **'It's just…': How helpline participants manage additional concerns once closing is underway** Leonard Wolfson Auditorium	
16.00-16.15	CLOSING Leonard Wolfson Auditorium	

PLENARY PRESENTATIONS in alphabetical order by first name.

Alison Pilnick, Professor of Language, Health and Society
Manchester Metropolitan University

Understanding the 'failure' of patient-centred care: a conversation-analytic perspective.

Patient-centred care (PCC) is typically framed as a means to guard against the problem of medical paternalism, exemplified in historical attitudes of 'doctor knows best'. In this sense PCC is often regarded as a moral imperative. However, systematic reviews of the adoption of PCC in healthcare settings do not find any consistent improvement in health behaviours or outcomes as a result. Rather than raising more fundamental questions about the approach, these findings are generally interpreted as pointing to the need for more or 'better' staff training. As a result, empirical research is often focused on the extent to which practice does or does not live up to checklists of PCC criteria, though these checklists are many and varied, and can produce conflicting results.

Patient autonomy is generally foregrounded in conceptualizations of PCC, to be actualized through the exercising of choice and control. But examining healthcare interaction in practice using conversation analysis shows that when professionals attempt to enact these underpinnings, it often results in the sidelining of medical expertise that patients want or need. Drawing on a large corpus of audio and video recorded healthcare interactions collected over 25 years from a wide range of practice settings, I will argue that in rightly problematizing unbridled medical authority, PCC has inadvertently also problematized medical expertise. The end result is that patients can feel abandoned to make decisions they feel unqualified to make, or even that care standards may not be met. Understanding this helps to explain why PCC has not produced the hoped-for improvement in health outcomes. It also shows the importance of analyses of healthcare interaction for healthcare policy. The broad moral principles of a values-based approach may be attractive to policy makers but may also create intractable interactional dilemmas for practitioners who have to talk these policies into being.

Johanna Ruusuvuori, Professor of Social Psychology
Tampere University

Touch and affect in health care interaction

Touch is regarded as perhaps the most emotionally charged sense in human social interaction. It is often considered to signal intimacy and the line between proper and improper touch is usually strictly regulated. Yet, touch is necessary, even obligatory for performing the institutional tasks in most types of healthcare encounters. Affect is omnipresent in any social situation and may be intensified in situations where professionals need to examine or perform potentially unpleasant operations on the patient.

This talk describes preliminary results and imminent challenges of an ongoing research project on touch and affect in healthcare interaction. The project tackles the dilemma of managing necessary institutional tasks while attending to patients' potential anxiety or fear. The main research question is: How do the embodied practices of touch and affect evolve and intertwine in naturally occurring co-present healthcare encounters? The original research goals include locating potential generic patterns in managing touch and affect in different cultural and institutional contexts of healthcare interaction, providing a basis for quantification regarding the role of affect-intensive sequences in healthcare encounters, and developing methodology and theory of interaffectivity through touch.

The data consist of primary care consultations in Finland and the UK, dental consultations in Finland, China, Iraq and US, and maternity and child health care encounters in Finland. The method is multimodal CA with co-operative and intercorporeal perspectives. The talk presents some pitfalls, as well as successes in an effort to reach these rather ambitious goals.

Rose McCabe, Professor of Clinical Communication
City, University of London

Communication in mental health assessments with people presenting to the Emergency Department in a mental health crisis

Emergency departments are key settings for the management of mental health crises. After being triaged in the Emergency Department (ED) and having their medical needs attended to, people are referred for a mental health psychosocial assessment by the psychiatric liaison team also located in the ED. Patients seeking emergency care report varying experiences from being believed and taken seriously and supported to not being believed, taken seriously or supported. Epistemic injustice provides a conceptual framework to explore how peoples' experiences of serious distress (e.g. self-harm and suicidality) are believed or not. I will discuss the application of conversation analysis to analyze *epistemics* in clinical communication, focusing on how knowledge is claimed, contested and negotiated. I will focus on how certain communication practices either (1) undermine, imply implausibility and recharacterize or (2) accept peoples' experiences of distress. I will explore how this occurs in the context of risk assessment and how evidence from conversation analysis of clinical interactions can be triangulated with patient and carer interviews, clinical entries in medical records and ED discharge letters. Finally, I will show how undermining or accepting peoples' experiences is linked to treatment decisions and how practitioners are required to act as gatekeepers, rationing under-resourced mental health services. This significantly undermines early intervention and patient recovery.

Steven Bloch, Professor of Communication and Social Interaction
University College London

'It's just…': How helpline participants manage additional concerns once closing is underway.

Heath helplines typically feature a caller seeking some form of help from a formally recognised organisation permitted to offer a specialist telephone and/or online chat advice service. Helpline interactions are somewhat different from other types of medical encounter. What may appear to replicate the more familiar phased structure of the primary care consultation (Maynard & Heritage, 2005) turns out to be different both in terms of the remote nature of the interaction and the accomplishment of key tasks (such as responding to a call for emotional support). This invites us to ask some rather practical questions: How do participants themselves orientate to the opportunities and constraints that helplines provide?

In recent years we have been working with a corpus of 30 calls to one UK based health helpline for people living with Parkinson's, one of the most common age-related degenerative neurological conditions. Callers to this helpline are typically experiencing a range of symptoms and medication management issues. The call for help and its response can, as a result, be quite complex. We have previously examined the pivot point between problem-presentation and the provision of advice (Bloch and Antaki, 2019); how call-takers satisfy callers without giving advice beyond their remit (Antaki and Bloch, 2020), and how call-takers deal with explicit objections to their advice (Bloch and Antaki, 2022). This work has revealed several practices that resonate with evidence from other helplines and contrasts with more medically oriented encounters.

In this presentation we will explore an additional phenomenon in relation to call organisation and additional concerns: helpline caller responses to 'anything else' formulations (Heritage et al 2007). Soliciting additional concerns in co-present medical encounters has of course already received rigorous attention (Robinson et al 2016) but here we deal with a different interactive environment with an arguably greater opportunity for a wider range of next-turn uptake options. We will consider the design of these responses including ‘it’s just X’ formulations which, we argue, act to hearably minimalise, or at least reduce, the impact of whatever follows. There is no doubt that these ‘anything else’ formulations are part of a wider closing activity – the organisational issue for callers is how to re-set the seeking help agenda whilst acknowledging that closing is already underway.

ORAL PRESENTATIONS in alphabetical order by first name.
Underline denotes presenting speaker.

Adam Brandt & Spencer Hazel
Newcastle University

Automating clinical encounters – developing AI voice assistants for routine healthcare calls to patients

Conversational AI technologies such as Alexa and Siri have over the past few years become established as everyday devices through which people manage their affairs or access information from the Internet. Although most common is still the text-based chatbot, designed to manage communications between a company or organisation and a client, increasingly we find voice-based automated Conversational User Interfaces being used, including in the healthcare sector. The benefit for healthcare providers is that this frees up valuable time for clinical staff to attend to patients who need further care, rather than making phone calls to those for whom no further interventions are needed. This has significant implications for the future of healthcare communication. However, the technology must be implemented without negatively impacting the patient experience, or the quality of the information gathered.

This presentation reports on work carried out by the authors in partnership with a HealthTech start-up. Ufonia has developed a AI-powered voice assistant, Dora, for carrying out routine telephone-based clinical conversations across a number of hospital trusts (see Brandt et al. 2023). The collaboration set out to investigate whether Conversation Analysis could provide the interface designers with tools and insights to further improve these automated phone calls. The project focused on how to draw on insights from conventional human-human clinical encounters to feed into the conversation design of Dora. This collaborative work, a partnership between Conversation Analysts, conversation designers and clinicians, trialled and implemented changes to the automated system, with a view to optimising the outcome for the healthcare provider, while at the same time delivering a better experience for the patient.

The project demonstrates how CA was able to feed into the design of the system, enabling a more natural user experience for patients by modelling the design on the normative patterns of equivalent clinical encounters.

References
Brandt, A., Hazel, S., Mckinnon, R., Sideridou, K., Tindale, J. & Ventoura, N. (2023) '*From Writing Dialogue to Designing Conversation: Considering the potential of Conversation Analysis for Voice User Interfaces*', in [Online]. 2023

Aija Logren[1] & Sakari Ilomäki[2]
[1]University of Eastern Finland, [2]Tampere University

Categorization of information sources and information users as pre-empting potential disalignment in stance and preference

A well-known feature of doctor-patient interaction is the epistemic asymmetry: while the patient has primary access to the knowledge considering their own experiences, the doctor is entitled to medical knowledge. Even though the patients may have independent access to medical information as well, presenting themselves as 'knowable' in the consultation is oriented to be problematic, and it is often mitigated with strategies such as hedging. In this presentation we examine episodes in which patients account for the source of the medical information they have acquired, and show how the participants work to collaboratively legitimise the patient's entitlement to knowledge.

By applying Conversation Analysis and Membership Category Analysis to video-recorded data on Finnish neurology outpatient consultations, we describe how the mutual orientation to patient's

acceptable entitlement to medical knowledge is achieved through the following actions:
1) distinguishing different sources of medical information (eg. ‘reliable websites’ and ‘trash websites’)
2) categorising people who use or produce the different types of sources of information (eg. ‘smart people’ and ‘bigots’)
3) categorising the patient as a member or non-member of a certain type of category of people.

This is collaboratively achieved by the patient and the doctor through series of sequences of categorisations and agreements. Interestingly, the actual content of the accessed information is not always discussed at all. We discuss how this practice may implicitly manage the participants’ stances and patient’s preference regarding the medical decisions, such as choice of treatment, and thus may function as a way to touch potentially problematic issues, such as adherence to treatment. Mutual orientation to the patient as legitimately entitled to certain type of medical knowledge may serve to build the relationship between the patient and the doctor.

Amanda McArthur, Somnath Saha & Mary Catherine Beach
Johns Hopkins Medicine, Johns Hopkins University

Responding to patient disclosures of medication nonadherence: Contexts and consequences

Background: For people living with HIV, adherence to antiretroviral therapy (ART) dramatically reduces transmission and improves health; however, many struggle to achieve this goal. Guidelines recommend routine counseling, emphasizing a collaborative approach that engages the patient’s perspective to explore barriers. Yet studies lack empirical data on what this means *in situ,* and clinicians have little guidance. We take a first step by examining disclosure-response sequences in ART nonadherence conversations.

Methods: This study draws on 124 audio-recorded encounters between clinicians in HIV clinics and patients whose viral load is unsuppressed, an indicator of ART nonadherence. Conversation analysis was used to examine initial patient disclosures of nonadherence and clinician responses, from the transition relevance place (TRP) through the first clinical question.

Findings: Initial disclosures may be bare (“I missed two”) but more often include contextual information including accounts (“they make me sick”) and acknowledgments of personal responsibility (“I wasn’t doing what I was supposed to do”). Following disclosures where patients have acknowledged personal responsibility, clinicians’ minimal acknowledgements (“mm hm?”) or pursuits of reasons (“why did you stop?”) tend to result in patient elaboration, whereas shifting immediately to the clinical agenda (“how many pills have you missed?”) observably disattends or cuts short the patient’s story. Conversely, following disclosures where patients have *not* acknowledged personal responsibility, clinicians’ minimal acknowledgements or pursuits of reasons tend to be met with silence or resistance, whereas shifting to the clinical agenda and *then* pursuing reasons results in more extensive patient elaboration.

Conclusions: The different ways patients disclose medication nonadherence create distinct interactional contexts shaping the consequences of clinician responses in terms of engaging the patient’s perspective. Acknowledgements of personal responsibility may convey that patients have more to say; in this context, deferring the shift to clinical questioning makes space for patients to tell their stories. When patients are not so forthcoming, shifting to the clinical agenda first and then pursuing reasons may be a resource for encouraging patient engagement.

Ana Cristina Ostermann & Paola Konrad
Universidade do Vale do Rio dos Sinos

“I don't have good news to give you”: Communicating death over the phone to families of patients in COVID-19 intensive care

During the COVID-19 pandemic, when vaccines were not yet available, some hospitals had to switch to telephone calls the interactions with patients' families which, among other updates, included the communication of the death – a type of news up to then delivered only face-to-face. Taking a conversation analytic perspective (Sacks, Schegloff, Jefferson 1974; Sacks 1992), this study investigates how the communication of death to families of Covid-19 patients happens over the phone in a corpus of 528 calls recorded between 2020 and 2021 in a hospital Intensive Care Unit (ICU) in Brazil. Our findings show that the news of death is delivered in three ways: (i) with pre-announcements that forecast in so many words the negative valence of the news; (ii) with other multimodal clues (e.g., prosodic anticipators, speech delivery perturbations) that forecast the difficulty of the news; and (iii) directly, without fronting the news valence. Studies of naturally occurring bad news delivery show that forecasting – rather than stalling or being blunt – is the most effective way of procuring the recipients' realization (Ostermann et al. 2017; Maynard 1996; 1997a; 1997b; 2003; 2017). However, with rare exceptions (cf. Beach, Dozier, Gutzmer 2018), those studies focus on the single encounters of communicating bad news. The data investigated here, which consist of daily, longitudinal updates on the patient's health suggest that the more family members know about the possibility of the upcoming death, the less forecasting is used by the professionals. The interactional history (Deppermann, Doehler 2021) is indexed in the distinctive ways of delivering difficult news and shows that even practices commonly understood as less effective (e.g. being blunt) are deemed appropriate ways of communicating death. The analysis shows that in this context, the delivery of news is finely calibrated vis-à-vis the families' gradually-built, cumulative understanding of the patient's previous clinical conditions.

Andrea Bruun[1], Leon Jordan[1], Richard Keagan-Bull[1], Jo Giles[1], Rebecca Anderson-Kittow[2] & Irene Tuffrey Wijne[1]
[1]Kingston University, [2]University of Oxford

Questions during funeral planning sessions with support staff and people with intellectual disabilities

Background
Talking about death has been identified as an important aspect of end-of-life care planning with people with intellectual disabilities. However, support staff find it difficult to discuss death and dying with the people they support. Communication barriers include the emotional aspect of the topic, lack of capacity and understanding, not knowing how to initiate the topic, and a lack of resources to support the discussion. To aide staff in these discussions, new resources were co-produced with people with intellectual disabilities, families, support staff, and healthcare professionals.

The aim of this study was to explore questions support staff ask people with intellectual disabilities during funeral planning sessions.

Method
Video-recordings of funeral planning sessions were collected in December 2023/January 2024. Data were transcribed and analysed using Conversation Analysis. Data analysis involved team discussions, including researchers with intellectual disabilities.

Recordings involved dyads of support staff and people with intellectual disabilities using the visual funeral planning resources. The newly developed resources that were used in the sessions were "Let's talk about funerals" conversation-starter pictures and "My funeral cards" planning cards.

Findings
We identified different ways that support staff asked questions during the funeral planning sessions. Questions included open information-seeking ones that elicited the perspectives of the person with intellectual disabilities when using the visual resources. Another type of question was fishing questions where support staff were searching for a specific answer to their questions from the person with an

intellectual disability. The type of question had an impact on the progressivity of the conversation during the session.

Conclusions
The identified questioning strategies will be used to inform guidance materials on how to support positive communication with people with intellectual disabilities about funerals, death, and dying.

<u>Anna Lindstrom</u>[1] & Rebecca K. Barnes[2]
[1]Uppsala university, [2]University of Oxford

Asking about allergies: Implementing safe prescribing of antibiotics in primary care

Background
Although approximately 10% of patients in Europe and North America report allergy to penicillin, only 2-10% have a true allergy. This is seldom tested, so clinicians rely on parent/caregiver reports. Many patients may be being unnecessarily prescribed second line broad spectrum antibiotics when they could be having first line treatment. This is associated with increased risk of treatment failure, higher costs, and implications for antibiotic resistance.

Methods
The data are drawn from detailed transcripts of video and audio-recorded consultations with adult patients for common respiratory infections in in-hours and out-of-hours primary care settings in Sweden and England. Ethical approval was granted in Sweden and England. We screened (n=67) Swedish and (n=98) British consultations for questions about allergies to antibiotic medicines. We applied conversation analytic (CA) methods making case-by-case observations and built a CA-grounded coding scheme to help search for patterns across the data.

Preliminary observations
Drug allergy questions were asked in 21/67 Swedish and 33/98 British consultations. They were more likely to be asked when the consultation resulted in an antibiotic prescription. Questions could be asked early or late in the visit. Most questions were optimised toward a ‘no problem’ outcome. Most patients reported no allergy, although often expressed uncertainty. Swedish drug allergy questions were more likely to be framed as to whether the patient tolerated antibiotics. In contrast, British clinicians tended to ask patients whether they were allergic to antibiotics.

<u>Anna Sowerbutts</u>
University College London

‘What does obey mean?’: Interactions between a young offender with language disorder and his youth offending team worker

Background. A disproportionately high number of young offenders present with Developmental Language Disorder. Given the myriad and complex communication requirements of the youth justice system, researchers and professionals have long argued that these young offenders will struggle in youth justice encounters, with potentially adverse legal consequences. This hypothesis has been examined through assessment of language skills and through interviews with practitioners and young people, but observational studies of genuine youth justice interactions featuring young offenders with DLD have not yet been published.

Methods. Audio-recordings of three routinely-occurring sessions between a young offender with language disorder and his youth offending team worker were made, totalling 2.5 hours. The data were transcribed and analysed according to the conventions of Conversation Analysis. The young participant was also asked to complete a rating scale to reflect his experience of each interaction.

Results. Two key themes emerged: how the hierarchy of advice-giving was calibrated to maintain engagement from the young person, and how language difficulties manifested and were managed within the interaction. Despite the young person's language difficulties, both parties took an active role in the conversation, communication breakdown was minimal and mostly resolved, and vocabulary difficulties were present but not always predictable.

Conclusions. The impact of the young person's language difficulties was greatly mitigated by careful management of the interaction by both parties, creating an environment where repair could be initiated by either participant and the young person was able to contribute to the agenda and direction of the conversation. Advice and support to youth justice staff from speech and language therapists should incorporate consideration of how to foster collaborative conversation, as a necessary precursor to resolving any communication challenges that arise.

Annesofie Ishøy Nielsen[1] & & Catherine E. Brouwer[2]
[1]Copenhagen University Hospital, [2]University of Southern Denmark

Interaction with Minimally Conscious Patients: Dealing with Lack of Response

In clinical encounters, professionals rely on patients' indications of pain or discomfort. One purpose is to determine whether to continue a specific treatment. A professional can effectively deal with this by posing questions such as 'Does it hurt?'. Patients in the minimally conscious state after Traumatic Brain Injury (TBI), however, are less able to verbalize or in other ways to respond to questions. A lack of response poses a problem since professionals may be uncertain whether they should proceed with the treatment. In this study, we investigate how professionals deal with a lack of response from patients concerning questions about pain and discomfort.

Employing Conversation Analysis, the study is based on 15 hours of videotaped interaction at a TBI unit at a Danish hospital. Most interactions concern the treatment of patients by physiotherapists and occupational therapists. A collection of 264 cases involving polar questions was built. Questions lacking a response were identified (218).

Most of the interactions consist of polar questions. These are central in detecting whether a patient tolerates the treatment. We found in most cases, that when patients do not respond to polar questions, the professionals understand the patient, at least momentarily, to be tolerant of the treatment. If the polar questions are occasioned by unsolicited indications of pain or discomfort (such as sound, sweating, measures of blood pressure) followed by a lack of response, there is a tendency for professionals to change their treatment approach.

Conclusions: When treating minimally conscious patients, professionals closely monitor the level of comfort – this is done partly by posing polar questions directly to the patient. In the (regular) case of a lack of response to such questions, staff employs a principle of (momentarily) proceeding with the treatment, unless other (objective or subjective) indications of pain are present.

Ayeshah Syed
Universiti Malaya

Opening Teleconsultations During Check-up Visits for Patients with Type 2 Diabetes Guided by a Teleconsultation Checklist

To ensure continuity of care for patients with type 2 diabetes (t2d) during the pandemic, teleconsultations were piloted at a Malaysian teaching hospital as a safer alternative to conduct checkup visits. However, in an LMIC context where stable telephone connections and high-speed internet is not accessible to all patients and where health literacy and patient agency is low, there were questions whether the communicative constraints of remote consultations could compromise treatment outcomes for type 2 diabetes. Moreover, the relative novelty of teleconsultations in the study context, security and patient privacy issues were also concerns. Doctors received training and a checklist to guide their communication during the consultations, to support their adaption to the new consultation mode. This study applies Conversation Analysis to a small dataset of teleconsultations for routine type 2 diabetes visits conducted via telephone (n=3) and video consultation (n=5), recorded as part of the CHROSMOS study. This presentation focuses on interaction during the opening sequences, corresponding with the checklist steps titled “Gain trust” and “Verify Identification and Consent”. Analysis showed typical patterns across all seven consultation openings, comprising Greeting-Response, Patient Identification and Doctor Self-identification sequences. Doctors made pre-announcements before initiating Security Question sequences. Expectedly, the openings were doctor-led, mostly via polar question-yes/no responses adjacency pairs. However, there were differences in whether patient consent to proceed was explicitly achieved and the sequential position of explicit consent taking. Moreover, not all doctors established the clarity of the connection, despite it being listed in the first checklist step. One feature of the video consultations was the identification of co-present family members, who stayed of frame until addressed by the doctor. Although based on a small pilot dataset, the findings provide interactional data showing how teleconsultation checklists are implemented in real-life consultations, which cannot be completely standardized.

B B. Stinesen[1], Petra WJ Sneijder[2], Irene Kelder[2], Herman van Dijk[1], RJEM Smeets[1] & AJA Köke[1]
[1]Maastricht University, [2]HU University of Applied Sciences Utrecht

Analysing and Evaluating Patient–Practitioner Interaction about Chronic Pain: A Workshop for Pain Rehabilitation Practitioners

Problem statement: Constructive communication that includes both the patient’s and the pain rehabilitation practitioner’s perspective is essential to adequately assess and treat chronic pain1. However, a previous discursive psychology2 study of interactions between patients and practitioners shows that their conversations about the psychosocial factors involved in the patient’s pain problem can be challenging. To improve their communication practices, practitioners may benefit from insight into patterns in their interactions with patients.

Methods: Based on findings of our previous study, we developed a Discursive Action Method3 workshop to (1) raise practitioners’ awareness of both their own and their patients’ interactional concerns and the interactional effects of their discursive strategies and (2) stimulate them to reflect on their communication practices. To explore if the workshop allows for these objectives to be met, two workshops were video-recorded. Participants’ discussions during the workshop were transcribed and qualitatively analysed.

Findings: In our presentation, we will share the theoretical foundations and the practicalities of the workshops’ design. Also, we will present the results of our analysis of participants’ discussions. The study shows that the workshop helps participants to identify both patients’ and practitioners’ interactional concerns and to recognize discursive strategies for managing those concerns. In addition, the workshop stimulates practitioners to evaluate their talk with patients and to reconsider their communication practices.

Conclusion and Discussion: The study shows that the workshop supports practitioners in developing ideas on how they can shape their future communication practices. Further research should address to what extent practitioners’ increased awareness of important mechanisms in their interactions with patients makes them more attentive and adaptive to these mechanisms while interacting with patients.

Blair Ying Jin
Hong Kong Polytechnic University

‘I am here again’: Display of patient loyalty in routine chronic visits

In an intense competition in healthcare, one great pressure is to retain patients, an issue that has attracted abundant work exploring factors that influence patient loyalty. At the risk of oversimplification, patient loyalty can be described as “a deeply held commitment to revisit or re-patronize in using services in the future despite having better options and, hospitals have functional, reliable, and tangible aspects of services that have potential to cause switching behaviour” (Ravichandran, 2015, p. 213). Existing research, however, has focused almost exclusively on determinants of patient loyalty, drawing primarily on interviews and survey data. While this scholarship provides immense insights into the association between patient loyalty, relationship-building, and communication, how loyalty is performed in real-life interactions cannot be fully expounded without describing the actual language use in situ. This study reports research on the display of patient loyalty in two sequential environments: the opening and closing phases of face-to-face medical consultations. Thirty-nine chronic routine visits between gastroenterologists and older adults were collected in a large state-owned hospital in Mainland China. Using conversation analysis (Sacks et al., 1974), it analyses data extracts in order to show 1) the design features of patient loyalty, 2) how it relates to participants’ understandings of the incumbency in their relationship category (Pomerantz & Mandelbaum, 2005), and 3) how it contributes to what the patient is doing in the sequential context.

References
Pomerantz, A. & Mandelbaum, J. (2005). Conversation analytic approaches to the relevance and uses of relationship categories in interaction. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of language and social interaction* (pp. 149-171). Mahwah: Psychology Press.

Ravichandran, N. (2015). Dimensions of patient loyalty and switching intention: Relational outcomes for benchmarking approach. *International Journal of Healthcare Management*, 8(4), 209-216. https://doi.org/10.1179/2047971915Y.0000000012

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn taking for conversation. *Language*, 50(4), 696-735. https://doi.org/10.2307/412243

Anikó de Geest, Kees van der Veek & Bogdana Humă
Vrije Universiteit Amsterdam

Respecifying “vaccine hesitancy” as an interactional accomplishment

Vaccine hesitancy (VH), broadly understood as the “delay in acceptance or refusal of vaccination despite availability of vaccination services” (Turner et al., 2021, p. 3568), is listed by the World Health Organisation (2019) as one of the ten threats to global health. While this concept has been quickly adopted by scholars, practitioners, and policy-makers world-wide, it has also been criticised for its lack of clarity, leading Peretti-Watel et al. (2015) to the question its theoretical grounding. More recently, a systematic review conducted on over 400 studies concluded that VH has been defined and used inconsistently (Bussink- Voorend et al., 2022). Thus, a growing body of work is debating the conceptualisation of VH, which can have direct implications for public health policies and vaccination-related interventions.

This body of work relies almost exclusively on hypthetico-deductive studies, which are entrenched in existing theoretical frameworks. With their bottom-up approach to studying health-related conduct, ethnomethodology (EM) and conversation analysis (CA) can provide a fresh perspective by respecifying vaccine hesitancy (Button, 1991; Garfinkel, 1988); that is, focusing on how it is locally and interactionally accomplished in naturally occurring conversations about child vaccination.

Using EM and CA, we examined a corpus of 179 calls between Dutch health professionals and parents whose children missed one or more vaccinations. These calls provide an ideal environment for examining VH in action. We found that VH was constructed by participants as rationally accountable individual conduct with the decision to (not) vaccinate being jointly placed solely in the parents' deontic domain.

While EM and CA are often described as theoretically agnostic, our study demonstrates how these approaches can contribute with valuable empirical insights to theoretical discussions in interdisciplinary fields such as child vaccination

Bogdana Humă, Robert Prettner & Hedwig te Molder
Vrije Universiteit Amsterdam

Formulating "doubt" about child vaccination

Parents who refuse to vaccinate their children often account for it by claiming to have doubts about vaccines. Existing research links doubt to vaccine hesitant behaviour (inter alia Dubé et al., 2016; Gust et al., 2008; Peretti-Watel et al., 2019) but, to date, no studies have investigated how doubt is spontaneously invoked in vaccine conversations between parents and health professionals. Existing discursive psychological research has shown that formulations of psychological constructs, such as thoughts (Barnes & Moss, 2007), emotions (Edwards, 1999), and attitudes (Potter et al., 2020), are deployed to manage situated interactional matters. Moreover, a close inspection of these formulations revealed that selecting between alternative lexical (Sikveland & Stokoe, 2016; 2020; Huma et al., 2021) and format options (Edwards & Potter, 2017) can engender different interactional trajectories. Therefore, examining how doubt is spontaneously invoked can shed light into its link to situated vaccine hesitant conduct.

In this study, we used conversation analysis and discursive psychology to examine two corpora of naturally occurring data: 62 face-to-face consultations and 179 telephone calls about child vaccination between Dutch health professionals and parents. Our analysis, based on a collection of 29 cases of "doubt" formulations, revealed that both parents and health professionals can construct "doubt" as either a lived experience (verb) "doubting" or as a psychological state (noun) "having doubts". We found that "having doubts" and "doubting" produce different versions of the psychological construct "doubt" with distinct implications for its accountability and topicalisation. "Having doubts" as a psychological state implies having misgivings about vaccination and is used to account for vaccine refusal and to discourage its topicalisation. By contrast, "doubting" as a lived experience indexes and accounts for indecision in relation to vaccination and facilitates its topicalisation.

Bregje de Kok[1], Stephen Adjei Baffour[2], Lucy Yevoo[3] & Adwoa Kpikpitse[3]

[1]University of Amsterdam, [2]Akenten Appiah-Menka University of Skills Training and Entrepreneurial Development, [3]University of Ghana

Persuasion and shared decision-making in antenatal care in Ghana.

Hypertensive disorder of pregnancy (HDP) is a serious disease that may threaten the life of both women and their babies. Ultimately, the only cure is termination of pregnancy in order to save the life of the woman, but this may put her baby's life at risk, especially if this happens at a relatively early stage of the pregnancy. In Ghana, when women are diagnosed with HDP at the ANC clinic, the usual course of action is hospital admission, alongside provision of medication to lower blood pressure. In this paper, we present analysis of audio-recordings of antenatal care encounters between health care workers and women with HDP in referral facilities in Ghana. We discuss first, the different strategies that practitioners use to persuade women with HDP to accept the proposed course of action (usually hospital admission). Second, we analyze how women respond to, and sometimes subtly resist, proposed courses of treatment. We discuss the implications of our findings for current thinking on shared-decision making and patient-centredness in health care. Furthermore, we reflect on methodological aspects related to doing Conversation Analytic (CA) research in the Global South, and argue for the relevance of context and culture in CA, and the need to acknowledge and decolonize the predominantly Euro-American focus of CA in the extant literature.

Caroline Tietbohl[1]**, Clara Bergen**[2] **& Anne Elizabeth Clark White**[3]
[1]University of Colorado Anschutz Medical Campus, [2]Didi Hirsch Mental Health Services, [3]University of California, San Diego

Physician self-disclosures in the context of discussions about diagnosis and treatment

Physician self-disclosures have been a long-debated practice. As Sacks discussed in his second stories lecture, psychotherapists must be able to listen and manage being reminded of their own experiences. However, recent work on enhancing clinical empathy shows that physicians consider sharing their own personal experiences as an effective way to express empathy, but also warns that physicians should share them judiciously. Our study examines how physicians incorporate their own personal experiences into discussions about diagnosis and treatment and how patients respond. We draw on four datasets of video-recorded medical encounters in the United States: internal medicine and family medicine (n=180), geriatric medicine (n=52), and general surgery (n=175). We use Conversation Analysis to build and analyze a collection of physician self-disclosures that are related to patients' medical concerns. Our findings show that physicians' self-disclosures yield polarizing responses from patients. We highlight key features of the position and design of physician self-disclosures that contribute to variations in patient responses, including 1) whether the physician self-disclosure was solicited by a patient or initiated by the physician, and 2) the social action the physician is performing when sharing their personal experience (e.g., reassurance, encouragement). While physician disclosures are often viewed as "second stories", our evidence suggests that self-disclosures can also initiate new topics. Furthermore, we illuminate potential challenges associated with physicians stepping into a 'peer role' and deviating from their traditional 'professional role.' Our study contributes valuable insights about the evolving nature of doctor-patient interactions and the intricate balance between professional authority and personal engagement.

Caroline Tietbohl
University of Colorado Anschutz Medical Campus

Gender differences in empathic validation provided during geriatric medicine consultations

Previous Conversation Analytic work has identified the practice of empathic validation in clinical encounters as a strategy that can normalize health outcomes, acknowledge health changes, and recognize the patient's choices (Tietbohl, 2022). In this study, I build on this work to address the question of who receives empathic validation. I focus on the differences between empathic validations provided to men and women with respect to frequency, types of validations, and patients' responses to those validations. Conversation Analysis was used to analyze a dataset of 52 video recordings of geriatric medicine consultations, resulting in a collection of 129 cases of empathic validation. In this collection, I find that women receive empathic validation less frequently than men (relative frequency of 2.0 versus 3.5 validations per visit). For both men and women, having a companion present in the visit (who were predominantly women, either the patient's wife or daughter) was associated with less frequent empathic validation - the lowest levels of validation occurring for women attending with female companions (relative frequency of 1.5 validations per visit). I also find that men more often received empathic validations focusing on internal factors (e.g. the patient's choices or changes in health), whereas women more often received validations focused on the external challenges affecting patients' health (e.g. validating the difficulty of events that have happened to them). While men and women overwhelmingly responded positively to empathic validations, women responded negatively more often than did men. This study contributes to our understanding of gendered communication patterns in clinician-patient interaction and to the ongoing discourse around the intricacies of empathic communication in healthcare settings.

Catherine J. Woods
University of Oxford

Remote discussion of emotional concerns in telephone versus face-to-face primary care consultations (REMOTION): A pilot study

Brief statement of the problem: The COVID-19 pandemic had a major impact on mental health and disrupted clinical routines for both patients and clinicians due to the rapid shift to an increased use of remote telephone consultations. While the move to more remote consultations offers several benefits to primary care, there are also several risks associated with this modality, such as missing cues associated with various medical issues, including cues to emotional symptoms/concerns related to possible mental health problems. The REMOTION Study aims to explore how patients volunteer emotional concerns and compare whether and how they are discussed and managed by clinicians (both General Practitioners and Advanced Nurse Practitioners), in telephone compared to face-to-face primary care consultations.

Methods: Semi-structured telephone interviews were first conducted with 20 clinicians (10 GPs and 10 ANPs) across the South of England between January to October 2022, to explore clinician experiences of adapting to the routine use of telephone consultations and their views on any perceived communication barriers between the modalities. 41 audio and video recordings of telephone (n=21) and face-to-face (n=20) consultations were also collected and analysed using the principles of Conversation Analysis (CA).

Preliminary observations: Within the dataset, 4/41 consultations involved the discussion of existing mental health problems (all by telephone) and 13/41 consultations involved the presentation of new emotional concerns, 11 in face-to face consultations and 2 by telephone. New concerns often arose incidentally, after the presentation and/or discussion of physical symptoms. Clinicians usually acknowledged the new concern and/or unpacked it with a short question series, but ultimate treatment recommendations often related to the physical symptoms-only rather than information or advice about mental health.

Bethan Benwell[1] **& Catrin S. Rhys**[2]
[1]University of Stirling, [2]Ulster University

Comprehending Complainability: Achieving empathy while maintaining professional neutrality in healthcare complaints communication

There is a tension in healthcare complaints communication between the institutional requirement to gather accurate information and the interpersonal significance of the emotive experience at the heart of the complaint. One interactional challenge emphasised by complaints handlers during training co-design workshops is the need to respond to complaints empathically while maintaining professional neutrality.

The ‘Real Complaints’ project combined conversation analysis of complaints encounters with complainant appraisals of those encounters through diarising and interviews. We examined calls that were rated by complainants as highly empathic in order to understand the complaint handler practices that lead to this sense of having been treated empathically. Strikingly, the complaint handlers in our corpus are often perceived as highly empathic despite never using overtly empathic expressions.

Careful analysis of calls that were rated by the caller as highly empathic pointed to affiliative practices that can be categorised as displaying comprehension turn-by-turn of the complainability of the details of the caller’s complaint narrative. These practices involve offering candidate understandings of the caller’s perspective, or making explicit stances that were merely implied in the complainant’s narrative. In this way, these practices achieve empathy by negotiating a shared understanding of the complainant's perspective on their complaint story. In contrast to overt empathy, which was 1) infrequent, 2) deployed in specific sequential contexts and 3) oriented to institutional progressivity, comprehending complainability as a set of practices was evident across our entire corpus, with noticeably empathic calls being differentiated by a high frequency of this type of affiliation creating a cumulative empathic impact.

Our presentation will show how these practices for displayed understanding of the caller's perspective have been incorporated into Real Complaints Training as an evidence-based approach to meeting the requirements for empathic active listening to ensure that complainants feel heard.

Chase Wesley Raymond, Caroline Tietbohl & Lauren Tolle
University of Colorado

Conversations about cost in primary care: notes on 'opportunity spaces'

Conversations about cost are ever more a topic of interest in healthcare communication (see, e.g., recent "Cost-of-Care Conversations" supplement in the Annals of Internal Medicine, 2019). And yet, conversation-analytic (CA) approaches have thus far been surprisingly absent from the majority of the discussion, where interview- and survey-based methods predominate. These studies leave open the question as to how the topic of cost actually emerges within the temporal unfolding of clinical consultations, which is the gap that this study hopes to begin to address.

Some patients may be agentive in topicalizing issues they have had or are having with cost, taking it upon themselves to bring up cost-related talk – be it as a first-positioned action, or as a response to some non-cost-specific action by the doctor:

(1) [UCHMG_22-11-10]
01 DOC: Good. (.) Okay.
02 DOC: -> What questions do you have for me?
03 PAT: => Um, so I have used the Rally system on there for my rewards,
04 DOC: Okay,
05 PAT: => Um, um, so because I'm getting rewards on, uh, for my, um,
06 => health care on, uh, UHC.
07 DOC: Uh-huh,
08 PAT: => So I'm wondering if I can get a physical because I get a hundred
09 => dollars on there for an annual physical...

While such open-ended questions from clinicians do provide an opportunity for patients to bring up cost-related concerns, they nonetheless place the burden on the patient to do so.

Contrast this with the how the doctor brings up cost in (2). Here, toward the end of a visit, the doctor creates a specifically-designed opportunity space for cost-related talk to occur (line 3) – 'Good-Rx' being a coupon program that renders medication less expensive.

(2) [PV1_03-08-22]
01 DOC: ...so I'll order that, perfect. And it's still Walgreens?
02 PAT: King Soopers.
03 DOC: -> Okay. And you still have the Good-Rx?
04 PAT: => Yes.
05 DOC: Okay, perfect. And then for the food, just trying to think...

As the doctor is reviewing medications and ordering refills, she checks to verify that the patient's pharmacy is still the same as before (called "Walgreens", line 1). When the patient corrects this information in line 2 – i.e., that she'd like the prescription filled at "King Soopers" instead – the doctor solicits confirmation that the patient still has the coupon information she will need for this different pharmacy.

This study aims offer insights into both the sequential emergence of cost-based talk in primary care consultations, as well as the turn-design features used to constitute it.

Data are video-recordings from an ongoing multi-site randomized clinical trial called PATHWEIGH, focused on weight management in primary care, supplemented with data from interviews with clinicians and staff at participating clinics.

Chloe Shaw[1], Ryann Sowden[1], Fliss Murtagh[2], James Tulsky[3], Fergus Caskey[1], Ruth Parry[4], Rebecca K. Barnes[5], Lucy Selman[1]

[1]University of Bristol, [2]Hull Medical School, [3]Harvard University, [4]Loughborough University, [5]University of Oxford

When 'option-listing' provides patients with the interactional opportunity to positively engage with a conservative treatment option

Choosing between Dialysis or Conservative Kidney Management (CKM) is challenging for older people with advanced kidney disease. How this choice is communicated by professionals majorly impacts patients and the choices they make. The OSCAR study (Optimising Staff-Patient Communication in Advanced Renal disease) aimed to identify how these treatment options are presented in consultations. In total 110 outpatient consultations were recorded (104 audiovisual, 6 audio) across four UK renal units. Sequences where doctors and nurses presented both Dialysis and CKM were transcribed and analysed using Conversation Analysis (n=21). Two approaches to presenting CKM were identified: 1) CKM as a main option (n=6), and 2) CKM as a subordinate option (n=15). Features of the former included: framing CKM as having potential personal benefits to the patient; explicitly labelling it as a treatment option; not framing it as only relevant or preferable to a minority of patients. In contrast, when CKM was presented as a subordinate option, features included: framing CKM as not of benefit to the patient; not explicitly labelling CKM as a treatment option; appending CKM to the main decision-making sequence; framing CKM as only relevant or preferable to a minority of patients. CKM as a main option was the less common approach, but associated with more interactional opportunities for patients to: ask questions about CKM, assert their perspective, and refer to CKM as a relevant option; and also with significantly higher post-consultation scores of shared decision-making on the SDM-Q-9. The analysis sheds light on a way to facilitate active patient engagement with treatment options.

Christopher J. Koenig
San Francisco State University

How can treatment recommendation formulations help patients feel included in primary care encounters?

Problems. Inclusivity in medical encounters is important to ensure procedural transparency, to address and (ideally) reduce health disparities, and to promote health equity across populations. Clinicians spend years learning to master technical, medical terminology that includes anatomy, diagnosis, treatment, and even administrative and organizational routines. However, few patients master the medical lexicon, which can exclude their participation in primary care encounters. This presentation examines how physicians' interactional practices in selecting lexical terms during recommending treatment contributes to interactional inclusion and, ultimately, health equity.

Methods. Data are 100 video recorded interactions of primary care encounters in California. Institutional ethical approval was obtained, and all participants gave informed consent. Excerpts were transcribed using Gail Jefferson's (2004) conventions and analyzed using Conversation Analysis (CA).

Findings. Following Sacks & Schegloff (1979) and Schegloff's (1972, 2006) characterization of formulation as an issue of meaningful word selection, this presentation begins with the observation that when recommending treatment physicians select from a continuum of terms that range from generic to technical. Second, physicians often use multiple terms when referring to a newly prescribed treatment. When a physician refers to the same treatment in a single visit using different lexical choices, both terms may become more recognizable, potentially scaffolding patient knowledge about the newly recommended medication.

Conclusions. When using multiple formulations for a medication, physicians construct a local context trajectory supplying patients with incremental knowledge about different facets of the recommended treatment. Using multiple formulations creates the potential for patients to better understand how the range of different terms for the same medication relate to one another incrementally. As some formulations are more and less understandable to patients, I argue using multiple formulations may help interactional include through enhanced patient understanding of a new treatment.

Clara Iversen[1], Marie Flinkfeldt[1] & Sarah Hamed[2]
[1]Uppsala university, [2]Stockholm University

Accomplishing (anti)racism in the context of unconditional support: Examining responses to callers' racialised talk in suicide preventive helplines

Problem: This paper investigates how mental health counsellors on helplines in Sweden deal with racism from callers. Previous research has identified racism as a problem in healthcare interactions, but there is little knowledge about the features of racialised talk and how staff respond.

Method: In this study, we use conversation analysis and membership categorisation analysis to examine racialised talk in 17 audio-recorded calls, a subset of 458 calls to suicide preventive helplines.

Findings: The analysis shows that racialisation functions as a resource for callers to make sense of their mental health difficulties. Call-takers manage this problem in three ways: 1) questioning racialised talk, 2) giving obfuscated support while ignoring racism, and 3) supporting callers' problems as mental health issues while resisting a potentially racist trajectory.

Conclusions: The findings speak to the complexity of responding to racism in a mental health setting, as counsellors must see to callers' needs and calling out racialised talk may alienate callers. The study offers direct insight into the workings of racism in healthcare and how practitioners can balance needs for support with an antiracist position.

Clare Jackson
University of York

Doing risk surveillance and management during labour

In the UK, midwife-led care is available for low-risk pregnant individuals expected to have a 'normal' delivery at full term. Despite midwives' emphasis on the physiological normality of labour, national guidelines mandate continuous risk surveillance throughout the intrapartum period. NICE Guidelines, for example, require frequent monitoring of fetal heart rate, maternal pulse, blood pressure, and temperature. Despite the low-risk context, this paper explores the situated accomplishment of risk surveillance in interactions between labouring women and midwives using conversation analysis.

The study, based on 37 recorded interactions in two UK midwife-led care units from 2018 to 2019, reveals two ways in which risk surveillance is interactionally routinised. Firstly, midwives implicitly refer to NICE guidelines, incorporating them into routine care. For instance, a midwife might say, "*I've got to be listening to the baby about every 15 minutes*." Secondly, midwives frequently use presumptive formats to initiate surveillance activities, such as stating, "*I need to do your pulse*."

These activities are presented as taken-for-granted, and as not requiring explicit verbal agreement, although this is commonly forthcoming. Positive assessments may be used to indicate no risk has been detected. However, when risk is detected, it is not generally immediately disclosed and may first lead to rechecking (e.g., following a monitoring, a second midwife says *'((Midwife's)) just asked me to count these heart beats…'*). The disclosure of risk detection is handled delicately (e.g., *Baby's heartrate's a little lower than: when you came in…').* This information prompts risk management planning, involving increased observation frequency or changes in assessment methods. In some cases, transfer to obstetric-led care may be recommended.

The study concludes that the seemingly low-risk nature of midwife-led care is contingent on ongoing risk surveillance. Risk surveillance is interactionally produced as both required and routine. Risk detection implicates increased surveillance and/or transfer to obstetric care.

Daniele Urlotti
University of Modena and Reggio Emilia

The epistemic upgrading of questions as a confirmation seeking device in mediator interpreted clinical encounters with migrants.

Interactional success during clinical encounters involving people with a migration background can be often hindered by the fact that service users and providers may not or may only partly speak a common language, a situation often requiring the intervention of linguistic mediators (Pöchhacker, 2008). Besides, when English as a lingua franca (ELF) is used as the language of mediation, discrepant levels of language proficiency between mediators and service users may add extra threats to the positive outcome of the clinical encounter, a problem which linguistic mediators may tackle by adopting specific communicative strategies (Urlotti, 2023).

By applying a conversation analytical methodology to the analysis of a corpus comprising around 300 audio-recordings of mediator-interpreted clinical encounters in ELF, between Italian service providers and migrant service users from Nigeria or Ghana, this paper aims to present a recurrent practice which is implemented when the migrant patients' proper understanding of the English language may look uncertain. More specifically the presented pattern is that, when migrant patients display an orientation to answering an information-seeking question only by providing minimal feedback, mediators may orient to deploying a follow-up declarative question (CouperKhulen & Selting, 2018), designed from an epistemically upgraded stance (Heritage, 2013), which is often interpreted by the interlocutor as a confirmation seeking device. Such questions are also often designed by recycling material from the previous information-seeking question.

The purpose of this paper is, therefore, to show that, by assuming an upgraded epistemic stance and avoiding introducing new linguistic material which their interlocutor may not be familiar with, linguistic mediators are capable of designing confirmation-eliciting questions which minimize the potential for misunderstanding and allow them to correctly gather the information required by the service providers, therefore contributing to the successful outcome of the clinical encounter.

References

Couper-Khulen, E. & Seltig, M. (2018). Interactional Linguistics. Cambridge University Press.

Heritage, J. (2013). Action formation and its epistemic (and other) backgrounds. *Discourse Studies*, 15(5), 551–578.

Danielle Jones[1], Karen Windle[1], Andreia Fonseca de Paiva[1], Felicity Slocombe[2], Jemima Dooley[3], Rachael Drewery[4] & Rose McCabe[5]
[1]University of Bradford, [2]Loughborough University, [3]University of Bristol, [4]University of Oxford, [5]City, University of London

Negotiating risk in memory clinic interactions: risk identification and the role of third-party involvement

Dementia is a leading cause of death and disability worldwide. Approximately 20% of the UK population aged ≥ 65 have Mild Cognitive Impairment (MCI), with 1 in 7 progressing to dementia. Twelve modifiable risk factors, (e.g., hypertension, excessive alcohol consumption, obesity, smoking) account for around 40% of worldwide dementias. Targeted interventions to reduce risks may prevent or delay dementia, mitigating further dementia diagnoses for those with MCI. Healthcare professionals, especially in memory assessment services, play a crucial role in communicating dementia risk, yet there is a lack of evidence on effective communication strategies to manage the uncertainty inherent in conveying dementia risk in clinical practice.

This study, utilising conversation analysis, investigates dementia risk communication in 43 MCI diagnostic feedback consultations, recorded in nine UK-based psychiatry-led memory assessment services from 2014 to 2015. Three recurring types of clinical risk communication were identified: 1) risk identification; 2) risk characterisation; and 3) risk management. This paper focuses on risk identification.

Clinicians strategically identify risky behaviour early in the consultation, often by eliciting the patient's perspective to achieve a shared understanding of risk and its potential consequence for future adverse health outcomes. However, patients commonly resist or playdown the severity of their risk behaviours (e.g., by underestimating alcohol intake), necessitating negotiation. Clinicians attend to discrepant information (e.g., "It's often the case that one who drinks underestimates it") often pursuing 'accuracy'. Third parties work to jointly achieve a consensus on risk severity.

This study emphasises the interactional challenges of achieving intersubjective agreement regarding risk levels, a process characterised by patient resistance and underestimation. Involvement of companions adds a layer of complexity to the negotiation of shared understanding regarding risk. As preventive efforts gain momentum, addressing these challenges becomes imperative, highlighting the need for tailored strategies and support for healthcare professionals in memory assessment services.

Eniola Boluwaduro
Radboud Universiteit

'What you'll help me do is *x*': Securing Patients' Adherence in Nigerian HIV Consultations

In treatment for HIV-positive patients in Nigerian out-patient specialist care setting, the consultation's aim is to minimize patients' undesired health outcomes and improve patients' quality of life. Previous research on the Nigerian HIV hospital setting focused on prevalent directive formats of treatment recommendations which foreground the physician's deontic authority (Boluwaduro, 2021). However, it was also found that physicians use other collaborative practices of recommending treatment, in which they present themselves or a collective "we" as beneficiaries of treatment. Although rarely used, compared to relatively more authoritative and direct recommendation formats, these collaborative practices are employed to secure patients' adherence to the treatment plan. In this article, we use conversation analysis to specifically examine these practices. The data, consisting of audio recordings of routine clinical consultations between 20 general practitioners and 70 patients, were gathered from visits to four outpatient clinics in Southwestern Nigeria.

The results show that physicians first establish a medically-verifiable problem before they recommend how patients' treatment should proceed. Collaborative practices include the use of beneficiary-prefaced directives (*'what you'll help me do is x'*) which serve to reverse the benefactor/beneficiary division of roles. Further, physicians orient to the shared benefit of patients' commitment to treatment by setting up instructed actions as a joint plan (*'so what we do is x')*. And by initiating first assessments (*'I'm not too happy with it'*), physicians appeal to their own emotions. They equally reserve the rights to evaluate treatment outcomes by deploying emotionally enacted positive or negative evaluations (e.g., *'you're not helping us, you're not helping yourself'*). Through these features treatment recommendations are treated as a collaborative project. We discuss the implications of these practices for healthcare delivery in the Nigerian clinical setting.

Evi Dalmaijer, Wyke Stommel, Wilbert Spooren & Berber Pas
Radboud Universiteit

Advice-giving and authority in a digital pediatric rehabilitation treatment

In recent publications, the Dutch Ministry of Health, Welfare and Sport, together with several other key health organizations in the Netherlands, emphasize *suitable* care and support. Suitability refers to collaboration with the patient, to a suitable place/location and moreover to the use of remote care when possible – on site only when necessary (Integraal Zorgakkoord, 2022). The increasing use of digital technologies in health care means that professional and care recipient are more and more often not in the same physical location during treatment. As a result, care, including advice-giving, increasingly takes place through technological means such as email, chat, video calling or instant messaging. This presentation aims to provide insights into how remoteness and technology impact advice-giving. We focus specifically on the role of authority in advice-giving (cf. Boyd, 1998; Heritage, 2005; Heritage & Sefi, 1992; Peräkylä, 1998, 2002). The data come from a digital treatment for young children with motor disabilities. The treatment mainly consists of parents performing and videotaping exercises with their child at home. They upload these videos to a digital environment where occupational therapists respond to videos in text messages, i.e., they provide feedback on the videos and formulate advice for the parents (see also Verhaegh et al., 2022). We apply conversation analysis to study the relation between text messages with advice and the videos displaying the implementation of advice. We found three different patterns of how advice unfolds: (1) advice > compliance > follow-up advice, (2) advice > no compliance > re-issuing advice, and (3) advice > account for no compliance > modified advice. Overall, professionals downplay their authority in the advice messages, orienting to advice as an imposition on parents, and displaying sensitivity to the parents' authority regarding their knowledge of, and relationship with the child. This implies that professionals work to establish and shape collaboration with parents.

References

Boyd, E. (1998). Bureaucratic authority in the "company of equals": The interactional management of medical peer review. *American Sociological Review, 63*, 200–224.
Heritage, J. (2005). Revisiting authority in physician-patient interaction. *Language Power and Social Process, 16*, 83.
Heritage, J., & Sefi, S. (1992). Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between Health Visitors and first-time mothers, In P. Drew & J. Heritage (Eds.), *Talk at Work: Interaction in Institutional Setting*s (pp. 359–417), Cambridge University Press.
Integraal Zorgakkoord. (2022). *Samen werken aan gezonde zorg.* Geraadpleegd op 20 juni 2023, van https://www.rijksoverheid.nl/documenten/rapporten/2022/09/16/integraal-zorgakkoord-samen-werken-aan-gezonde-zorg
Perakyla, A. (1998). Authority and accountability: The delivery of diagnosis in primary health care. *Social Psychology Quarterly,* 301-320.
Peräkylä, A. (2002). Agency and authority: Extended responses to diagnostic statements in primary care encounters. *Research on Language and Social Interaction, 35*(2), 219-247.

Verhaegh, A., Nuijen, N., Aarts, P., Nijhuis-van der Sanden, M., Willemsen, M., Groen, B., & Vriezekolk, J. (2022). Parents' experiences with a home-based upper limb training program using a video coaching approach for infants and toddlers with unilateral cerebral palsy: A qualitative interview study. *BMC Pediatrics, 22*: 380. http://doi.org/10.1186/s12887-002-03432-w.

Felicity Slocombe[1], Elizabeth Peel[1], Alison Pilnick[2] & Saul Albert[1]
[1]Loughborough University, [2]Manchester Metropolitan University

Reminiscence respecified: A conversation analytic examination of practice in a specialist dementia care home

Problem/Issue: The prevalent discourse on reminiscence in dementia care research lacks comprehensive insights into the structure of actual interactions. Few studies have addressed this gap by examining the structuring and negotiation of reminiscence activities in care home environments.

Methods: To address this, our study focused on transcribing informal one-to-one reminiscence interactions between individuals with dementia and professional caregivers from a larger video dataset. We employed conversation analysis using a novel relational approach to explore the interactional practices utilised by both carers and people living with dementia.

Major Findings: Our analysis revealed significant divergences between recommended manualised practices and observed interactional practices. Notable examples include the infrequency of open questions and the prevalent use of closed questions, contrary to current practice recommendations. These disparities underscore the importance of interactional research in informing reminiscing practice and training manuals.

Conclusions: Examining how reminiscence operates in practical settings allows for more informed approaches to conducting such activities. Our findings offer guidance for those involved in reminiscence work in care home settings and contribute novel insights to lay the groundwork for an empirical base in enhancing reminiscing training manuals.

Fiona Stevenson
University College London

Negotiations around the implementation of a digital health intervention (DHI) for management of long covid into secondary and community care

Background
From 2020 large numbers of people experienced ongoing symptoms following covid infection. This led to concern established National Health Service (NHS) models of rehabilitation service delivery would struggle to meet demand. In response a digitally delivered, remotely supported rehabilitation intervention (DHI) was developed. This paper considers the work of a multi-disciplinary team (academics, clinical specialists, industry partners) to move the product into clinical practice to address a real time medical problem (long covid) about which awareness and the associated knowledge base was continuously evolving.

Methods
Data comprise 44 hours of online meetings between the DHI team and clinicians, clinical commissioners and experts in governance and information technology video-recorded between April 2020 and May 2021. Clinicians tasked with implementation included physiotherapists, occupational therapists, speech and language therapists, and psychologists. Conversation analysis is used to examine the introduction of the idea of the DHI through to initial implementation in one NHS Trust

Findings

Participants who actively promoted the DHI foregrounded their clinical credentials, and this worked to add legitimacy to the product being offered. Opportunities for participants to shape and customise the DHI was presented as a key selling point. This enabled health professionals to demonstrate their expertise and networks in terms of local service needs and thoughts about the structure of the delivery of medical services more generally.

Conclusions
Empirical examination of how a DHI is negotiated into practice provides insights into the dynamic application of different types of professional knowledge to support implementation, such as invoking clinical credentials to provide legitimacy and foregrounding opportunities to tailor interventions to take account of the priorities of different specialities.

<u>Geraldine M. Leydon</u> on behalf of the REDUCE team
University of Southampton

‘God you’re going to have to remind me of the scoring options as we go along’: the telephone administration of the PHQ9 depression questionnaire in the REDUCE Trial.

Background: The PHQ9 questionnaire is widely used in the UK. It has been validated for diagnosing and measuring the severity of depression in face-to-face encounters. Pinto-Meza et al reported it could be used over the telephone, and the scores had strong concordance with those completed in person. There is, however, a dearth of evidence of how the PHQ9 is interactionally managed.

Data: The REDUCE feasibility trial sought to support eligible patient participants with a diagnosis of depression to taper and cease their antidepressant medication. As well as a supportive website, three support calls with Psychological Wellbeing Practitioners (PWPs) were offered. Within the calls PWPs used the PHQ9 to monitor participants’ mood. In this paper we examine how PWPs and patients accomplished PHQ9 completion.

Methods: Calls were transcribed verbatim in readiness for analysis. Following repeated reading and listening the PHQ9 sections of a sample of first calls were overlaid with Jeffersonian transcription conventions for a more detailed analysis.

Findings: 49 recorded calls were available and the first 20 were analysed. Progression through the PHQ-9 was disrupted in two key ways. PWPs’ construal of the response categories and corresponding scoring system was interactionally turbulent with PWPs required to repair definitions of the response types available. Patients sometimes struggled to recall response types and the process of selecting the best one to optimally convey their individual mood state sometimes required additional interpretive work.

Conclusions: Participants skilfully translated the structured measure of the PHQ9 into workable questions and responses. Further analysis should identify whether key findings pertaining to the turbulence of PHQ9 completion are supported in a larger dataset of both telephone and face to face encounters. Further analysis could also explore how practitioner and patient endeavours to measure experiences using the PHQ9 can be supported.

<u>Irene Kelder</u>
HU University of Applied Sciences Utrecht / Amsterdam University Medical Centres

“Normally I always ask briefly…”: How patients and healthcare professionals in oncology construct sexuality as a delicate topic

Background
Cancer and its treatments can cause significant changes in intimacy and sexuality that affect quality of life

of patients and their partners[1]. It is important that healthcare providers (HCPs) discuss this topic with their patients, for instance, because this may help to normalize the issues patients encounter[2]. Given the limited understanding of how intimacy and sexuality is discussed during the disease trajectory, our aim is to gain insight into how these topics are addressed and managed in consultations between cancer patients and HCPs.

Method
We studied 28 consultations between cancer patients and HCPs in the Netherlands, covering various treatment stages. Six HCPs and 28 patients (19 women, 9 men) with a form of gynaecological cancer or rectal cancer were included. Audio recordings were transcribed and analysed using the analytic principles of Discursive Psychology[3].

Major findings
Our analysis demonstrates that both patients and HCPs keep the topic of sexuality at a certain distance and hence construct the topic as delicate. This is manifested in employing unspecific constructions (patients), using active voicing, generalisations and epistemic hedging to keep distance (HCPs), and constructing sexuality and related problems as a non-issue (patients).

Furthermore, the analysis showed that both patients and HCPs orient to norms surrounding sexuality. However, when HCPs orient to matters as norm-breaching, it may discourage patients from discussing sexual problems. Thus, by generalising and normalising patients' experiences, HCPs invite talk about these experiences. Finally, by marking delicacy, HCPs can show their receptiveness to the potential delicacy of the topic of sexuality for patients.

Conclusion
In conclusion, we have provided a source for oncology HCPs to gain insight into the interactional effects of their talk about sexuality with cancer patients. This may help HCPs to eventually tailor their talk to the specific sensitivities in these interactions.

Iris van der Scheer
University College London

The discussion of common mental health concerns in GP-patient interactions

Mental health problems contribute to mortality and the burden of disease worldwide. They are also related to the development of other medical (chronic) illnesses. Nine out of ten adults with mental health problems receive support from their GP, but there is limited systematic work investigating how help is requested and provided and at what point in the trajectory of the consultation requests and responses to requests typically occur.

The project investigates how common mental health concerns are raised/discussed in primary care interactions and develops outputs for facilitating this discussion. The project is divided into three parts: (1) a narrative review (2) a conversation analytic study and (3) co-creation events.

The review has shown that there are different interactional resources that can facilitate or hinder the discussion of common mental health. Examples are the use of sensitive questions by the GP, formulations, and normalising.

The CA study comprises an analysis of 231 unselected recordings of UK primary care consultations. Common mental health concerns related to a physical, social or life event, can be initiated in different ways and these may elicit a response from the GP while accounting for the visit at the same time. Likewise, GPs may respond in different ways to presentation. They may delay responses to common mental health concerns and first attend to practical or physical issues.

The co-creation events built on the first two parts of the project. During these events, we worked together People with Lived Experience and GPs, reflected on the findings, and gave them the opportunity to share their experiences and opinions. The presentation will reflect on combining CA with another method.

All in all, the study has shown that the presenting and responding to a common mental health concern might not always be straightforward and participants perform interactional work to accomplish this.

Isabel Windeatt-Harrison, Traci Walker, Simon Bell, Daniel Blackburn, Jon Dickson, Stephen Jones, Alistair Wardrope, & Markus Reuber
University of Sheffield

The first step in triadic decision-making involving people with dementia: determining who talks when

Background
Everyone, including people living with dementia (PLWD), should have the opportunity to participate in decisions about their health. Existing guidance on involving patients in decision-making is based on two-party encounters (dyads), but PLWD typically bring a carer/companion along to medical appointments. Most decisions are therefore made in three-party interactions (triads).

Methods
Our four-year study uses Conversation Analysis to explore how decisions are made in triadic conversations when one person has cognitive difficulties. Work includes collecting a new cross-sectional database of triadic clinical encounters involving PLWD, and then recruiting PLWD/carer dyads to record appointments with a medical practitioner in a variety of settings over two years, to analyse changes over time in both PLWD's contributions and the role of carers.

Findings
In the first part of the project, we examine how PLWD can enter multiparty interaction, a necessary first step to taking part in decision-making. We show how carers' and clinicians' pronoun usage can include, or exclude, PLWD from discussions about their symptoms. Using third person pronouns (she/he) results in the PLWD being talked about rather than to, excluding them from participating fully in the interaction. However, use of the second person pronoun (you) scaffolds the PLWD's response, helping them participate. Furthermore, mid-turn pronoun switching, which appears inclusive through the use of second person, actually limits the PLWD's opportunities to talk. Perhaps most importantly, we show that third person pronouns, and pronoun switching, are not inherently exclusionary, and that sequential context is key to understanding the use and treatment of any pronouns.

Conclusion
To make decisions within interaction, PLWD must be given the opportunity to contribute their thoughts and opinions. Companions and clinicians use of second person pronouns, along with third person and pronoun switching that is responsive to the PLWD, support PLWD to participate in interaction.

Jack B. Joyce, Virginia Calabria & Charlotte Albury
University of Oxford

Using CA to design and refine a communication-intervention in a clinical trial: how health coaches provide weight loss support

Issue
The paper reports how we developed a CA-informed communication intervention to be delivered by health coaches. Our intervention is a guided self-experimentation of different weight loss programmes for people newly diagnosed with type 2 diabetes (T2D). Building on CA literature and our pilot qualitative research we

created an 'aide-memoire' to keep participants engaged and reframe failure not as individual failure but failure of the programme to meet the needs of the individual. The intervention was then evaluated and iterated using CA to improve its efficacy.

Methods

We recorded all points of contact in the participant's journey with the health coach (at weeks 0, 2, 6 and 10). We focused on moments in the journey likely to correlate with interactional trouble—such as, decisions around trying another weight loss programme after one has not worked. Using CA we observed how coaches delivered the aide-memoire to identify (in)effective practice and optimise future iterations of the communication intervention.

Findings

Our analysis reveals how coaches and people with T2D navigate self-experimentation with weight loss programmes, and how coaches maintain positive support and news delivery in the face of reported difficulty by participants. Moreover, our preliminary work informs the further refinement of a communication-based intervention grounded in CA results.

Conclusions

The findings add to the body of literature demonstrating the efficacy of delivering weight loss options as 'good news', and that maintaining overall positivity seems to engender acceptance and adherence to the pathway to diabetes remission. We also demonstrate how CA can be used to monitor and improve ongoing intervention delivery in clinical trials.

Kleopatra Sideridou
Newcastle University

'Mouth opening sequences in dental appointments: a collaborative interplay'

Conversation analytic studies of dental interactions have been scarce in the healthcare research corpus so far. With most of the research mainly focusing on the dental practitioners' training (e.g. Hindmarsh et.al 2014; 2011, Hindmarsh 2010), little attention has been paid to the joint conduct of the dentist and patient in dental consultations. The process of the mouth inspection offers a unique local contingency where, in contrast to many other healthcare settings the patient has limited verbal interaction with the healthcare provider. The opening, retraction and re-opening of the patient's mouth during the examination and/or treatment process is the phenomenon under analysis here. For my study, I collected approximately 10 hours of video-recorded appointments in a private dental practice in the UK. Relevant interactional episodes have been isolated, transcribed and unpacked with a focus on the communicative resources the participants employ to coordinate the consultation in an effective manner. Analysis shows how both participants coordinate their conduct to perform the oral examination and embed this within the broader activity of the dental appointment. The analysis also reveals how the patient monitors the dentist's talk, movement and use of aids and objects, in order to precisely time the presentation of the inside of their mouth for examination. The dentist usually initiates the mouth inspection by implementing a series of steps that frame this action as recognizable for the patient. The analysis breaks down these seemingly unnoticed, fixed routine practices, which are in fact products of a collaborative interplay between the dentist and the patient. This sub-collection is part of the wider action of the patient making their mouth available for inspection in dental appointments and the impact this particular sequence of activity has on the interactional resources available to the participants.

References:

Hindmarsh, J. (2010) 'Peripherality, participation and communities of practice: examining the patient in dental training', in N.Llewellyn and J.Hindmarsh (eds.) *Organisation, Interaction and Practice: Studies in Ethnomethodology and Conversation Analysis*, Cambridge: Cambridge University Press, pp 218- 240.

Hindmarsh, J., Reynolds, P. & Dunne, S. (2011) ‘Exhibiting understanding: The body in apprenticeship’, *Journal of pragmatics*, 43(2), pp. 489–503.

Hindmarsh, J., Hyland, L. & Banerjee, A. (2014) ‘Work to make simulation work: 'Realism', instructional correction and the body in training’, *Discourse studies*, 16(2), pp. 247–269.

Laura Jenkins[1], Alexa Hepburn[2], Jonathan Potter[2], Colin Macdougall[3]
[1]Loughborough University, [2]Rutgers University, [3]University of Warwick

Interactional insights into risk communication in paediatric allergy

Medical risk is typically estimated using epidemiological statistics, sometimes adapted to individual patient characteristics, indicating the probability of a negative outcome. In situations where treatment decisions are made, practitioners are faced with patients/carers working with a range of mundane notions of chance and probability. We present findings from analysis of 30 video-recordings of consultations between one doctor, 30 children and their parent/carers in a UK paediatric clinic. In this paper, we investigate how a doctor in a paediatric allergy clinic translates technical versions of the risk of severe allergic reactions for child patients and their carers, assessing competence and understanding. We focus on how the prescription of an Epinephrine auto-injector (such as an ‘EpiPen’) for emergency allergy treatment is built as a shared decision. Analysis identifies several related practices, with this paper focusing on two: (1) the way risk is translated, typically into categories of low, medium, and high risk, and (2) the management of different types of uncertainty.

We illustrate how risk can be conveyed by clinicians using low-medium-high risk categories, accompanied by embodied gestures to render the reasoning visible, giving parents more tools to make an informed decision. We also highlight different types of uncertainty, e.g., orientations to lack of sufficient research evidence to guide medical practice. Crucially, these discussions involve an assessment of recipiency, in which the clinician gauges how much technical understanding the patient/carer has. Further, orientations to uncertainty about the patient’s history – e.g., what participants remember about food ingested – are often invoked. We can see how invoking uncertainty operates to level the epistemic gradient between the doctor and patient/carer, and results in a pedagogic sharing of the sophistication involved in coming to a decision.

Our discussion will consider our own translational challenge of addressing the statistical and medical notion of risk in an interactional analysis.

Laura Jenkins[1], Stuart Ekberg[2] & Nan Christine Wang[3]
[1]Loughborough University, [2]Queensland University of Technology, [3]Hunan University

Communication in paediatric care: A state-of-the-art review of conversation-analytic research

Communication is core to paediatric care. It is the vehicle by which essential clinical tasks are delivered and by which children’s contributions are enabled or constrained. For this reason, communication has been the focus of a substantial body of research, within which conversation analytic (CA) studies of recorded naturally occurring interactions contribute distinctive understandings. However, to date there has been no detailed review of CA’s unique contributions. In this paper we report a state-of-the-art review of this growing body of research. We searched Medline, PsychINFO, Sciencedirect, Google Scholar, and EM/CA Wiki database for research articles and book chapters published up until June 2022 which report close CA of recorded naturally-occurring interactions with child patients. Our search identified 73 empirical papers across clinical and community settings internationally, including paediatric primary care, specialist services for palliative care, oncology, pain, and allergy, vaccination appointments, health visiting, dentistry, pharmacy, and allied professions (e.g. speech and language therapy).

Our state-of-the-art review presents an overview of CA studies of clinician and caregiver conversations about a child patient, with a particular focus on decision-making and treatment delivery. In addition, we describe studies which focus on episodes involving the child, illuminating the verbal and non-verbal resources by which adults and children co-ordinate their behaviour in relation to each other, display engagement, and manage participation in paediatric healthcare encounters. The findings have potential to enhance clinical practice by illuminating how healthcare tasks are practically accomplished, and to enrich our knowledge of children's participation in consultations by revealing the mechanisms which constrain and enable their involvement. We call for better synthesis of findings with broader CA literature (e.g. non-clinical child interactions; adult triadic clinical encounters; fundamental knowledge of social interaction), increased support for scholarly work in non-Western settings, and emphasise scope for applied initiatives. The data reported are in multiple languages.

Lauren Bridgstock[1], Alison Pilnick[2], Sarah Goldberg[1], Rowan Harwood[1]
[1]University of Nottingham, [2]Manchester Metropolitan University

"Wonderful Wonderful": Use Of Praise In The Care Of People Living With Dementia

The acute hospital environment is known to be difficult for people living with dementia (PLWD), and healthcare staff often view communication with this group as challenging (Griffiths, Knight et al., 2014). Elderspeak has been defined as a form of communication used towards older people, particularly PLWD. It involves features such as high pitch/tone of voice, simplified sentences/grammar, terms of endearment and excessive praise. It is often assumed to be patronising or infantilising (Ryan et al., 1995; Williams et al., 2017; Shaw and Gordon, 2021). However, empirical literature on the use of praise specifically is limited within this context. While the Alzheimer's Society (2022) suggest that PLWD should be offered plenty of praise and encouragement, reflecting the pervasive person-centred care ideology that existing abilities of PLWD should be supported (Kitwood 1997; Brooker 2007), this suggestion is not grounded in research. However, some research on the use of praise in wider contexts suggests it may have useful structural functions in conversation, such as signalling a transition between interactional units (e.g., Antaki et al., 2000).

This paper uses CA to examine functions of praise within a collection of video data recorded on UK hospital wards during the VOICE and VOICE2 research projects. The data show routine healthcare interactions between PLWD and healthcare professionals, analysed as part of a PhD project investigating the use of elderspeak in this setting. Preliminary findings suggest praise: 1) works as a supportive action to aid orientation to tasks and activities and 2) has implications for the preservation of agency and face (Goffman, 1955). The analysis will contribute to the empirical literature on interactions with PLWD; it also aims to aid the development of future communication training resources, leading to improvements in their quality of care.

Liliia Bespala[1,2], Miriam Meyerhoff[2] & Charlotte Albury[2]
Zaporizhzhia State Medical & Pharmaceutical University, Ukraine[1], University of Oxford[2]

Balancing Epistemics: a Study of Self-Repairs in Opportunistic Weight Loss Advice Interactions

Introduction. Guidance recommends that GPs offer patients with obesity opportunistic weight loss advice. However, weight-related conversations pose challenges for both parties within the clinical context, primarily due to epistemic imbalances. Doctors inherently wield medical expertise, while patients uniquely embody the first-hand experience of living with obesity. Moreover, unsolicited advice often caries problematic implications about the recipient's competence, resulting in resistance to recommendations (Heritage & Sefi, 1992; Tremblett et al., 2022). Our study demonstrates how these challenges are effectively navigated through the use of conversational repair.

Methods. Drawing on data from 237 consultation recordings of the Brief Interventions for Weight Loss (BWeL) trial, we collected 90 instances of self-repair. Conversation analysis was applied to explore the interactional import of the repairs, examining the nuances of repair operations and the strategic utilization of linguistic resources.

Results. In weight loss discussions, both GPs and patients perform repairs to either upgrade or downgrade their initial epistemic stances. Upgrading repairs empower clinicians to underscore the gravity of weight-related issues or amplify the benefits of weight loss. Conversely, GPs launch downgrading repairs to acknowledge limitations in the weight-medical condition relationship or temper their claims regarding the effectiveness of specific weight-loss methods. When confronted with patient disalignment, doctors adeptly initiate a downgrading of their stances, complying with the patient's epistemic primacy through experience. This is followed by an upgrading repair to reassert the doctor's epistemic authority of expertise. The dynamic interplay between doctors' and patients' stances is geared towards upholding epistemic balance and congruence in talk.

Conclusions. Our findings underscore the crucial role of self-repair as an interactional tool that mitigates resistance displays, supporting the smooth delivery and reception of unsolicited weight loss advice.

Madeleine Tremblett[1], Tim Auburn[2] & Cordet Smart[3]
[1]University of the West of England, [2]University of Plymouth, [3]University of Exeter

Identity in multi-professional teams: the negotiation of tasks

The problem
Multiprofessional team working is assumed to be difficult, due to factors such as professional protectionism and fear of identity loss (Academy of Medical Royal Colleges, 2020). Despite anticipated difficulties, few studies have examined these teams working in their main arena: team meetings. One important function of these multiprofessional team meetings is to determine future tasks and next steps for patients. This paper examines the negotiation between professionals of what these next steps should be.

Methods
Data was collected in 2018 and 2019, from three Community Learning Disability Teams in the UK. The total length of all the meetings recorded and used in analysis was 12 hours and 37 minutes. Conversation analysis (CA) was used to analyse 22 extracts, at points in the interactions when there were negotiations on the next steps the team should take for clients.

Major findings
Negotiations were characterised by propositions and counter propositions. These often occurred when team members proposed a course of action, that often made relevant a specific professional's role, which were then countered by that professional. Countering was achieved by professional's separating themselves from the team by using first-person pronouns and making statements on their next steps. In both propositions and counters professionals orient to epistemics and deontics, important for how their turns-at-talk were receipted by other team members.

Conclusions
Bringing together multiple professionals to determine optimal next steps for patients requires some negotiation on who could and should do specific tasks. Professionals orient to knowledge of professional identity to propose tasks that others could do, and to counter these propositions. As such, rather than being problematic, professional identity was used as a conversational resource.

Magdalena Solarek-Gliniewicz
University of Oslo

Strategies to establish common understanding under medical consultations in a second language (seen from conversation analysis perspective)

Norway has for a long time reported on the lack of specialised physicians in the country. Numerous Polish doctors learnt Norwegian and moved to work there.

How is the interaction between doctors and patients when the doctor speaks to the patient using his/her second language? What are the strategies the Polish physicians use to secure mutual understanding with their Norwegian speaking patients?

My data consist of 40 video-recordings of patient-doctor consultations from 6 Norwegian hospitals. The theoretical framework for the study is other-initiated repair theory
(Okoye, 2019). I analysed my data using Thematic Analysis and Conversation Analysis (Sidnell & Stivers, 2013).

In my talk I will show:

1. what the trouble sources that lead to repairs in the analysed consultations are,
2. how the repairs are initiated and solved,
3. how the feedback given by the patients is used to correct and adjust doctor's language use.

My results show that there is almost twice as many repairs initiated by patients as by physicians. Repairs initiated by the patients mainly occur after utterances containing physicians' grammatical anomalies (especially quanitifiers and time expressions). Repairs initatiated by the physicians mainly occur after utterances containing dialectal features and neighbour languages. In addition, I have found that the physicians in most cases respond to patients' repairs (by approving, clarifying, repeating, correcting own mistakes and explaining professional terms), only occasionally they misunderstand the feedback or do not respond to it at all.

My study has further implication for teaching foreign languages to medical professionals and introducing the importance of different types of repairs to secure mutual understanding with their patients.

References:
Okoye, A. C. (2019). Other-Initiated Other-Repair: Repair Organization While Playing a Place-Based Augmented-Reality Game. *PSU McNair Scholars Online Journal*, 13, (1),6.
Sidnell, J. & Stivers, T. (Eds.) (2013). *The handbook of conversation analysis.* Blackwell.

Marco Pino[1], Victoria Land[2] & Elliott Hoey[3]
[1]Loughborough University, [2]University of York, [3]Vrije Universiteit Amsterdam

Moving towards (and away from) possible discussions about disease progression and end of life: Some emergent outcomes of companions' actions in palliative care interactions

Several initiatives in Western countries aim to move death and dying from the realm of the unspoken to the sphere of open debates and interpersonal communications. It has been proposed that open discussions about the end of life (EOL) can benefit people, especially those for whom the prospect of dying is nearer—older people and people with advanced illnesses. There is nevertheless some evidence that these discussions do not happen enough. Several authors have proposed that this is partly because companions (informal caregivers, family members, and friends) discourage talk about mortality. This conclusion is mostly based on self-report, and there is very little evidence of whether and how companions discourage talk about mortality in practice.

This presentation addresses this question by examining a corpus of palliative care interactions recorded in a large UK hospice through conversation analysis. It focuses on a collection of patient possible allusions to disease progression and EOL and examines their companions' (i.e., accompanying family members and friends) subsequent actions. Our findings challenge the conclusions of previous studies. Companions' actions do have as one of their outcomes that they steer the interaction away from the possibility of immediately elaborating on the patient's allusion, and of making matters related to disease progression or EOL explicit (despite these being relevant possibilities). However, these actions do not appear designed to avoid an engagement with talk about mortality. Rather, a lack of engagement with talk about mortality is best seen as an emergent outcome of actions that are designed to implement other interactional projects, which are coherent with a sequence of actions and broader activity underway.

Marine Riou[1] & Niru Perera[2]
[1]Université Lumière Lyon, [2]Curtin University

Accentism, intersubjectivity, and disaffiliation in French emergency calls

Language barriers are an important source of health inequity in clinical encounters. Conversation analytic research has started documenting practices to negotiate language choice (e.g. Raymond 2014) or to maintain mutual understanding when the caller has limited proficiency (e.g. Garcia 2022). We focus on accent bias, or "accentism". Ethnographic research identified the negative effects of covert and overt accentism experienced by migrants (Dryden & Dovchin 2021), and experimental research showed that speakers with an accent are perceived as less credible (Lev-Ari & Keysar 2010) and less confident (Abu Guba 2023). Accentism can therefore have serious consequences for the construction of shared knowledge between caller and call-taker.

We use a corpus of French emergency medical calls as a window into a global phenomenon which likely bears on this type of interaction in any language and setting. We compiled a collection of calls involving callers who speak French as a foreign language with low- and highproficiency, and callers using a non-standard variety of French as their first language. We argue that accentism can compound the usual interactional difficulties found in emergency calls: missing crucial information delivered by the caller and leading to disaffiliative sequences.

References

Abu Guba M.N., Daoud S., Jarbou S. (2023). Foreign accented-speech and perceptions of confidence and intelligence. *Journal of Psycholinguistic Research* 52: 1093–1113.

Dryden S., Dovchin S. (2021). Accentism: English LX users of migrant background in Australia. *Journal of Multilingual and Multicultural Development* 0: 1–13.

Garcia A.C. (2022). Interactional challenges for non-native speakers of English in emergency telephone calls. *Journal of Pragmatics* 193: 222–234.

Lev-Ari S., Keysar B. (2010). Why don't we believe non-native speakers? The influence of accent on credibility. *Journal of Experimental Social Psychology* 46(6): 1093–1096.

Raymond C.W. (2014) Negotiating entitlement to language: Calling 911 without English.
Language in Society 43(1): 33–59.

Marine Riou[1,2,3], Nirukshi Perera[3], Stephen Ball[3,4], Austin Whiteside[4], Judith Finn[3,4]
[1]Université Lumière Lyon, [2]Institut Universitaire de France , [3]Curtin University , [4]St John Western Australia

The epistemic phrase ‘I (don’t) think’ in emergency calls: a mismatch of callers’ practices and call-takers’ orientation

During emergency medical calls, call-takers must make quick assessments and decisions based on information provided by callers, who may have limited experience or expertise in assessing a medical situation. In this context, a range of interactional practices negotiate all dimensions of epistemicity: what callers know, how they know it, how certain they are about it, and whether they can be considered reliable sources for this knowledge.

This study analyses a collection of 75 cases of callers using the epistemic phrase I think and 25 cases of its negative counterpart I don’t think in Australian emergency calls. We investigate the interactional purposes to which callers use I (don’t) think, call-takers’ orientation, and subsequent trajectory of calls.

With I (don’t) think, callers signal an assessment about the patient as deriving from their own perspective, as in (1). There is a key difference between presenting an assessment as subjective vs. uncertain, but our data indicates that call-takers often conflate these two dimensions of epistemicity. Call-takers typically orient to I (don’t) think as expressing uncertainty and they request verification, as in (2). Such requests for additional checks can lead to unnecessary delays and disaffiliative sequences when callers consider they have already provided the requested information, and callers rarely change their assessment after verification. We therefore argue that there is a mismatch between callers’ and calltakers’ practices regarding I (don’t) think, which can have negative consequences for emergency medical dispatch.

(1) Caller I got a- gentleman that's unconscious? I think he’s had
a stroke?

(2) Caller she- her eyes are open and ⌈she:'s (.) cold. ⌉
Call-taker ⌊is she breathing. ⌋
(.)
Caller I don't think so.
Call-taker okay are you able to check?
(.)
Caller h not really.
I- I just checked then.

<u>Marit Nygård Halvorsen</u>
Oslo Metropolitan University

Midwives' Approaches in Thematizing Violence in Antenatal Care

Background
In 2014, the Norwegian Directorate of Health introduced new guidelines recommending midwives in antenatal care to ask pregnant women about exposure to violence. Introducing such a topic is difficult, and previous studies have demonstrated the need for further education and organizational support in this area.

Methods
As a part of my PhD project, and a larger midwifery education project, I aim to discover how and when midwives introduce the topic of violence by using CA – conversation analysis, as my theoretical and methodological framework. The data material consists of 34 video recordings from the first or second consultations of 34 pregnant women and 8 midwives in antenatal care. This selection was made because

the midwives are supposed to ask about violence during the first consultation, and sometimes second consultations.

Results
Preliminary findings show that the midwives display great sensitivity to how the topic is introduced and that they gradually move towards the topic, for instance by linking it to previous talk before posing the question in a pre-sequence, and by giving various accounts for asking, usually in a post-sequence. Not doing the interactional work by preparing and/or consolidating the topic, shows signs of trouble and a decreased time spent on the subject. Thus, treating this as a normal routine question may limit the pregnant woman's possibility to answer.

Conclusions
Midwives carry out interactional work when thematizing violence antenatal care, indicating the sensitivity of asking pregnant women about this topic. The way these questions are introduced and asked may have interactional consequences for the responses the pregnant women provide. These findings may offer clinical implications for midwives and other health professionals who ask about violence, and/or other delicate topics.

Merran Toerien
University of York

Invoking the patient's right to accept or refuse treatment: the deviant cases that reveal two norms for medical decision-making

The right to accept or refuse treatment is legally present in most medical consultations in the UK and other healthcare systems around the world. That right can be enacted without overtly invoking it. For instance, there is robust conversation analytic evidence that doctors' treatment recommendations – regardless of format – are understood as proposals to be accepted or rejected by the patient. Even when doctors give patients a choice, our prior research showed that this is handled without naming the patient's *right* to choose. In this paper, I ask: what special interactional work are doctors doing when they do invoke the patient's right to accept or refuse?

I searched a dataset of 224 neurology outpatient consultations, recorded for a study of patient choice in the UK's National Health Service. Across the 246 decisions we identified previously, the (officially omnipresent) right to accept or refuse was invoked in just 28 (11%). Using conversation analysis, I investigated the decision-making sequences in which this occurs, and found a common pattern:

- Neurologist's turn: initiates a treatment decision
- Patient's response: patient resistance (of some kind)
- Neurologist's post-expansion: includes invoking the patient's right to accept or refuse.

I show that, in this interactionally delicate position, neurologists do four main things:

1. Resisting an attempt to refuse treatment
2. Resisting being positioned as the decision-*maker*
3. Granting the right to refuse treatment
4. Resisting making a recommendation.

Some of these may seem contradictory. However, I argue that – when understood as a form of deviant case analysis – this collection exposes two norms for medical decision-making: i) That decisional responsibility *should* lie with the patient; ii) That the decision *should* be based on the doctor's biomedical knowledge. I conclude that these norms provide an explanatory framework for previous conversation analytic findings on treatment decision-making.

Nan Wang
Hunan University

Fail to respond or fail to recognize: Caregivers’ unsolicited expression of concerns and doctors’ responses in Chinese paediatric primary care encounters

Patient expression of concerns is common in medical communication. In primary care and surgical settings, patients are found to disclose psychological distress or cues in over half of the visits (Levinson et al., 2000; J. W. Robinson & Roter, 1999); in paediatric cancer care, patients could express as many as 11 emotional cues/concerns per visit (Mellblom et al., 2016). Effective response to patient expressions of concerns is crucial for patient health outcomes. Physicians’ failure to take account of patients’ concerns is found significantly impacting patient satisfaction, medication adherence, and various indirect outcomes (Baker et al., 2003; Derksen et al., 2013; Korsch et al., 1968; Korsch & Negrete, 1972; Street et al., 2009). In paediatrics, when caregivers are uncooperative in adhering to the treatment regimen, they may leave the child at risk of missed diagnosis of severe conditions (Baker et al., 2003; Thom et al., 2002). Despite the significance of patients' and/or caregivers' expression of concerns for various important medical outcomes, existing research has found that doctors often fail to respond to them or even fail to recognize them.

Based on 60 video-recordings of paediatric primary care encounters randomly selected from a larger dataset, this conversation analytical study shows that caregiver unsolicited expression of concern is prevalent in 96.6% of the cases and occurs throughout the consultations. The study also proposes a taxonomy of caregiver concerns, involving (1) medical, (2) pro-medical, (3) life-social, and (4) logistics-related. Physicians respond to these concerns in 76.1% of the cases, while the rest are left unresponded to or interrupted. Furthermore, it is found that physicians are significantly more likely to respond to caregivers' medical or pro-medical concerns. In sum, the study highlights the importance of understanding the full range of caregiver concerns in medical interactions and provides insights into opportunities for physicians to respond effectively.

Paul Drew[1], Neil Marlow[2], Tom Morris[2] & Chloe Shaw[3]
[1]University of York, [2]UCL, [3]University of Bristol

Informing parents about their child’s condition in neonatal critical care

In research into conversations between doctors and parents of very sick babies in neonatal critical care (method is CA), we have shown that who initiates the moment of coming to a decision about the baby’s future treatment - whether the doctor or the parents – has significant consequences for how decisions are presented. If doctors initiate decisions, they tend to make a recommendation (“Our feeling as a team is that we should offer to palliate him and to discontinue intensive care”) or they may refer to a choice to be made but without specifying the options. However, when parents initiate decision points (e.g. asking “What’s next?”), doctors usually either refer to or list specific treatment options. We further found that parent initiations followed by doctors suggesting choice of options are associated with greater alignment between doctors and parents. These results have encouraged us to examine the interactions immediately before a decision point (the moment when future treatment decisions are mooted). Some patterns are emerging in the information doctors give about babies’ current conditions, for example telling the parents about changes that have occurred overnight, that are associated with parents having difficulty understanding the direction in which the information is heading, as a result of which they are not in a position to initiate the decision point. We show that certain patterns in giving information can help to avoid misalignment and discord between doctors and parents.

Piera Margutti[1] & **Vittoria Colla[2]**
[1]University of Modena & Reggio Emilia, [2]University of Bologna

Patients' overlapping talk: conveying concerns in oncology treatment visits by withholding the progressivity of interaction

Despite recent emphasis on patients' participation and "centredness", the inherently asymmetrical structure that characterize medical encounters, as well as other variables, still hinder patients' participation and their chances to present their issues. Especially in oncological care settings, patient participation is particularly complex and crucial, due to the highly specialized domains and the treatment impact of on patients' daily and future life. Although oncological patients often become "experts" on their conditions and therefore play quite an active role in the visit, research shows that they nevertheless encounter difficulties in finding ways to raise their worries, facing the fact that the progression of the interaction is mainly determined by the doctors' agenda. Moreover, the oncology treatment visits in our corpus, i.e., visits dedicated to recommending a specific treatment (e.g., surgery, radiotherapy), do not normally feature a structurally established "problem presentation phase". This poses a practical problem to patients: when and how can they raise their worries?

Patients in our data adopt a variety of practices to do that. Based on a corpus of 103 video-recorded visits collected in Italy and adopting conversation analysis, this presentation illustrates one of these recurrent practices. Patients take the turn in interjacent overlap (Jefferson 1986) when a concern of theirs might be relevantly touched: they 'interrupt' the progressivity of talk and the ongoing action implemented by the doctors to add some relevant matters. In this way, patients achieve two different outcomes: they expand beyond closure a previously concluded course of action, impeding doctors to move on to other matters, or they initiate a new sequence embedded in a still ongoing course of action.

In the cases in our collection, doctors leave the floor to patients and extensively address their concerns in the following turns. Thus, patients modify doctors' agenda and successfully implement their one.

Rachael Drewery[1], Alison Edgley[2] & Alison Pilnick[3]
[1]University of Oxford, [2]University of Nottingham, [3]Manchester Metropolitan University

Compassion, patient tellings and the design of healthcare professionals' responses

Background
Healthcare policy, research and training encourages healthcare professionals to display compassion through communication practices such as listening, eye contact and touch. Yet, these generic recommendations, regarding responses to patient suffering, rarely address how such communication occurs within its institutional and interactional context. Conversation analysis provides a rigorous method for exploring how compassion, or responses to patient suffering, are enacted in actual healthcare interaction. Patient problem tellings are one area where patients may display this suffering, and a compassionate response may be relevant. As part of a larger study on compassion in advanced clinical practitioner (ACP) - patient interaction, the current paper explores the design of ACPs' affiliative responses to patient problem tellings.

Methods
We collected twenty-seven audio visual recordings (five hours and seventeen minutes) of interaction between ACPs and patients on healthcare of the older person wards. Sequences containing patient tellings were extracted, transcribed (Jefferson, 2004) and analysed using conversation analysis.

Findings
Analysis shows that when ACPs respond to patient problem tellings, they can affiliate with the patient's feelings, experience, and/or stance. These responses are contextually sensitive, appearing to vary

depending on the patient's problem and its amenability to treatment. Additionally, the design of ACP responses to patient problem tellings navigate a number of competing demands, including acknowledging and showing understanding that the patient is suffering, while navigating epistemic and 'face' issues.

Discussion
Exploring ACP responses to patient problem tellings provides evidence of the specific, contextually sensitive practices healthcare professionals use in one area of patient suffering, which can be incorporated into communication skills training. These findings also contribute to wider debates about both the conceptualisation and enactment of compassion in healthcare.

Rebecca K. Barnes & Catherine J. Woods
University of Oxford

Communication in primary health care: A state-of-the-art review of conversation-analytic research

Primary health care is widely recognized as the 'front door' into many health care systems, providing a first point of contact for patients, and often performing a gatekeeping role to other services. It has a wide remit and is rooted in a commitment to social justice, equity and participation. Comprehensive generalist physicians, nurses and other specialists play a central role. Our aim was to review CA studies on communication in primary care and consider their contribution to wider primary health care research and practice.

We performed a comprehensive search of a number of bibliographic databases with no date or other restrictions employed. All results were exported into a review software package, and any duplicates removed. Titles and abstracts were screened independently by both authors against strict inclusion and exclusion criteria. We used Google Scholar to conduct forward and backward citation tracking to identify any further studies and agreed key categories for data extraction.

177 empirical studies (137 journal articles, 90 from medical or health-related journals; and 40 book chapters), spanning four decades (1981-2022), and 16 countries, with data in 17 languages were included. Most studies originated in North America and England, with the predominant language being English, and were largely focused on interactions between physicians and undifferentiated adult patients. Over time, CA research on primary care has coalesced into three main themes: managing agendas, managing participation and managing authority.

Our review is a testament to the contributions made by the field to mapping the unique interactional "fingerprint" of communication in primary care. The research to-date has provided original insights into topics of longstanding interest to primary care research as well as evidence of important gaps between professional theories, policies and 'good practice' guidance and how these play out in practice, presenting opportunities for wider clinical, educational and research applications.

Rebecca O'Brien[1], Alison Pilnick[2], Suzanne Beeke[3], Isabel Windeatt-Harrison[4], Lauren Bridgstock[1], Sarah Goldberg[1] & Rowan Harwood[1]

[1]University of Nottingham, [2]Manchester Metropolitan University, [3]UCL, [4]University of Sheffield

"I want to get out… I've got a child at home": intersubjectivity and reality disjunctures in the care of people living with dementia.

Intersubjectivity (the shared understanding of thoughts, meanings or feelings between two people) is a phenomenon which has long exercised philosophers (see for example Husserl, 1960). However, it is a practical problem as well as a philosophical one; as Schutz (1966) argues, the intersubjectivity of the lifeworld is the basis on which all social relationships are founded. The pivotal role of language in achieving intersubjectivity creates particular problems where one party to an interaction has a medical condition which affects their use of language, or as Garcia (2012:351) puts it, “medical problems where talk is the problem”. Dementia is one such condition: it can have significant impacts on communication and comprehension abilities (Dooley et al, 2015). In this paper we present data from two UK-based NIHR funded projects (VOICE and VOICE2), collected from acute healthcare of the elderly wards in two general hospitals.

We collected 94 video and audio recordings of naturally occurring interactions between healthcare professionals and people with dementia. For VOICE 2, patient participants were identified by their healthcare team as people with dementia who were also prone to showing distressed behaviours. Times, activities and contexts where distress had been triggered previously for the individual were identified and targeted for data collection. Data were analysed using conversation analysis.

Using Pollner’s (1975) concept of reality disjunctures, and drawing on previous work by Lindholm (2015) and Hyder and Samuelsson (2019), we explore how hospital staff respond to the challenge of competing experiences of the world. We analyse the ways in which the lack of a common reality becomes apparent, the approaches staff use to manage or avert the distress which can occur as a result, and the consequences of these approaches.

Rose McCabe[1], Mariel Wuolio[2] and Anssi Peräkylä[2]
[1]City, University of London, [2]University of Helsinki

Communication in mental health care: A state-of-the-art review of conversation-analytic research

Talk is central in mental health presentations, diagnosis and treatment. We conducted a narrative review and synthesis of conversation analytic studies of mental health clinical interactions. We included 103 studies spanning 4 decades across 19 countries with data in 13 languages. Studies focused on (1) problem presentation and eliciting information (2) interactional profiles of people with/out a mental health condition (3) diagnosis (4) decision making (5) co-constructing experience (6) professional responses to patient experience and affiliation. Cross-cutting themes were: doctorability; delicacy in presenting, probing, topicalising and responding to sensitive subjective experience; patient resistance and facework; building consensus cautiously and balancing institutional/deontic authority in decision making; and affiliation with subjective experience in order to promote client change. CA has informed diagnosis, training and evaluation of communication. There is limited or no research on children and young people, carers and inpatient settings. CA in mental health can test/challenge theories of disorder, illustrate how therapeutic techniques work moment-by-moment in interaction and add to evidence on diagnosis and decision making in healthcare more widely.

Ruiyu Tang
Ocean University of China

“You Think I’m an Augur?” Sequential Consequences of Invoking Categories beyond Doctor-patient Collection in Clinical Interaction

Although the collection of doctor-patient as a basic membership category collection is recurring in clinical interaction repetitively, there are many other seemingly irrelevant categories invoked outside the collection that have a remarkable influence on the progressivity of conversation. Thus, this study concerns how various membership categories invoked beyond doctor-patient collection affect clinical interaction. This study adopts a mixed-method approach, combining conversation analysis and membership category analysis. Data cover video recordings of different office visits from the outpatient department for about 300 hours. Visits are completely recorded without editing, achieving the demands of naturally occurring data for conversation analysis. Based on sequential analyses of 300-hour recorded doctor-patient interaction at clinics, this paper examines categories invoked in particular sequences by doctors and patients, finding that doctors display dislignment in response when patients depart from categories overstepping doctor-patient collection, which disrupts the progressivity of current talk, and projects doctors' tendency to close the current topic. However, confronted with doctors' prior turn which indicates the category exceeding doctor-patient collection, patients express alignment subsequently, facilitating the progressivity of talk. These findings may provide advice for doctors and patients on maintaining the successivity of interaction.

Ruth Parry
Loughborough University

Communication in palliative care and about end of life: A state-of-the-art review of conversation-analytic research

Increasing numbers of published conversation analysis (CA) studies examine palliative care and interactions in other settings pertaining to end-of-life (EoL) and related plans (e.g. cardio-pulmonary resuscitation). This growth provides an opportunity to take stock of the knowledge produced.

Methods: I conducted a 'State -of-the-art' review. These cover: "where we are now in our current understanding of this topic. This is how we got here. This is where we could go next. " 1p659 I used systematic review procedures, although I was sole reviewer. I imposed criteria to include only studies which used established CA steps, processes, and components. I sorted findings into themes.

Findings: The 22 studies included examined high stakes, sensitive, conversations about EoL, prognosis, and future care. The studies mostly focused on the difficulties involved, and the interactional means by which people limit, circumvent, or overcome these. 18 studies examined English data, two Dutch, one Swiss-French, one Japanese.

There is detailed evidence on recurrent practices by which people initiate and manage the topics of (1) dying; (2) prognosis; and (3) future care planning, and (4) how they interactionally manage emotions. Three very recurrent interactional features were found across these topical themes. First, people recurrently move into delicate topics via cautious step-by-step sequences. Second, practitioners and patients recurrently refer to death and dying indirectly, i.e., without using the most direct reference terms available; Thirdly, practitioners recurrently communicate in ways that show a preference for patients or companions to volunteer topics, plans, and decisions - that is, they work to encourage patients or companions to 'go first' in explicitly introducing or proposing them.

Reference

Barry, E., et al. (2022). Understanding State-of-the-Art Literature Reviews. J Graduate MedEd, 14(6). https://doi.org/10.4300/JGME-D-22-00705.1

Ruth Parry[1], Marco Pino[1] & [2]Sharan Harris-Christensen
[1]Loughborough University, [2]Treetops Hospice Trust & University Hospitals of Derby and Burton NHS Foundation Trust

Translating Conversation Analytic perspectives and evidence into existing communication training: the RealTalk approach

Communication training offered by higher education and healthcare organisations frequently focuses on sensitive and end-of-life conversations. It is largely based on expert opinion and studies of posthoc reports about communication, and reliant on roleplayed / imagined interaction. Existing provision is firmly established, so introducing and spreading alternative provision would be likely to have limited success.

We designed resources targeting existing trainers, designed to integrate with existing practice whilst enhancing its evidence-base and authenticity.

RealTalk resources centre around streamable video-clips of real-life interactions. These comprise personal data, so trainers must agree to stringent safeguards. Crucially, clips are accompanied by specific, actionable learning points. These articulate academically-framed Conversation analysis (CA) evidence in engaging, practitioner-accessible language.

CA-based interventions often rely on trained analysts for delivery. RealTalk resources do not. Resources can be used ‘off-the-shelf’, although our qualitative evaluations show train-the-trainer workshops achieve better uptake of resources, and enable trainers to more effectively incorporate CA perspectives and evidence. Training emphasises principles, rather than rote-learned protocols or phrases. Guidance encourages trainers: to model identification and articulation of ‘micro-skills’; to steer trainees to focus on what is observable and hearable within clips and avoid simplistic judgements and hypothetical considerations.

Loughborough, the host university, has licensed RealTalk to Treetops Hospice – an education-active hospice. 453 trainers are registered, most are UK-based.

Evaluations found the clips’ “realness” deepens engagement in learning and discussions; and that trainers develop new skills in giving ‘objective’, specific, detailed feedback to learners, whilst trainees develop skills in noticing and articulating subcomponents of complex interactional activities.

We hope to inspire other analysts and trainers who share our motivation to translate CA perspectives and evidence into education and practice.

Sakari Ilomäki[1] & Aija Logren[2]
[1]Tampere University, [2]University of Eastern Finland

Epistemic, deontic, and affective relevance of patients’ ideas and integration of knowledge in neurological outpatient clinics

Patient-centeredness, involving the integration of patients’ ideas into treatment processes, has long been an ideal in healthcare. However, many interactional hurdles exist for patients’ ideas to arise and to be dealt with: there is no clear place for patients’ independent knowledge production and patients can treat their own initiatives as problematic. Professionals’ answers to patients’ ideas have mostly been studied from the viewpoint of their accuracy.

In this presentation, we use Multimodal Conversation Analysis to examine how patients bring forward their ideas and how medical professionals respond to them in ways that integrate lay and professional knowledge together. Concentrating on episodes where patients explicate their understanding or ideas about the causes of their symptoms and potential treatments, we examine the potential intertwining of epistemic, deontic and affective elements of patients’ turns and how they shape the professionals’ responses. Data are video recordings from Finnish neurology outpatient consultations.

Patients’ treat their ideas as potentially delicate, mitigating them for example through footing practices. When doing this, they use verbal and embodied means to connect their ideas to what has been discussed earlier. When patients explicate their ideas, professionals provide patient education and explore the relevancy of the proposed idea. The ways in which professionals orient to the epistemic, affective and deontic aspects invested in those ideas are shaped by the idea’s position in the overall structure of the consultation (e.g. history-taking, prescribing) and multimodal turn-design features through which they are produced.

We conclude by highlighting the intricate interplay of knowledge, emotions, and decision-making rights in clinical interactions. This should be considered when developing theoretical and practical models of patient-centered care.

Sara Keel
University of Zurich

Solving a problem with an app in physiotherapy consultations as an opportunity for situated learning

This contribution investigates a face-to-face physiotherapy consultation in which a mobile eHealth application (hereafter "the app") is introduced to a patient. More specifically, it offers a single case analysis of an instance in which the physiotherapist encounters a problem with the app's interface when specifying how many sets and repetitions the patient should perform the instructed exercise at home.

Given the rapidity and dynamic of digital transformation in healthcare, users acquisition of required digital competences (eHealth literacy) is key. On the one hand, internal and external continuous training efforts play an important role. On the other hand, users acquire competences to an important extent in their day-to-day work, for example, when fixing problems with digital technology in situ. Yet, we know little about how healthcare professionals and patients handle problems with technology during consultations, let alone how they thus (possibly) acquire digital competences.

Our paper addresses this gap. It is based on multimodal transcriptions of synchronized video-recordings of real-life physiotherapist-patient interactions and the physiotherapist's computer screen. Adopting conversation analysis, it provides a single case analysis of a reoccurring problem with the app's interface during a consultation: the physiotherapist unsuccessfully uses the drop-down menu provided by the interface to specify the number of repetitions the patient needs to do an exercise at home.

Physiotherapists tend to experience problems with digital technology during consultations as causing disruptions to workflow and interaction with patients. Our single case analysis shows how on the first instances of occurrence, the physiotherapist spells the encountered problem out aloud and involves the patient in the achievement of an ad-hoc solution. However, upon further occurrence of the same problem the adoption of the ad-hoc solution is not further invoked or commented upon by participants. Thereby, the analysis reveals how in-situ physiotherapists and patients treat the (re)occurrence of a (same) problem with digital technology not merely in terms of disruption but also as a resource for situated learning.

Suzanne Beeke[1], Rebecca O'Brien[2], Alison Pilnick[3], Isabel Windeatt-Harrison[4], Lauren Bridgstock[2], Sarah Goldberg[2] & Rowan Harwood[4]
[1]University College London, [2]University of Nottingham, [3]Manchester Metropolitan University, [4]University of Sheffield

"It's okay you're not gonna fall": Accounting for care in acute healthcare settings with patients with dementia to avoid, de-escalate or resolve episodes of distress

Background
Interactants offer accounts as explanations for what they are doing (or not doing) by making explicit motives, reasons and causes (Heritage, 1990). Accounts are routinely provided, or demanded in contexts where they are absent. People with dementia occupy a quarter of UK acute hospital beds, and experience many accountable care activities involving difficulty, discomfort or pain, and this can lead to distress. Accounts for healthcare may precede an activity to avoid or minimise distress, or respond to expressed distress or reluctance (Parry, 2009). Healthcare professionals report that they want to know how to avoid and deal with distress when caring for people with dementia.

The VOICE2 study aims to identify what skilled practitioners do in interaction in acute healthcare settings with patients with dementia to avoid, de-escalate or resolve episodes of distress, and identify trainable practices.

Methods
Hospital patients with dementia showing distressed behaviours during admission were recruited from older persons' wards of two UK acute hospitals. Staff were recruited from the multidisciplinary team, including nurses, healthcare and therapy assistants, allied health professionals and doctors. Video/audio recordings of 53 naturally occurring healthcare interactions targeted situations that had previously triggered distress. Recordings were transcribed and analysed using conversation analysis.

Findings
Accounts occasioned by the patient occur in response to expressions of distress, for example concern, reluctance and complaint of discomfort or pain. Accounts also occur in response to ungrantable actions ('I want to go home'), serving as indirect refusals. Accounts initiated by the HCP occur before a necessary but potentially distressing proposal or request. Acknowledging, apologising and mitigating are linked to accounting. Acknowledging in the absence of accounting can lead to trouble whereby patients explicitly request an account.

Conclusions
Several trainable accounting practices were identified in the context of avoiding or dealing with distress.

Timothy Halkowski
University of Wisconsin - Stevens Point

Metric shifts in doctor-patient discussions of alcohol & tobacco use

In health care discussions of alcohol or tobacco use, there are occasions where the practitioner provides a candidate metric in their question to the patient, as in the following example, where the patient has just confirmed that she drinks alcohol.

Dr: How much every wee:k (.) or every day.
Pt: O:h I drink (.4) maybe a couple beers on the weekend.
hhI hhon't drink every day.

Given that any particular rate metric can in theory be used to accurately describe any amount of alcohol or tobacco usage, one can ask, why is this particular metric which was initially provided by the doctor shifted off of by the patient? What are they achieving or doing via this metric shift? What does this interactional procedure accomplish? Using conversation analysis, I investigate instances where patients do this action, and explore its implications for the subsequent interaction.

By shifting off of the candidate metric used in the physician's question, a patient may be seen as rejecting that prior metric. Shifting off of that provided metric is seeable as a purposive action.

By shifting to a new metric, the patient can be seen as highlighting some aspect of their answer. In this paper I demonstrate some of the ways this procedure is used by patients.

Some of those uses are:

- to indicate (first by negation, then affirmation) what sort of 'drinker' or 'smoker' one is;

- to defeat the doctor’s attempt to generate a ‘regularized rate of use’; and,
- to shift from a measurement metric to an evaluative metric, & thereby indicate that a measurement metric is not appropriate in this instance.

Xinxin Yang & Ray Wilkinson
University of Sheffield

Known Answer Question Sequences: A Comparative Analysis of Persons with Aphasia-Therapist and Persons with Aphasia-Spouse Interactions

Known Answer Question (KAQ) sequences have been extensively explored in conversations involving persons with aphasia (PWAs) and their significant others (e.g., spouses), with varied findings on the presence of negative emotions by PWAs. Additionally, no studies have investigated KAQ sequences in therapeutic conversations. To address these gaps, this study, using Conversation Analysis (CA), will examine KAQ sequences in conversations involving Mandarin speakers of aphasia in both therapy and home settings. Our findings reveal four distinctions in KAQ sequences between PWA-spouse and PWA-therapist interactions: 1) Therapists employ more strategies and provide more clues than spouses in eliciting answers from PWAs (e.g., when managing errors, therapists may reject it in the first place whereas spouses frequently repeat the error back to PWAs in flat intonation); 2) Therapists exhibit greater flexibility in completing KAQ sequences (e.g., therapist may abandon answer pursuit to complete KAQ sequences, yet abandoning seldom occurs in PWA-spouse talk); 3) KAQ sequences in home settings are lengthier compared to those in therapy settings; 4) Spouses in KAQ sequences express negative emotions with negatively affect-loaded utterances (e.g., anger, tease), one striking negatively-oriented eliciting practice by spouses involves framing errors with Mandarin particle ‘A’ (e.g., this is battery A); therapists do not display negative emotions in KAQ sequences. These four distinctions contribute to the finding that the regularly-employed KAQ sequences in therapy session may create more problems than help when being used at home. This study develops existing knowledge on negative emotions by PWAs in KAQ sequences through adding negative emotion displays by spouses. Moreover, it expands research scope by including KAQ sequences in therapeutic conversations, offering implications for interventions.

DATA SESSIONS in alphabetical order by first name

Anca-Cristina Sterie
Lausanne University Hospital

Introducing and managing end-of-life topics in discussions between spiritual counsellors and hospitalised older adults

Brief description of the data: Data presented come from a collection of 30 recorded discussions between a spiritual counsellor (chaplain) and 17 patients admitted for rehabilitation in the geriatrics service of a university hospital. Conversations are in French. Data will be presented with three-line transcription, including translation to English.

Type: Audio

Ethical permissions: Patients and chaplain provided oral and written informed consent. The study was approved by the University of Lausanne's ethical commission. Anonymized data can be shared for scientific purposes.

Caroline Tietbohl[1] & Anne E.C. White[2]
[1]University of Colorado Anschutz Medical Campus, [2]University of California, San Diego

Exploring Encouragement Across Clinical Settings

Interest in empathy and compassion in medicine has grown in recent years given its potential to improve patients' long-term treatment outcomes and to protect physicians against burnout. However, variations in conceptual and operational definitions of empathy make it challenging to identify exactly how and in what context empathy should be expressed. In this data session, we will build on prior work that uses CA to create a more precise vocabulary around specific expressions of empathy (e.g., empathic validation, reassurance). Specifically, we will examine a collection of cases involving encouragement (i.e., instances in which clinicians attempt to promote patient behaviors outside the visit, such as treatment adherence or scheduling follow-up care). Our data includes video-recorded adult primary care (internal medicine, family medicine, geriatric medicine) and specialty care visits (pain management, surgery) from four data sets. Institutional Review Board approval and written consent was obtained for all data.

In Part 1 (first 30 minutes), we will break into two groups and share a collection of 10 cases from different datasets. Each group will develop an approach to operationalizing encouragement and then both groups will collaboratively write a preliminary definition of "encouragement". In Part 2 (middle 30 minutes), participants will break into small groups to explore patient responses to encouragement to operationalize categories of patient response (e.g., disengagement, active resistance). For Part 3 (the final 30 minutes), the whole group will explore patterns across cases in which a specific type of patient response occurred (e.g., patient dis/engagement).

Gilian Noord
University of Nottingham

Interactional difficulties in GP-patient telephone consultations in UK primary care

The COVID-19 pandemic has resulted in the rapid introduction of remote consultations in primary health care. Although COVID-19 currently has a decreasing impact on the provision of primary care, remote services (e.g., telephone consultations) are here to stay. In this data session we will focus on a fragment of an audio recording of a telephone consultation between a general practitioner and a patient in UK NHS primary care. While I am open to any and all analytic observations, I would particularly welcome observations that relate to interactional difficulties arising for the GP and the patient and how these are negotiated in this fragment. Ethical approval from the NHS Health Research Authority (23/YH/0249) was obtained for the collection of the data. The participating general practitioner and patient provided informed consent for audio-recording and for playing the anonymised recording in data sessions. We ask you not to cite, circulate or reproduce the data.

Heidi Kevoe-Feldman[1] & Galina Bolden[2]
[1]Northeastern University, [2]Rutgers University

"I don't wanna die": Managing caller panic in high-stakes emergency calls

In this data session, we will examine a U.S. 9-1-1 emergency call during which the caller dies. The data is an audio recording of a 9-1-1 emergency call, made publicly available just after the incident and transcribed using the Jeffersonian transcription method. The incident involves a caller's final moments as she succumbs to flood waters filling her vehicle. We will focus on the dispatcher's management of the highly distressed caller. Our analytic questions are:

How does the call taker maintain the institutional agenda of the call in the face of caller distress?

What (if any) interactional traces of call-taker burnout might be evident in the call?

Are there effective practices for managing caller panic that supervisors can translate into training?

Overall, the data session aims to deepen our understanding of interactions during high-stakes emergency calls (e.g., Kevoe-Feldman, 2021; Hepburn & Potter, 2007; Paoletti, 2012; Tracy & Tracy, 1988; Whalen & Zimmerman, 1988) and of how to apply analytical findings to training practices.

Heidi Meyer & Sjaan Gomersall
The University of Queensland

'We don't use that language here!' – Clinical dietetics and how dietary health behaviour change talk occurs in type 2 diabetes community healthcare

Introduction: How healthcare professionals and patients talk about health behaviour change can impact patient health outcomes and patient experience of healthcare. The therapeutic benefit of consultations extends beyond the medical expertise of the clinician, and there is value in the social and relational aspects of the interaction itself. With type 2 diabetes (T2D) cases rising globally, methods to document, quantify and improve dietary health behaviour change talk in clinical settings are of critical importance. Dietitian-led healthcare interactions that focus solely on diet and dietary habits as a lifestyle behaviour have been scarcely studied using CA to date. This study, therefore, aims to explore the conversational strategies used by dietitians when engaging in dietary health behaviour change talk with clients living with type 2 diabetes.

Data to be presented: This data session proposes to present video-recorded excerpts from a corpus of one-to-one clinical dietetic healthcare interactions within a community-based, interprofessional type 2 diabetes clinic in Brisbane, Queensland, Australia. Data will show adult patients living with type 2 diabetes interacting with a clinical dietitian, with dietary health behaviour talk covering recent (recalled) dietary behaviour. Interactions often progress to future dietary health behaviour and negotiations around the same. Ethical permission has been granted by The University of Queensland (ref: 2023/HE000578) for deidentified data to be presented for research purposes.

Johanna Lindell
University of Copenhagen

Evidentials and epistemic humility in assessment consultations

Growing migration to Denmark and resulting population diversity may result in increasing health inquality, as migrant patients with complex problems often face significant obstacles to communicating their problems in part due to language barriers (Rosenkrands et al. 2020). Some patients are in the health care system for years, even decades, with un- or misdiagnosed illnesses due in part to miscommunication (Sodemann 2020).

For this data session, I draw on a corpus of 10 triadic assessment consultations between physician, patient and interpreter at a pioneering clinic for migrant patients with complex chronic physical (and often also mental) health issues.

The presented sample draws on a collection of pre-questions, questions and candidate answers from the audio-recorded consultations with a focus on the physicians´ marked K- stance (Heritage, 2012). The selected consultations are conducted in Danish and Levantine Arabic.

In the data session, I would invite shared investigation of how physicians use direct and indirect evidentials to downgrade their epistemic stance, orient to the possible fallibility of their knowledge and position the patient as a reliable witness with superior epistemic rights to their own medical history, and ask if and how this ´epistemic humility´ and empathy may be entwined.

Ethical permission was given by SDU-RIO, notification number 11.240 (20-11-2020) and oral consent obtained from all participants.

References

Rosenkrands, H. S., Kristiansen, M., Hansen, A. L., & Norredam, M. (2020). Providing targeted healthcare services for immigrants with complex health needs. Danish Medical Journal, 67(10), [A03190160].https://ugeskriftet.dk/dmj/providingtargeted-healthcare services-immigrants-complex-health-needs

Heritage, J. (2012). Epistemics in Conversation. In J. Sidnell & T. Stivers (Eds.) *The Handbook of Conversation Analysis* (pp. 370-394). Wiley-Blackwell
https://doiorg.ep.fjernadgang.kb.dk/10.1002/9781118325001.ch18

Sodemann, M. (2020). *Det du ikke ved får patienten ondt af: Tværkulturel klinik og kommunikation*. (Eget forlag). http://www.ouh.dk/laerebo

Lieve van Hengel
Vrije Universiteit Amsterdam

Categorization Work in Group Discussions on Child Vaccination

In the Netherlands, children get vaccinated against 12 infectious diseases, scheduled to be delivered to children between 3 months and 14 years. Across the range of vaccines within the National Immunization Program, the participation rate among the Dutch-Moroccan and Dutch-Turkish children in Rotterdam and Amsterdam is the lowest, prompting our interest in studying it. During my PhD-project, naturally occurring group discussions with Dutch-Moroccan and Dutch-Turkish parents were recorded. These conversations haven taken place in Dutch, Moroccan, or Turkish and have been subsequently translated into English. Ethical permission to record these conversations and show the data during data sessions was obtained.

During this data session, we will look at fragments of video-recorded conversation featuring Dutch-Moroccan and/or Dutch-Turkish parents. The recordings come from the above mentioned naturally occurring group discussions that are facilitated by an organization that provides workshops to parents with migrant backgrounds who currently reside in the Netherlands, a traditionally hard-to-reach population. During these discussions, parents, along with a designated 'debate leader', engage in conversations covering a range of topics related to child upbringing, spanning from domestic violence to fostering healthy lifestyles. As part of these discussions, they also talk about child vaccination. While exploring the data on the topic of child vaccination, significant attention is given to the categorization work carried out by parents. This aspect will be the primary focus of our data session.

Maria Stubbe
University of Otago

‘For young people like you’: Negotiating age categories in primary care consultations

Data description:
The video/audio data excerpts to be examined are from a collection of routine New Zealand primary care consultations where participants make explicit references to age and/or stage of life. The data is from the ARCH Corpus of Health Interactions, collected progressively since 2004 and held at Otago University, Wellington in New Zealand.

Focus of data session:
A person’s age or stage of life often has clinical relevance for diagnosis and treatment. References to age or stage of life in our collection are often treated as unproblematic by participants, but sometimes occasion negotiation, resistance or interactional ‘trouble’. For instance, participants may be seen to contest the definition or predicates of a given age category, to resist being categorised in a particular way, or to orient to age categorisation as a delicate matter. This data session will examine the interactional work being done by age categorisation sequences in selected excerpts, especially where categories of age or stage of life appear to be contested or framed differently by the participants.

Ethical permissions:
Data held in the ARCH Corpus are permanently archived (with consent of participants) for unspecified future re-use in research and education. This allows sharing of de-identified video/audio excerpts and transcripts with authorised researchers and educators. Ethical permission for the specific project ‘Age and identity in healthcare interactions’ was granted by the NZ Health and Disability Ethics Committees (Ref:17-CEN/26/AM03).

Rebecca K. Barnes & Adaku Agwunobi
University of Oxford

Identifying problems for action in pharmacist-led structured medication reviews

We will be sharing data from the OSCAR Study which is investigating the real-world implementation of ‘structured medication reviews’ in primary care: ‘A structured, critical examination of a patient’s medicines with the objective of reaching an agreement with the patient about the continued appropriateness and effectiveness of the treatment, optimizing the impact of medicines, minimizing the number of medication related problems and reducing waste’ (Room for Review, 2002). These clinical medication reviews are for people who have complex or problematic polypharmacy and are led by GP-practice based pharmacists who have access to patients’ electronic health records. The reviews are conducted either in the GP surgery, over the telephone or, if necessary, in patient’s own homes.

To date we have collected recordings in eight different GP practices between nine pharmacists and 33 patients living with multiple long-term conditions and taking multiple medicines (25 video-recordings of GP surgery reviews; 5 audio-recordings of telephone reviews and 3 video-recordings of reviews in care homes). We are interested in how pharmacists identify problems for action, specifically around patients' experiences of side-effects. In this data session we will be working with a video-recording and transcript of a face-to-face review between a pharmacist and patient at their GP-practice. Data are in British English.

Data collection for this study was approved by an NHS Research Ethics Committee (22/SC/0373). All participants gave permission for pseudonymised clips from their recordings and transcribed excerpts to be used for the purposes of research, training and dissemination.

Valeria Barbieri
University of Modena and Reggio Emilia

Miscommunication in medical interaction: problems of understanding in doctor-patient consultation

The extract proposed is a 5-minute-long sequence from an oncology-related visit, videorecorded in one general hospital in the Emilia Romagna region (North Italy). It is part of a corpus of 103 visits, which have been collected in 5 hospital units for two projects funded by the University of Modena and Reggio Emilia. Data collection started in 2021 and it is still in progress. The project aim is to investigate doctors' and patients' actions and conducts, their orientation to participation and shared-decision making

My PhD project contributes to this larger project, with a focus on miscommunication. It is quite common to find cases in which the progression of the ongoing activity is suspended to solve moments of misunderstanding, misalignment, disengagement, displaying asymmetry of knowledge and perspective. The aim of my research is to identify the phenomena related to this domain, analyze them and account for causes, frame in which they occur, and how participants solve this obstacle.

Participants' consent was obtained according to Italian law n. 196/2003 and EU Regulation n. 2016/679, which regulate the handling of personal and sensitive data: images and voices are anonymized with filters.

The sequence at issue is taken from an oncological visit with a middle-aged woman, who is suffering from a breast cancer. At the time of this videorecording, she had already undergone chemotherapy. The visit precedes surgery, where the two present surgeons, provide information about the results of the chemotherapy rounds, the surgery she will have, and other more general medical information.

Virginia Calabria, Charlotte Albury & Paul Aveyard
University of Oxford

Not being able to exercise: how GPs treat patients' accounts based on mental vs physical health co-morbidities with diabetes

This data session focuses on data from a project looking at how practitioners give lifestyle advice during diabetes annual review consultations with people living with type-two diabetes (T2D). GPs follow a health check list that includes tests related to diabetes values (blood, cholesterol, kidney function an HbA1c), physical examinations (height, weight and BMI), medication reviews, and questions about lifestyle (smoking habits, alcohol intake, diet and physical activity) and mental health. These are followed by advice and suggestions (including, if patients agree, referrals to smoke-cessation programs, dieticians or weight-loss programs).

The corpus, from which two excerpts are selected for this data session, consists of 23 hours of face-to-face and telephone consultations between GPs and/or diabetic nurses and people with T2D. It is made up of 81 consultations in medical practices in England, Wales and Scotland, for a total of 93 participants: 71 patients interacting with 17 practitioners, plus 3 carers, 1 child and 1 student nurse. Data from the project were recorded as part of the 'Addressing lifestyle behaviours in the management of diabetes and hypertension' study (Ethics reference: 21/PR/0241), and can be shown for research purposes, but not recorded or shared with third parties.

The aim in this data session is to compare two pieces of data, each presenting a sequence in which the GP asks about the patient's physical activity and the patient provides an account for the lack thereof. In one excerpt, the patient provides a physical reason; in the other, the patient brings up a mental-health related condition. Whilst the distinction between these two aspects is not necessarily clear-cut, we are interested in seeing how GPs respond to the emergence of different types of multiple long-term conditions-multimorbidity (MLTC-M) with T2D, as reasons for not being able to follow lifestyle advice (e.g., doing exercise, losing weight, etc.).

Yicen Guo
University of Oxford

Interactional Benefits and Challenges of Adult Patient Companions' Participation in Chinese Medical Consultations

Accompanied adult medical consultations are widespread in China but discouraged in many hospitals. This mismatch between institutional policy and reality and its potential impact on patient care is important to investigate, especially considering the huge volume of medical visits in Chinese public hospitals. Although the role of patient companions in medical interaction is beginning to draw more academic attention, few conversation analytic studies have addressed this phenomenon.

In order to investigate this, I collected audio-recordings of 32 consultations in the Department of Vascular Surgery at Peking Union Medical College Hospital in August 2022. Overall, 32 patients and 24 companions were involved in the audio recordings and the data have a total duration of three hours and 42 minutes. During the visits, two junior doctors recorded the patients' medical history and conducted initial physical examinations before the patients saw the senior surgeon.

I gained verbal consent to record from all participants prior to data collection and analysis, including the doctor and his assistant, each patient and their companion for a pilot study. The language of the data is Mandarin Chinese. Relevant extracts have been translated into English and transcribed according to conventions developed by Gail Jefferson.

CA&CE 2024 DELEGATE LIST in alphabetical order by first name

Adam Brandt	Newcastle University
Aija Logren	University of Eastern Finland
Aleksandra Borek	University of Oxford
Alison Pilnick	Manchester Metropolitan University
Amanda McArthur	Johns Hopkins Medicine
Ana Ostermann	Universidade do Vale do Rio dos Sinos
Anca-Cristina Sterie	Lausanne University Hospital
Andrea Bruun	Kingston University
Anna Lindström	Uppsala university
Anna Sowerbutts	University College London
Anne Elizabeth Clark White	University of California San Diego
Annesofie Ishøy Nielsen	Copenhagen University Hospital
Annette Klarenbeek	HU University of Applied Sciences Utrecht
Anouk Teunissen	HU University of Applied Sciences Utrecht
Ayeshah Syed	Universiti Malaya
Bethan Benwell	University of Stirling
Blair Ying Jin	Hong Kong Polytechnic University
Bogdana Humă	Vrije Universiteit Amsterdam
Bregje de Kok	University of Amsterdam
Caroline Tietbohl	University of Colorado Anschutz Medical Campus
Catherine E. Brouwer	University of Southern Denmark
Catherine J. Woods	University of Oxford
Catrin Rhys	Ulster University
Charles Antaki	Loughborough University
Charlotte Albury	University of Oxford
Chase Wesley Raymond	University of Colorado
Chloe Phillips	University of Oxford
Chloe Shaw	University of Bristol
Christopher J. Koenig	San Francisco State University
Clara Iversen	Uppsala university
Clare Jackson	University Of York
Colin Macdougall	Warwick Medical School
Daniele Urlotti	University of Modena and Reggio Emilia
Danielle Jones	University of Bradford
Deborah Chinn	King's College London
Dongyi Zhu	Shaanxi Normal University
Eniola Boluwaduro	Radboud Universiteit
Evi Dalmaijer	Radboud Universiteit
Felicity Slocombe	Loughborough University
Fiona Stevenson	University College London
Galina Bolden	Rutgers University
Geraldine M. Leydon	University of Southampton
Gilian Noord	University of Nottingham
Heidi Kevoe-Feldman	Northeastern University
Heidi Meyer	University of Queensland
Irene Kelder	HU University of Applied Sciences Utrecht / Amsterdam University
Iris van der Scheer	University College London
Isabel Windeatt-Harrison	University of Sheffield
Jack B. Joyce	University of Oxford
Jo Sims	Loughborough University
Johanna Lindell	University of Copenhagen
Johanna Ruusuvuori	Tampere University
Julie Norton	University of Leicester
Kleopatra Sideridou	Newcastle University

Laura Jenkins	Loughborough University
Lauren Elizabeth Bridgstock	University of Nottingham
Lieve van Hengel	Vrije Universiteit Amsterdam
Liliia Bespala	Zaporizhzhia State Medical & Pharmaceutical University University of Oxford
Lucy Selman	University of Bristol
Maddie Tremblett	University of the West of England
Magdalena Solarek-Gliniewicz	University of Oslo
Marco Pino	Loughborough University
Margo Turnbull	Hong Kong Polytechnic University
Maria Stubbe	Otago University
Marie Flinkfeldt	Uppsala University
Marine Riou	Université Lumière Lyon 2
Marit Nygård Halvorsen	Oslo Metropolitan University
Mary Catherine Beach	Johns Hopkins University
Merran Toerien	University of York
Mimi Suzuki	City, University of London
Nan Wang	Hunan University
Nick Smith	University of Leicester
Pamela M. Rogerson Revell	University of Leicester
Petra W.J. Sneijder	HU University of Applied Sciences Utrecht
Piera Margutti	University of Modena & Reggio Emilia
Rachael Drewery	University of Oxford
Rebecca Anderson-Kittow	University of Oxford
Rebecca K. Barnes	University of Oxford
Rebecca O'Brien	University of Nottingham
Roisin Dillon	University of Oxford
Rose McCabe	City, University of London
Rosey Meiring	Hywel Dda University Health Board
Ruiyu Tang	Ocean University of China
Ruth Parry	Loughborough University
S. Sanaa Hyder	The University of Manchester
Sara Keel	University of Zurich
Sjaan Gomersall	University of Queensland
Steven Bloch	University College London
Suzanne Beeke	University College London
Timothy Halkowski	University of Wisconsin - Stevens Point
Valeria Barbieri	Università di Modena e Reggio Emilia
Virginia Calabria	University of Oxford
Xinxin Yang	University Of Sheffield
Yicen Guo	University of Oxford
Yinong Tian	Shandong University