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Understanding telephone consultations in primary health care: A conversation analytic study

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Thesis submitted to the University of Nottingham for the degree of Doctor of Philosophy

November, 2025

Abstract

The context in which health care is delivered around the world has changed dramatically in recent years. The COVID-19 pandemic resulted in the rapid acceleration of various forms of 'remote' consultations in primary care, including telephone consultations. While research shows that, for a wide variety of patient groups, telephone consultations can be both safe and appropriate, little is known about how patients and GPs actually conduct them, and the limited evidence is largely based on interview-based data.

This thesis contributes to this knowledge gap by presenting a conversation analytic study examining how GPs and patients organise and manage their interaction when consulting over the phone. The dataset comprises twenty-nine audio-recordings of naturally occurring GP–patient telephone consultations, collected across three general practices in a single county in England. The analysis explicates some of the interactional practices through which GPs and patients manage key aspects of telephone consultations. The first analysis chapter focuses on medication reviews, now commonly conducted over the phone, showing how discussions around medication effectiveness, tolerability and necessity are routinely structured, and how the sequential organisation and question design subtly shape patients' opportunities to participate in decision-making. The second chapter examines closing sequences, showing how GPs' questions during closings constrain the disclosure of additional questions and concerns. The third chapter focuses on silences during GPs' background activity, demonstrating that the absence of visual cues requires additional interactional work in order to present these silences as relevant, meaningful parts of the consultation. By documenting these interactional practices, the study provides a detailed account of how GPs and patients conduct telephone consultations. The findings highlight that a telephone consultation is not simply a substitute version of a face-to-face encounter but constitutes a distinct interactional environment requiring particular and additional interactional work. This research contributes to the growing body of conversation analytic health care studies and offers evidence-based considerations and recommendations for clinical training, practice and policy.

Acknowledgements

This thesis would not have been possible without funding from the Economic and Social Research Council (ESRC). I am equally grateful to the incredible patients and general practitioners who participated in this study, as well as the many wonderful receptionists, research managers and other practice staff members whose time and effort made this possible.

I am deeply grateful to my supervisors Professor Alison Pilnick, Professor Elizabeth Stokoe, Professor Tony Avery and Professor Rachel Fyson for your continued support, advice and encouragement, not only during supervision meetings but also in the many informal conversations in the corridor that kept me motivated. I cannot thank you enough for the opportunity you have given me and for helping me going through difficult times. Without you this project would undoubtedly not have been possible.

I am thankful to my family, friends and my wonderful partner for looking out for me, knowing when to leave me be, and for helping me switch off when I needed it most. Your love, patience and encouragement carried me through this journey.

Abbreviations

CA	Conversation Analysis
CI	Chief Investigator
COVID-19	Coronavirus Disease 2019
CQC	Care Quality Commission
ESRC	Economic and Social Research Council
GCP	Good Clinical Practice
GP	General Practitioner
HRA	Health Research Authority
IT	Information Technology
NHS	National Health Service
NIHR	National Institute for Health and Care Research
NP	Nurse Practitioner
PI	Principal Investigator
PIS	Patient Information Sheet
PPI	Patient and Public Involvement
RCGP	Royal College of General Practitioners
RDN	Research Delivery Network
REC	Research Ethics Committee
UK	United Kingdom
UoN	University of Nottingham

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Chapter 1. Introduction

The context in which health care is delivered around the world has changed dramatically over the recent years. The COVID-19 pandemic resulted in the rapid acceleration of various forms of 'remote' consultations in primary care, including telephone consultations (Khan *et al.*, 2020; Krist *et al.*, 2020; Murphy *et al.*, 2021), with many practices routinising remote services as a tool of delivering health care (Royal College of General Practitioners, 2020). This change to service delivery allowed care provision to continue whilst limiting the risk of COVID-19 transmission. However, due to their perceived flexibility in terms of patient access, remote services in health care are here to stay (Dean, 2022). This accords with the 2019 NHS Long Term Plan vision that "patients will be able to avoid up to a third of face-to-face outpatient visits" (NHS, 2019, p. 28) and aligns with the NHS Ten Year Plan's emphasis on moving from analogue to digital services (NHS, 2025a), thereby helping to manage the ongoing rise of patient demand within a limited capacity. While the term 'remote' entails both telephone and video consultations and despite the potential of video consulting during the COVID-19 pandemic (Royal College of General Practitioners, 2021a), contact with GP

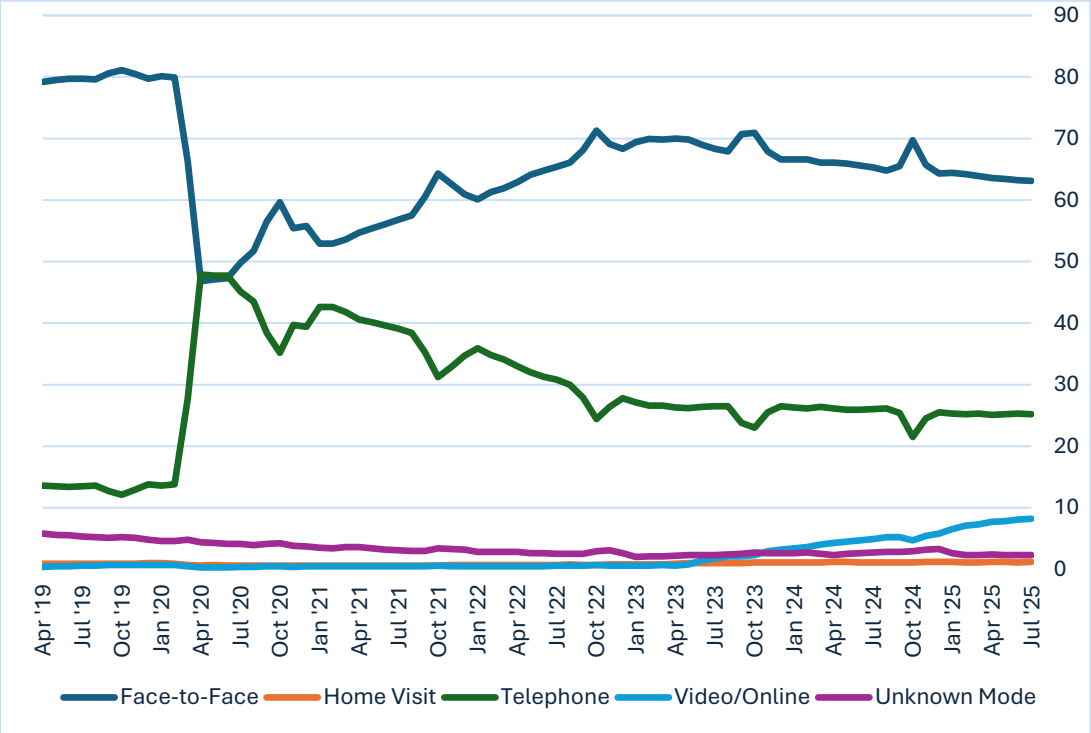

Figure 1. Distribution UK NHS General Practice appointment types (NHS, 2025b)

surgeries for this project and Figure 1 above show that the vast majority of remote consultations are now taking place over the telephone.

Historians of medicine have shown that the use of the telephone as a tool for delivering health care is, in fact, not new at all but has been used for this purpose since its invention in 1876 (Car & Sheikh, 2003). By the 1970s, clinical enthusiasts described the telephone as equally important as standard medical equipment, such as the stethoscope (Hallam, 1993). However, despite the increased use of telephones in daily life and a range of benefits that the telephone offers in medical encounters, the role of the telephone in medical practice remained until recently, for many clinicians, highly controversial (Delichatsios *et al.*, 1998). More recent pre-pandemic evidence suggested that telephone consultations were nevertheless a promising alternative to face-to-face appointments in general practice care (Ekeland *et al.,* 2010), especially in rural and remote areas (McGrail & Humphreys, 2009). Much existing research focuses on comparing telephone and face-to-face appointments (Car & Sheikh, 2003; Hammersley *et al.,* 2019; McKinstry *et al.,* 2009; Pinnock *et al.,* 2005) and therefore is mainly concerned with the relative risks and benefits the telephone is offering. Given the current evidence, primarily based on elicited accounts of patients and GPs, it seems that telephone consultations offer an appropriate alternative in some settings but that this evidence is not necessarily generalisable to the whole field of primary health care or to all populations served. The ways in which patients and GPs *actually conduct* a telephone consultation are still little understood.

The purpose of this PhD thesis is to describe in detail what aspects of telephone consultations look like, and to examine how they work in practice. It will focus on identifying some of the core interactional practices of telephone consultations and it will investigate how these core practices are designed and delivered and what these instances reveal about the affordances and limitations of the telephone as a medium for primary health care. Across three specific contexts, this thesis will demonstrate what works effectively, how GPs and patients manage the affordances and limitations of the telephone and, ultimately, how they are collaboratively produced. By identifying, describing, and sharing what constitutes effective practice in these contexts, the findings presented in this

thesis may aid medical professionals and policy makers by developing or improving guidance on how to communicate with patients over the telephone.

I begin in Chapter 2 by reviewing the existing literature on telephone consultations. The literature review explores how the expansion of remote consultations, particularly telephone consultations, has changed the delivery of primary health care. The routinised use of telephone consultations, caused by the COVID-19 pandemic, potentially improved the general accessibility and efficiency of (primary) health care but also raised important questions regarding its possible risks. I will draw on a wide range of empirical studies, highlighting both the potential benefits and disadvantages regarding the safety, effectiveness and acceptability of telephone-mediated care. In doing so, I will identify a critical gap in the current body of literature: while we know what clinicians and patients *say* about remote consultations, we still know little about what actually *happens* during these encounters.

Chapter 3 introduces conversation analysis (from hereon CA) as the methodological lens through which this thesis examines GP-patient communication in *naturally occurring* telephone consultations. I will show that, rather than relying on retrospective accounts or simulated encounters, CA allows for a detailed exploration of how interactants produce, organise and manage their actions in real-time talk. Through reviewing existing CA studies focusing on health care communication, this chapter demonstrates the potential of this method to put forward evidence-based rigorous recommendations regarding which interactional practices do or do not work best in particular settings. I will claim that, only by carefully and systematically exploring the actual interaction in telephone consultation, we can put forward concrete recommendations for medical professionals, policy makers and educational curricula developers.

Following the methodological grounding presented in Chapter 3, in Chapter 4 I will describe the specific methods and practical design of this study. I will detail the participant recruitment process, how I recorded, stored and transcribed the data, offer a descriptive overview of the data and discuss a wide range of associated ethical considerations I took into account. The chapter also includes a description of how I analysed the data. Rather than approaching it with preconceived ideas about the values (e.g., strengths and limitations) of telephone

consultations, I will instead focus on identifying what GPs and patients *themselves* treat as relevant within their interaction. Therefore, the three analysis chapters presented in this thesis prioritise participants' orientations over my interpretations.

The findings are presented in Chapter 5, 6 and 7; each examining a distinct feature of telephone consultations. Chapter 5 examines a particular type of consultation which was prevalent in my dataset: the medication review. By focusing on how GPs and patients discuss medication continuation, reduction, or discontinuation, this chapter explores the subtle interactional work involved in these seemingly routine encounters. For instance, I will show how GPs' formulations during these discussions (e.g., "are you happy to keep taking that?") often implicitly favour continuation of medication, reinforcing a certain degree of medical authority. While medication reviews may be regarded as straightforward tasks that can be conducted effectively over the phone, the findings presented in this chapter suggest these discussions are more complex and interactionally delicate than might be assumed.

Chapter 6 focuses on a particular phase in the consultation: the closing. This phase of a consultation plays a crucial role in ensuring that (all of) the patient's concerns are fully addressed. It may offer patients the final opportunity to raise questions or concerns that they could not have fitted into the flow of the conversation. Previous research of face-to-face consultations already established that many additional concerns may remain undiscussed (Heritage *et al.*, 2007). Interview-based evidence suggests that this issue seems to be intensified in telephone consultations (Rosen *et al.*, 2022). However, how this actually unfolds in real-time telephone is still underexplored. I will focus explicitly on the ways in which GPs check whether the reason for the consultation has been addressed and whether patients are willing to bring the consultation to an end. Understanding these practices is especially important in relation to current clinical communication models (such as the Calgary-Cambridge model) that lack detail on precisely *how* GPs should elicit additional concerns.

Chapter 7 examines another interactional feature frequently observed in my data: how periods of silence co-occurring with GP's 'background work' are made meaningful through a range of interactional practices. Despite their

ubiquity, these silences are an underexplored aspect of primary care telephone consultations. My findings show that, when patients are not able to see the GP attending to background tasks, these silences do require a range of additional interactional work. I will show that and how silences in telephone consultations are not simply absences of talk but can carry important interactional significance, particularly when coinciding with GPs' background activities.

In the final chapter, I will discuss how these reported findings fit within the broader context of this thesis. I will examine how they build upon, challenge, and refine the existing body of literature and what implications they hold for future research and practice. I will end by outlining the strengths and limitations of my work and suggesting directions for future research in remote primary care communication.

Chapter 2. Literature review

2.1 Introduction

The literature/narrative review that will be presented in this chapter is conducted as per the paper of Arksey and O'Malley (2005) in which the authors describe when such a review would be an appropriate method and how this kind of literature review should be undertaken. Arksey and O'Malley (2005) propose that such an approach is suitable for both examining the extent, range and nature of a research study and for identifying research gaps in the existing literature, which makes it a fruitful approach in the context of this PhD study. One of the key features of such a review is the requirement to identify all relevant literature without including or excluding any sources based on the design of these studies.

Arksey and O'Malley (2005) describe an iterative step-by-step process of reviewing the field consisting of five different stages. After identifying the research questions, and then identifying which specific aspects of the research questions are most important, the second step is to identify relevant studies. The main point of a narrative review is to be as comprehensive as possible in finding studies. In this literature review, studies were searched via NUsearch (the University of Nottingham's library discovery tool) and other sources; electronic databases (JSTOR, Scopus, Web of Science), reference lists, hand-searching of key journals (e.g., Journal of Telemedicine and Telecare) and existing networks, relevant organisations and conferences. Search terms I used included 'telephone consultations', 'remote consultations', 'remote care', 'telehealth', 'telemedicine', 'telecare', reflecting an overarching focus on forms of care that are mediated by technology rather than in-person interaction. In order to capture the broader landscape of remote interactions in different health care settings, I also included the search terms 'digital health', 'virtual care', 'online consultations' and 'video consultations'. Checking the bibliographies and reference and citation tracking of selected studies turned out to be particularly valuable. This process did identify further references, until a saturation point was reached where virtually no new ones were being identified.

Step 3 involves selecting relevant studies for the end product by devising criteria in a post hoc manner, in which these criteria are evolving along the process itself. The inclusion criteria used in this literature review concerned the type of study, type of method and data, type of remote consultation, geographical location of health care system and patient group. Although I did not exclude any types of consultation, patient groups or geographical locations in advance, I ultimately prioritised studies focusing on telephone consultations in a primary care setting within the UK NHS. The fourth step described by Arksey and O'Malley (2005) includes charting the data, which was done by setting up an extended annotated bibliography, offering the aims of the selected studies, the methodology, used research data and a glossary of their main findings.

The final step is collating, summarising and reporting the results, which is done in the remainder of this chapter. It will focus on the advantages and harms associated with remote care (2.2) and on what to consider when implementing remote care services (2.3). These sections draw on more contextual and policy-oriented literature that situates the subsequent, more focused discussions. Including this wider body of literature is essential because previous research on remote care often evaluated the use of remote technologies in isolation, rather than examining how they are embedded within wider healthcare systems (Herlitz *et al.*, 2023). Despite the fact this literature is not the primary empirical focus of this thesis, engaging with this literature is nevertheless useful for contextualising the development and practical delivery of remote care services, including the routine use of telephone consultations in primary care practice. Subsequently, in section 2.4 I will discuss how the COVID-19 pandemic changed the stance towards remote care, how this resulted in the rush to video consultations (2.5) and why video consultations were never fully adopted (2.6). These sections demonstrate that, despite strong policy and clinical expectations around video consultations, telephone consultations have become the most enduring and widely used form of remote primary care delivery. Therefore, these sections review literature that, whilst not directly focused on the central analytic concerns of this thesis, provides the necessary contextual background for understanding the wider development, implementation and normalisation of telephone consultations within contemporary primary care. I will then turn to what

constitutes the core literature for this PhD thesis, namely research particularly on telephone consultations. This more directly relevant (although limited) body of literature focuses on how telephone-mediated clinical interactions are interactionally organised in practice, and therefore aligns most closely with the aims and subsequent findings of this thesis. Section 2.7 will take a closer look at telephone consultations, starting with an overview of the literature on comparing telephone to face-to-face consultations (2.7.1), their interactional organisation (2.7.2), some reported communicative challenges associated with telephone consultations (2.7.3) as well as an overview of the (limited) inclusion of telephone communication skills in medical training and education curricula (2.7.4). Finally, Section 2.8 provides a brief summary and explains how this PhD study will make an original contribution to the current knowledge field.

2.2 Benefits and risks of remote health care

Pre-pandemic evidence had already suggested that remote consultations are safe and efficient (Atherton *et al.*, 2018; Atherton *et al.*, 2020; Donaghy *et al.*, 2019; Ignatowicz *et al.*, 2019; Thiyagarajan *et al.*, 2020) and reported that remote consultations may improve access to UK general practice for working adults, parents, those with anxiety or agoraphobia, patients unable to leave the house, and those living in remote locations (Khan *et al.*, 2020). Improving access to care extends to the fact that remote consultations seem to effectively reduce no-show visits (Qin *et al.*, 2024; Shao *et al.*, 2024). It is also environmentally friendly as patients are not required to travel to their GP practice, reducing emissions (Dullet *et al.*, 2017). In addition, a significant body of studies highlighted that remote health care is beneficial for particular patient groups, such as patients with diabetes and hypertension (Brant *et al.*, 2016), patients with autism spectrum disorders (Ferguson *et al.*, 2019), mental health concerns (Varga *et al.*, 2024), in obstetrics and gynaecology (DeNicola *et al.*, 2020), in the management of chronic conditions (Jin *et al.*, 2019; McFarland *et al.*, 2019) and patients dealing with cardiac rehabilitation (Rawstorn *et al.*, 2016).

Furthermore, Raj *et al.* (2022) reported that, in a US context, older adults stand to benefit tremendously from remote care because they often need to visit

different providers or specialists due to multiple chronic conditions. However, other studies suggested that older adults are less likely to make use of remote care because of barriers such as low health literacy (Koops van 't Jagt *et al.*, 2019) and low digital literacy (Tsai *et al.*, 2017). If, in such cases, a caregiver supports older patients when utilising remote care services, these caregivers indeed describe concerns about their older relative's digital literacy and ability to independently use the required technology (Raj *et al.*, 2022).

Regardless of the reported benefits of remote health care and the positive stance of patients and clinicians towards the use of remote consultation systems, multiple studies (Greenhalgh *et al.*, 2018; Hammersley *et al.*, 2019; Liberati *et al.*, 2021; Rosen *et al.*, 2022; Wherton *et al.*, 2021) stated that a doctor-patient relationship, that had been established in a previous face-to-face consultation, is key in the success of remote consultations. An already established therapeutic relationship allows both medical professionals and patients to be more relaxed about remote consultations (Wherton *et al.*, 2021), whereas building a therapeutic relationship remotely can be experienced as problematic (Liberati *et al.*, 2021; Onor & Misan, 2005; Papoutsi *et al.*, 2022). Similarly, when a medical condition had already been diagnosed in a face-to-face encounter, patients and clinicians also feel more comfortable about remote follow-up consulting (McKinstry *et al.*, 2009).

In addition to the difficulty of establishing or maintaining a therapeutic relationship, Rosen *et al.* (2022) described two other risks associated with remote consultations in UK general practice. They conducted semi-structured interviews with patients and clinicians. Rosen *et al.* (2022) concluded that (a) the information in remote health care encounters is inadequate in both content and tone, and (b) a lot of concerns remain unsurfaced and caring routines are lost. Furthermore, regarding the quality of care, Rosen *et al.* (2022) stated that clinicians reported that in remote consultations (i) diagnoses are often missed or delayed (since traditional physical examinations are not possible), (ii) safeguarding is compromised (due to the lack of privacy) and (iii) patients are over-investigated or over-treated, to make up for the lack of information. Moreover, it is possible that remote consultations increase health inequalities. Speakers of English as an additional language may be disadvantaged, and it may

also negatively impact the therapeutic relationship and patient safety as well as patient satisfaction (Khan *et al.*, 2020; Parker *et al.*, 2021). Similarly, Majeed *et al.* (2020) reported that on the one hand, remote consulting may offer safe and timely assessment for many patients but on the other hand it may be problematic for English as an additional language speakers, hard of hearing patients and technologically illiterate patients.

As mentioned above, previous research suggested that in remote consultations a lot of concerns can remain unsurfaced and as a result of that diagnoses are often missed or delayed (Rosen *et al.*, 2022), since a clinician needs maximum information in order to reach a correct diagnosis. From this perspective, a study by Khan *et al.* (2020) claimed that some patients may not disclose health problems over the phone, including symptoms of relatively severe diseases. A lack of privacy may also make disclosure of domestic violence, safeguarding issues, and mental health problems difficult. In addition, in an interview-based study by Liberati *et al.* (2021), clinicians expressed more concerns about the effectiveness of remote care in assessments and identifying risks. Especially when clinicians are not able to see patients, it becomes difficult to effectively recognise signs that patients' mental health is deteriorating, for example through a noticeable lack of self-care. It makes it difficult, and in phone consultations perhaps even impossible, to note essential (although subtle) non-verbal cues such as body language and levels of tension. This also means that professionals may partly lose the ability to check a patient's understanding, often visible via non-verbal communication (Little *et al.*, 2015a; Little *et al.*, 2015b). Furthermore, another possible disadvantage is that remote consultations can be less effective for less educated patients lacking necessary literacy skills (Goodyear-Smith *et al.*, 2005; Newhouse *et al.*, 2015; Pearl, 2014).

Hammersley *et al.* (2019) described and compared the content and quality of video, telephone and face-to-face follow-up consultations, in which a clinical relationship had already been established in a face-to-face encounter. The authors recorded and analysed remote consultations in general practices in Scotland, using RIAS (Roter Interaction Analysis System) which is designed to reflect the content and context of dialogues. On average, telephone consultations were slightly (approximately half a minute) shorter than video and notably

shorter (approximately four minutes) than face-to-face appointments. Moreover, telephone and video consultations contained fewer problems raised than face-to-face consultations, which presumably is a factor in face-to-face consultations typically lasting longer. Subsequently, the authors assessed the consultation quality using the RCGP (Royal College of General Practitioners) quality framework. The quality of video and telephone consultations were found to be quite similar. The RIAS data showed that face-to-face consultations were much richer in terms of information provision and advice given, in comparison with telephone and video consultations. Patient satisfaction with telephone and video consultations were similar and patients were most satisfied by face-to-face appointments.

In addition to the risks for patients, an often overlooked implication of consulting remotely relates to clinicians' own experiences of delivering remote care. Payne and Dakin (2024) highlighted how an entire day of telephone consultations, often in physical isolation from colleagues and patients, can lead to a sense of detachment and dissatisfaction. The reduced interpersonal contact contrasts sharply with the aspects of general practice (the face-to-face human contact with both patients and colleagues) that many clinicians find most rewarding (Rosen & Leone, 2022). For some practitioners, however, the option to work remotely offers notable advantages, including greater flexibility, improved work-life balance and a sense of more control over their working day (Payne & Dakin, 2024).

2.3 Implementing remote care services

A study by Atherton and Ziebland (2016) aimed to provide guidance to policymakers, practitioners and researchers for planning, implementing and eventually evaluating alternative forms of primary care consultations. They conducted an ethnographic study at multiple GP surgeries in the UK. As Atherton and Ziebland (2016) highlighted, one thing to take into account when implementing alternatives is that new technologies always cause organisational/professional disruptions and dynamics. For instance, a point worth considering here is how patients could be made aware of alternative

offered options. In addition, the organisation of alternatives within health care settings raises certain considerations, such as how to manage situations where a part-time member of the health care staff does not pick up an urgent email. Another concern is whether patients can deal with the responsibility of communicating by email, fearing that the relative ease of this may result in a stream of emails, meaning that patients over-consult or misrepresent their symptoms, increasing the overall workload for GPs. Moreover, as Newbould *et al.* (2017) stated, the implementation of remote forms of health care appeared more effective in GP surgeries that were well organised, whereas surgeries already facing high workloads prior to implementation experienced greater challenges.

Payne and Dakin (2024) discussed the role of remote consultations in modern day general practice, arguing that there is no one-size-fits-all approach. They emphasise that effective implementation depends on understanding the needs and preference of the local patient population, as well as ensuring that clinicians possess the skills and experience required to deliver safe and appropriate remote care. Building on this perspective, Tipre *et al.* (2024) identified demographic and contextual factors (such as age, level of education, rurality) shaping patients' access to and preference for remote care. They caution that without paying attention to these variations, the implementation and/or expansion of remote care risks exacerbating existing health inequalities. Together, these studies underscore the importance of tailoring remote care models to both practitioner capabilities and patient populations to ensure that it is integrated into primary care in an equitable and sustainable way.

Another body of literature focuses on providing guidance for medical professionals in choosing which (remote) communication modality would be most useful for particular patients under specific circumstances. The UK General Medical Council (2021) encourages the use of remote consultations if (i) the clinical need or treatment request is straightforward; (ii) the patient is able to receive and understand all required information; (iii) there is a safe system for prescribing in place; (iv) the clinician has access to the patient's medical records; (v) a physical examination is not required; and (vi) the patient has the capacity to make informed decision about their treatment. In line with such considerations, Greenhalgh *et al.* (2020a) offered advice and guiding principles

on NHS remote consultations (choosing between telephone or video consultations, how to do a remote consultation, and what to think about when arranging follow-up and next steps in the consultation) with patients with COVID-19. The authors conclude that the telephone is suitable for dealing with patients with mild and uncomplicated symptoms, however video has the benefit of therapeutic presence and offering more visual information useful for diagnosis. Therefore, video may be appropriate for the sicker, more anxious patients, and patients dealing with multiple conditions. Also, patients with hearing impairment may prefer video over telephone, as video offers additional non-verbal cues. Taken together, this underscores the fact that, ideally, remote consultations should be offered as one possible mode of care rather than the default or only option, ensuring that modality choice (face-to-face, video, telephone, etc.) remains responsive to patient needs and clinical appropriateness.

2.4 COVID-19 and remote care

The COVID-19 pandemic resulted in a sudden increase in remote consulting in health care (see Figure 1, page 1). This increase mostly included telephone consulting, a limited use of video and a considerable increase in text messaging (Murphy *et al.*, 2021). Before the pandemic, there was an existing interest in remote consultation services in UK general practice (and in secondary care (Greenhalgh *et al.*, 2018)), partly in response to continuing pressure from policymakers; through changes to the national general practice contract, the General Practice Forward View (NHS, 2016), the Digital-first Primary Care review (NHS, 2018) and the NHS Long Term Plan (NHS, 2019). New technologies, such as AccuRx, SystmOne and other e-consultation services (such as the NHS App), enabled medical professionals to provide remote care in a more accessible way. However, the implementation of remote consulting services was slow due to a combination of technological difficulties, resistance among medical professionals and low patients' uptake (Baines *et al.*, 2020). Eventually, the pressing need to minimise face-to-face contact in the context of the pandemic contributed to overtaking prior resistance among clinicians and precipitated the rapid

implementation of various forms of remote consulting (Barkai *et al.*, 2021; Joy *et al.*, 2020;).

Through successive waves in the pandemic, in general the enthusiastic stance towards remote consultation services varied. One possible explanation for this is because the situation changed from one dictated by the reason to limit COVID-19 infection (Marshall *et al.*, 2020) to, eventually, a situation moving towards a 'new normal' for primary health care post-COVID-19 (Khan *et al.*, 2020). In this changing context, the balance between perceived benefits and harms of remote consulting was subjected to closer attention, including its implications for, for instance, accuracy of diagnoses, continuity of care, and the doctor-patient relationship (Gray *et al.*, 2020; Khan *et al.*, 2020; Swinglehurst *et al.*, 2020). Additionally, already during the early phases of the pandemic, GPs reported concerns about increased clinical risk with remote consultations and, when lockdown eased, some had difficulties setting thresholds for going (partly) back to face-to-face appointments (Murphy *et al.*, 2021).

This changing balance between perceived benefits, risks and practical challenges associated with remote consulting is further illustrated by Murphy *et al.* (2021). They stated that at the beginning of the pandemic, there was general agreement among health care professionals that shifting to remote consultions was necessary. This resulted a quick change to approximately 50% of all GP appointments being delivered remotely by April 2020 (see Figure 1, page 1). Although consultation rates dropped in the beginning of the pandemic, GPs and NPs prioritised vulnerable patient groups, those with mental health difficulties and older patients. Clinicians reported that telephone consultations were adequate for a large proportion of patient concerns. On the other hand, video consultions were used far less frequently, and were considered even less essential as lockdown eased. Indeed, Figure 1 (see page 1) shows that video, even during the pandemic, was never seen as having significant utility.

2.5 The rush to video consultations

In order to limit COVID-19 transmission, numerous health care organisations across the world quickly introduced new service models to avoid in-person

contact. Video consulting was a major part of this development, demanding rapid and extensive technical and cultural change (Greenhalgh *et al.*, 2020b; Shaw *et al.*, 2018). Video consulting services were adopted and used in various ways across many clinical settings and health care systems in various countries (Wong *et al.*, 2021), including the NHS in the UK. Policy across the UK was to implement and expand remote consulting to limit the risk of infection while continuing to deliver safe health care (Wherton *et al.*, 2020). Since the start of the pandemic and lockdown measures in early 2020, the then Secretary of State for Health, Matt Hancock, repeatedly called for NHS services to become remote by default (Mroz *et al.*, 2021).

Before the pandemic, the adoption of video consulting in NHS health care services was slow, resource intensive, time consuming and the actual use of video consulting was primarily limited to particular clinical settings typically with a local clinical leading enthusiast (Shaw *et al.*, 2021). Moreover, according to Wherton *et al.* (2021), video consultations were primarily used for follow-up consultations in chronic (stable) conditions and were particularly adopted in secondary care. These consultations were mainly focused on conveying test results and making sure that patients remained asymptomatic. Furthermore, medical professionals only opted for video consulting in cases where a clinical relationship was already established through a prior face-to-face encounter (Wherton *et al.*, 2021) and where physical examinations were not required but visual cues would still be of vital importance (Donaghy *et al.*, 2019).

In general, research suggested that patients across varying groups and characteristics (age, sex, socioeconomic status, etc.) with a wide range of health care conditions were willing to welcome video consulting services (Berner *et al.*, 2016; Mitzner *et al.*, 2017; Peterson *et al.*, 2016), were generally satisfied with the use of videoconferencing in medical care (Donaghy *et al.*, 2019; Ignatowicz *et al.*, 2019), and were in general capable of participating in video consultations (Greenhalgh *et al.*, 2022). However, while patients reported that they felt video consultations provided a patient-centred environment, both patients and clinicians stated in post-hoc interviews that face-to-face consultations were still preferred over video consultations (Thiyagarajan *et al.*, 2020) and were regarded as the ‘golden standard’ (Donaghy *et al.*, 2019).

At the start of the pandemic, there was quite some optimism that this would serve as a 'burning platform' to push the NHS towards a large-scale adaptation of video consultation services (Greenhalgh *et al.*, 2020b). And, indeed, in March 2020 after NHS England started funding video consulting services, four out of five general practices had access to these services (Murphy *et al.*, 2021). This attempted change to video consulting built on the General Practice Forward View (NHS, 2016), the Digital-first Primary Care review (NHS, 2018) and the NHS long term vision (NHS, 2019). As Wherton *et al.* (2021) report**,** during the pandemic video consultations expanded beyond follow-up consultations in secondary care and were deemed to be appropriate in psychiatry, psychology, counselling, respiratory medicine, and speech and language therapy. In all these instances, visual (non-verbal) communication was key and protective equipment (i.e., wearing face masks) might interfere in face-to-face encounters. However, this replacement with video only worked to a certain extent, as certain conditions requiring a thorough visual examination still required an in-person appointment.

Despite the promise of video consulting and the introduction of social distancing regulations, statistics (see Figure 1, page 1) show that video consulting was never really put into widespread use in UK general practice. In England, video and e-consultations (consultations conducted over the internet, for instance using email and other forms of (instant) messaging) combined added up to approximately less than 0.5% of all appointments in general practice since the beginning of the pandemic. As we can see in Figure 1, the role of video consultations was (and still is) marginal in NHS general practice and did not change as a result of lockdown measures, whereas telephone consultations increased significantly at the start of the pandemic and stayed (although slightly decreasingly) popular throughout the pandemic and post-lockdown.

Despite its low uptake, there are a number of studies reporting potential benefits for video consulting in primary health care. For instance, a study by Parsons *et al.* (2022), which was based on interviews with GPs and patients, looked at GP-patient video consultations as a private service in the UK. They found that in this context most visits were for mental health disorders and also that video consultations do suit patients with mild mental health conditions such as (mild) depression and generalised anxiety disorders. Another interview-based

study by Greenhalgh *et al.* (2022) also found that clinicians judged video consulting as having an added value for patients with mental health problems. Furthermore, Wherton *et al.* (2020) showed that video consultations are also well suited for the sicker, more anxious patients or patients with comorbidities, because it provides additional visual information, diagnostic clues and therapeutic (visual) presence. In some cases, video would even be more appropriate and better than the other remote alternatives for these patient groups. In addition, both Wherton *et al.* (2020) and Greenhalgh *et al.* (2022) reported that patients with deafness or partial hearing found telephone consultations impossible, while such patients able to lip-read, see other non-verbal cues or use the chat function of video consulting software often favoured video consulting instead. In another study by Wherton *et al.* (2021), medical professionals also noted that video consulting could be more beneficial than the other remote alternatives for more paternalistic reasons. As reported by medical professionals, teenagers do not take telephone consultations seriously and are more likely to pay attention if they were seen by video. On top of that, most patients who opted for and were favourable towards video consulting were younger people, who are more experienced in communicating online (Hammersley *et al.*, 2019), which makes video consulting even more promising, especially for younger patients. Other studies with patients and medical professionals reported that video consultations were particularly helpful for working people, people with mobility problems and, again, for people with mental health problems (Donaghy *et al.*, 2019), presumably since in this context visual cues are particularly important because of demeanour, affect, etc.

In addition to the benefits discussed above, Greenhalgh *et al.* (2022) described four other cases in which video does have an added value, as judged by GPs. First, they stated that video consultations are beneficial in out-of-hours contexts, for rapid visual assessment, for reassurance and following up problems that were not resolved. Second, clinicians reported that video consulting could be beneficial for emergency assessment of unwell patients and therewith could assist them in determining if and what kind of care patients require. Third, video consultations were regarded as beneficial for trainees and early-career GPs, as they are usually quite skilful with using online communication technologies and

it offers them the possibility to watch these consultations back and receive feedback on them. Fourth, video consulting was judged as having a benefit for assessing lifestyle and general coping in chronic disease self-management as this requires virtually no physical examinations.

Furthermore, Greenhalgh *et al.* (2016) reported that video consultations do not solely offer potential benefits to patients and clinicians but also to the wider health care system. Besides the fact that patients do not need to travel to a clinic anymore, video consultations are potentially also more cost-effective for the health care system. For instance, Imai *et al.* (2022) reported that in video consultations there is an increased diagnosis accuracy, ultimately causing fewer readmissions in comparison with telephone consultations (Rush *et al.*, 2018). In short, all the studies described in this section underscore the potentially positive impact video consultations can have on primary health care.

2.6 The low uptake of video consultations

As we can see in Figure 1, video consultations never lived up to the expectation of widespread adoption, while telephone consultations made up approximately 50% of all consultations at the start of the pandemic and remained popular throughout. A large number of studies focus on the disadvantages and barriers associated with video consulting in health care. The main reported problem is that with video consultations technical issues with audio and/or video were quite common (Barkai *et al.*, 2021; Donaghy *et al.*, 2019; Hammersley *et al.*, 2019; Seuren *et al.*, 2021; Shaw *et al.*, 2020). Despite a conversation analytic study by Seuren *et al.* (2020) showing that physical examinations for patients with heart failure can be done in video consultations (although quite time-consuming and challenging for both doctors, patients and relatives), they are still regarded as 'clinically risky' by clinicians and are therefore less acceptable for medical professionals (Greenhalgh *et al.*, 2016; Greenhalgh *et al.*, 2022). Another factor causing reluctance to use video among patients was a lack of familiarity with video conferencing and low digital literacy. Especially older patients preferred telephone rather than video consultations (Wherton *et al.*, 2021). On the other

hand, younger patients were found to be more likely to opt for a video consultation (Hammersley *et al.*, 2019).

A study by Greenhalgh *et al.* (2022) specifically focused on why GPs rarely do video consultations in UK general practice. They interviewed and organised focus group discussions with primary care medical staff. In their interviews, GPs indicated that in telephone consultations they were also able to reach a working diagnosis through consulting a patient's medical records, by history taking, and comparing it with their familiarity and own knowledge of a patient. One GP, for instance, reported that video is in essence the same as a telephone call with the complement of being able to see the patient's face. Greenhalgh *et al.* (2022) further elaborated on this and add that most of the interviewed GPs reported that neither telephone nor video consultations were appropriate for dealing with acute medical emergencies. This might imply that video is not giving GPs any additional benefits over audio-only for most routine consultations, and that for anything else – i.e., urgent cases – patients need to be seen in person anyway.

However, a study by Payne and Clarke (2023) showed that video consultations are nevertheless frequently used in (out-of-hours) urgent primary care settings. Focus group discussions with GPs (both in and out-of-hours) in the UK indicated that urgent care GPs used video consultations as 'an adjunct' to the telephone to enhance the initial assessment of patients. They reported that this approach improved the accuracy of directing patients to the appropriate service. This aligns with earlier studies in pre-hospital care, where video consultations were found to enhance the assessment of patients with stroke (Gibson *et al.*, 2013), burns and trauma (Weinstein *et al.*, 2014) and mental health issues (Saurman *et al.*, 2014). Practitioners also highlighted the value of video consultations in strengthening patient rapport, building trust and facilitating bringing in third parties into the consultation if necessary. Other similar studies also reported that, in terms of building rapport, video consultations were regarded as more effective than telephone consultations (Donaghy *et al.*, 2019; Gren *et al.*, 2022). Payne and Clarke (2023) reported that initial assessments of patients usually start on the phone and then might switch to video in cases where this would offer GPs any relevant extra information. GPs reported that it is helpful to switch to video (i) to identify patients who were/seem seriously unwell and

escalate their care; (ii) to justify asking a patient to come in, especially when a patient would have to travel a long distance to the practice; (iii) to help decide which patients could be safely treated without an in-person appointment; and (iv) to assist with directing patients to appropriate services.

Greenhalgh *et al.* (2022) also focused on physical examinations in video consultations. Even GPs who were more experienced with video consults and with remotely performing physical examinations stated that these examinations were often lengthier and challenging for both the GP and patient. Again, clinicians disliked the possible safety implications of such examinations; they felt they could rely less on examinations undertaken by patients compared with examinations undertaken by GPs themselves, which makes video consultations 'clinically risky' (Humphrey *et al.*, 2025; Greenhalgh *et al.* 2016; Greenhalgh *et al.* 2022). In-person examinations were deemed to be easier, quicker and more likely to produce higher-quality assessments (Greenhalgh *et al.* 2022; Morillon *et al.*, 2025).

On the other hand, in the context of pandemic restrictions, GPs found that telephone consultations were adequate for most problems in known patients, as most problems did not require a visual assessment or physical examination. However, in some rare instances, visual cues were crucial for excluding rare but potentially serious acute problems (e.g., an infection), favouring a video consultation (Wherton *et al.*, 2021). But, as Wherton *et al.* (2021) also reported, in primary care most new problems are low risk and self-limiting, which means that the lack of visual cues in telephone consultations is therefore not always necessarily problematic.

In short, despite a highly favourable policy context, rapid developments in video consulting technologies, the pressure of COVID-19 lockdowns and measures and plenty of reported benefits, video consulting was either never really fully adopted or soon abandoned in UK general practice. While technological issues associated with video consulting explained some non-adoption and abandonment, the other key reason was the lack of a relative advantage of video consultations over telephone consultations. As Greenhalgh and Wherton (2022) aptly noted, "most technologies in health care fail because clinicians do not use them" (p. 258). Clinicians often judged that many (routine)

problems could be sorted adequately and safely by telephone and in-person assessments were regarded as more appropriate for the more urgent (emergency) appointments.

2.7 Telephone consultations

2.7.1 The telephone as an alternative to the face-to-face consultation

As discussed above, telephone consulting was regarded as a promising alternative to face-to-face appointments in general practice care, even before the COVID-19 pandemic (Ekeland *et al.*, 2010). A systematic review conducted by Downes *et al.* (2017) concludes that due to the minimal amount of research of telephone consultations in primary care (a problem which persists to date), it is difficult to make sound conclusions as to their potential suitability, especially in new institutional settings. In this section, I will review the existing research about telephone consultations from a wide range of disciplines and methods. I will show how the current body of evidence is relatively limited with some particular limitations (Section 2.7.1.1). Then, in Section 2.7.1.2, I will review what we know from CA studies of primary care face-to-face consultations, illustrating the value of a CA approach in understanding GP-patient interaction and indicating its potential value for studying telephone consultations. Finally, in Section 2.7.1.3, I will focus on the small body of CA research on primary care telephone consultations, highlighting what it might be able to reveal about their recurring interactional practices.

2.7.1.1 What do we know about telephone consultations in general?

One of the main differences from the traditional face-to-face consultation (and from video consultations) is the lack of visual cues. As already noted in section 2.2, when clinicians are unable to see the patient, it potentially becomes more difficult to recognise the signs that their (mental) health is changing. It becomes virtually impossible in the case of telephone consultations to perceive important non-verbal cues as body language and levels of physical tension, which also means that professionals may lose some of the ability to check a patient's understanding, which is often conveyed via non-verbal cues (Little *et al.*, 2015a;

Little *et al.*, 2015b). Greenhalgh *et al.* (2016) indicated that because of this lack of visual cues, telephone consulting requires considerable skill and judgment qualities from the clinician. As a result, clinicians doing telephone consultations are likely to have a low threshold of asking a patient to come in for an in-person assessment, implying their routine use tends to be *inefficient* rather than *unsafe* (Greenhalgh *et al.*, 2021; McKinstry, 2002).

Another main difference is that telephone consultations are on average shorter than face-to-face appointments (Hammersley *et al.*, 2019; Hobbs *et al.*, 2016; Jiwa *et al.*, 2002; McKinstry, 2002; McKinstry *et al.*, 2010; Pinnock *et al.*, 2003; Totten *et al.*, 2019); it has been suggested that this is because they are more time efficient in managing continuing illnesses than face-to-face consultations (Pinnock *et al.*, 2005; Wassen *et al.*, 1992). Doctors tend to talk more than patients during telephone consultations, with patients more often requiring clarification or repetition of information (Agha *et al.*, 2009). Related to this, Snoswell *et al.* (2024) conducted a quantitative survey among patients in Australia who had recently attended a remote (either video or telephone) consultation, most of which were with their GP. Participants were asked about their preferred consultation modality (either video, phone or in-person) across a range of different scenarios. Their findings suggest that the (potential) length of the consultation influences preference: shorter consultations were generally associated with a preference for remote appointments, while longer consultations tended to elicit a preference for in-person care. In all instances, patients preferred the telephone over a video consultation as well.

A study by McKinstry *et al.* (2010) looked at audio-recordings of telephone and face-to-face consultations and used statistical analyses to analyse features of the data. The data were collected at nine different general practices in Scotland. The authors found that telephone consultations indeed tend to be shorter than face-to-face consultations, provide fewer presented problems, less rich information, less counselling and advice and less rapport building. The authors used the Roter Interaction Analysis Scale to assess the content of the consultations with the RCGP quality assessment criteria. McKinstry *et al.* (2010) concluded that telephone consultations were less likely to include sufficient information to rule out serious illnesses. Nevertheless, patient involvement and

patient satisfaction outcomes were measured using a post-consultation questionnaire and were similar in both consultation types, meaning that remote health care encounters were satisfactory for both patient and practitioner.

Pinnock *et al.* (2003) aimed to determine whether routine telephone reviews of patients with asthma improved access and is a good alternative to face-to-face reviews in general practices in Britain. Again, it was found that telephone consultations were on average significantly shorter than face-to-face. Compared with face-to-face consultations in the investigated general practices, telephone consultations allowed a greater number of asthma patients to be reviewed without compromising clinical outcomes or patient satisfaction. Both types of consultation addressed the same type of topics, and because phone consultations were shorter, they suggested that it was likely that for routine review of asthma, phone consultations are an efficient option. Patient satisfaction was similar in both conditions as well. However, again, it is uncertain whether these findings are generalisable to the wider field of general practice.

Another study by McKinstry *et al.* (2009) took a closer look at how telephone consultations differ from face-to-face appointments in terms of content, quality and safety and how telephone consulting could be most appropriately incorporated into routine primary health care. The authors focus explicitly on primary health care in Scotland, organising focus groups with GPs, NPs, admin staff and patients and triangulating findings through a national questionnaire. In their study, participants saw telephone consulting as a possible compromise to achieve access targets, as it could avoid conflicts by providing an alternative to (not-possible) face-to-face consultations. On the other hand, GPs expressed concerns about increasing access to an already overloaded service which reduced control over their workload, which they saw as likely postponing rather than resolving problems. Furthermore, the absence of visual cues resulted in an expectation for 'high' verbal skills to compensate, on both sides of the consultation. Telephone consultations also created an anxiety among patients for getting a description of symptoms right, with a perception that a quick physical examination was superior to any number of words. In addition, Rosen *et al.* (2022) highlighted that, for the same reason, there is also anxiety amongst GPs that things will be missed, causing misdiagnosis.

Whilst the pandemic increased the need for further research on telephone consultations in primary health care, much of it still focused on specific patient groups, or was based on elicited accounts of patients and health care professionals, or relied on quantitative characteristics of telephone consultations. For instance, Imai *et al.* (2022) examined the uptake of telephone consultations of patients with type 2 diabetes in Australian general practice, separating their analysis by patient characteristics. They found that older patients, female patients and patients residing in remote areas were more likely to use telephone consultations. Another study by Gonzalez *et al.* (2018) showed similar results for telehealth uptake in Spain. Imai *et al.* (2022) showed that patients with chronic kidney disease and patients with prescribed antidiabetic medications were also more likely to use phone consults. A further study by Krahmer *et al.* (2021) indicated higher patient telehealth uptake in patients with diabetes of older age and using insulin in the United States.

As already stated above, the evidence suggests that remote consultations, particularly video, seem to suit patients with mild mental health conditions relatively well (Donaghy *et al.*, 2019; Greenhalgh *et al.*, 2022; Parsons *et al.*, 2022). In addition to this, a telephone consultation may be preferred (and/or beneficial) by patients with mental health or social conditions making face-to-face consultations (which also includes video consultations) more difficult (Gray *et al.*, 2010). However, again, these studies constitute for evidence based on clinicians' and patients' experiences in specific conditions which makes wider applicability uncertain.

2.7.1.2 What can CA studies tell us about face-to-face primary care consultations?

Although I am not able to comprehensively cover all CA studies on in-person GP-patient consultations in NHS primary care in this section, I will provide a discussion of some examples to illustrate the value of a CA approach in understanding GP-patient interaction, in order to indicate its potential value for studying telephone consultations. A substantial body of CA research has focused on particular sub-types of consultations or discussions of specific topics, and others focused on interactional practices recurring across various consultation types. Barnes and Woods (2024) conducted a comprehensive literature review,

covering approximately forty years of CA research and studies, across different countries and health care systems, on communication in primary health care. They suggest there are three broad themes to this research: (i) managing agendas; (ii) managing participation; and (iii) managing authority. The remainder of this subsection is structured around these three themes.

The first theme Barnes and Woods (2024) identified is *managing agendas*. In a health care context, agenda setting refers to the process by which a clinician and a patient (collaboratively) identify and prioritise the issues or concerns to be addressed during a consultation (Levenstein *et al.*, 1986). This is important as patients often bring multiple concerns to a primary care consultation (Leydon *et al.*, 2018; Salisbury *et al.*, 2016), and, when handled well, it can prevent important concerns from remaining unsurfaced and improve the overall efficiency of the consultation (Barry *et al.*, 2000). It offers a framework for general practitioners to determine which issues can be addressed during the current visit and which may need to be postponed until another visit or referred elsewhere (Barnes & Woods, 2022). Based on British data, Heath (1981) suggested that the opening sequence of a consultation acts as a space in which the participants move from greetings and potential small talk to the main topic of the visit. He distinguished between 'Type A' initiators, typically used in new appointments (such as 'How can I help you today?') and 'Type B' initiators, more commonly observed in follow-up consultations (such as 'How are you doing today?'). Heath (1981) demonstrated that these opening questions were designed to guide the patient, supporting them in producing an appropriate initial topic relevant for any subsequent medical assessment. A study by Dooley & Barnes (2022) offered an additional perspective on the interactional practices through which doctors manage agenda setting. This study examines how health care professionals and patients living with dementia negotiate the 'reason-for-visit' during NHS out-of-hours home visits. They found that, in their data, instead of asking the traditional 'what can I help you with'-question, health care professionals typically articulated the reason for the visit based on information provided by the patient's carer. In all cases this led to misalignment, with patients subsequently denying that they experience any symptoms or that they were willing to seek help from a medical professional. However, as long as the reason-for-visit is stated, the authors conclude that such

potential misalignment does not necessarily halt the progressivity of the consultation. In sum, these findings underscore the implications of how doctors initiate the reason for the consultation for both patients' eventual disclosures and the following trajectory of the consultation. These insights formed the basis for my analysis in Chapter 6, where I will examine how general practitioners elicit patients' additional concerns, however particularly during the closing phase of telephone consultations.

The second theme identified by Barnes and Woods (2024) is *managing participation.* The concept of participation generally refers to the patient's (interactional) involvement during medical consultations, especially during treatment decision-making (Robinson, 2003). For example, a study by Barnes (2018) focused on a particular interactional practice in UK primary care in-person consultations, so-called pre-recommendations. These are questions by GPs, initiated after the diagnosis phase, such as "Have you taken anything so far?" or "What have you tried taking?", preceding a contingent medicine treatment recommendation. Barnes (2018) showed how these pre-recommendations enable GPs to collect relevant information about possible previous or current usage of a medication, thereby avoiding recommending a treatment the patient is already taking or has taken and found to be ineffective or is not willing to take. Pre-recommendations seem to serve as a vehicle for including the patient in the decision-making process by allowing their input, minimising presenting potentially ill-fitted treatment recommendations and thereby reducing the chance of patient resistance. Overall, Barnes (2018) highlighted how pre-recommendations subtly structure consultations to facilitate patient involvement while maintaining the overall progressivity of the consultation. In Chapter 5 of this thesis, I will examine how doctors seek to involve patients during medication reviews (conducted over the phone) by asking about their experiences with using particular medications.

The third theme discussed by Barnes and Woods (2024) concerns *managing authority.* This involves how participants negotiate asymmetries relating to authority, for instance regarding the imbalance in (and right or entitlement to) medical knowledge. For example, Stevenson *et al.* (2021) investigated how patients raised prior use of the internet during consultations

with their GP. The authors looked at instances in which patients explicated that they consulted online resources related to their symptoms, (potential) illness or treatment concerns. Stevenson *et al.* (2021) found that, in their data, patients bring prior use of the internet into the conversation to support three key actions: to (i) validate concerns about significant (possible) health problems; (ii) justify needing treatment for a particular problem; and (iii) support or oppose particular treatment options. In addition, patients carefully designed their turns in which they invoked use of the internet in order to avoid encroaching the GP's domain of medical authority such that the GP is still seen as the one having the authority over making the final decision(s) about treatment. This interactional delicacy functions to acknowledge the GP's authority while still allowing patients to raise potentially relevant information.

Similarly, other topics in consultations also illustrate how medical authority is managed. For instance, Wheat *et al.* (2022) investigated how GPs, during routine consultations, initiate the topic of smoking. They found that this is typically done by asking about smoking status during the history-taking phase, which often led to patients' resistance (e.g., by minimising their smoking), especially when GPs ask patients to quantify the amount they smoke. The delicate nature of this topic is also observable when GPs linked the patient's smoking to their medical condition, as this also led to resistance. The authors show that, whilst clinical guidance advocates for GPs to provide advice on how to quit smoking, GPs only occasionally offered support for cessation. Notably, in the instances in which this did occur, GPs did so by using interactional practices that limited opportunities for patients to respond (e.g., by either accepting or rejecting the advice) and thereby conveyed an (implicit) endorsement of the proposed action suggested by the advice. Wheat *et al.* (2022) concluded that instances in which a GP does follow clinical guidelines commonly contain interactional difficulties and that the common ways of talking about smoking interrupt the progressivity of the overall consultation. They also highlighted a gap between what policy prescribes and what practitioners do in reality, and underlined that the ways in which talking policy recommendations or guidelines into action can be less straightforward than anticipated beforehand (see Pilnick, 2022)

Taken together, the studies discussed in this subsection highlighted how CA can uncover the subtle, fine-grained interactional practices and (associated) potential difficulties in GP-patient interaction. It remains, however, an empirical question whether and how these findings would apply straightforwardly to telephone consultations, underscoring the need for the (type of) research conducted in this PhD thesis.

2.7.1.3 What do we know so far about telephone consultations from CA studies?

This section focuses on the small body of CA research on telephone consultations, highlighting what it might be able to reveal about their recurring interactional practices. Notably, CA research on routine (in-hours) telephone consultations in NHS primary care is sparse, underlining the pressing empirical and methodological significance of this PhD thesis. I will discuss three CA studies in this section, related to the themes of *managing agendas* and *managing participation* introduced in the previous subsection.

To begin with, a study by Drew (2006a) focused on some of the interactional patterns which seem evident in after-hours telephone calls to a British GP practice, handled by a single general practitioner. He found recurrent misalignments between callers and the doctor in how both parties understand the urgency and seriousness of the presented medical problem. Namely, callers see their concerns as potentially urgent whilst the doctor frequently treats these concerns as signs of 'normal', routine illnesses. Drew's (2006a) analysis involves three interactional patterns pointing towards this misalignment. First, callers provide a dramatic detailing of the patient's symptoms, commonly in response to questions that did not directly ask for the specific symptoms they described. Second, callers and the general practitioner attribute a distinctive diagnostic significance (the 'seriousness') of the presented symptoms, usually observable by the general practitioners downgrading the just reported symptoms by the patient. Third, callers explicate what they think might be issue by offering a diagnostic hypothesis. The analysis shows that callers typically do this as a last resort when it appears the general practitioner is about to close the call without, for example, offering a home visit. Therefore, these findings seem very specific to the out-of-hours context, as callers tend to emphasise the severity of their

presented problem to rationalise their use of the service, making it unclear how (and whether) these findings would translate to an in-hours context. Nevertheless, Drew (2006a) showed how CA provides a fine-grained, empirically grounded insight into how telephone consultations unfold, showing how both the general practitioners and callers deploy conversational practices shaping whether problems are treated as urgent or routine, which would be missed by more general, interview- or survey-based research methods.

Hewitt *et al.* (2010) examined the communicative practices of doctors and patients in both telephone and face-to-face consultations, to ultimately understand the contrasts between the two different modes. As discussed above (Section 2.7.1.1), there is evidence that doctors might limit possibilities for addressing additional concerns (McKinstry *et al.*, 2010) and that telephone consultations reduce quality and patient safety. In order to uncover whether this was the case, Hewitt *et al.* (2010) investigated audio-recordings of telephone and face-to-face consultations in NHS primary care. They concluded that there are no underlying differences between the communicative practices used in face-to-face and telephone consultations. However, one structural difference was that, typically, telephone consultations were centred around a single-issue concern whereas typically face-to-face appointments allow a wider range of multiple concerns to be addressed. The majority of phone consultations during which a patient introduced a new problem ultimately led to a face-to-face consultation rather than a diagnosis over the phone. This finding contributes to the fact that telephone consultations tend to be shorter than face-to-face appointments. Furthermore, the interaction in telephone consultations was found to be more continuous and orderly, whereas there are more periods of silence (non-speech) in face-to-face encounters, enabling patients to introduce additional topics, including small talk as well. They found that doctors ask fewer questions when a patient describes a problem over the phone and, finally, doctors are less likely to ask whether patients do have additional concerns they would like to address in telephone consultations.

Building on Hewitt *et al.* (2010), who found that telephone consultations in primary care tend to focus on a single issue with doctors less likely to check for additional concerns, a more recent Australian project examined how patients

during secondary care telephone consultations might contribute to both the clinical (i.e., what they want to talk about) and the interactional (i.e., when they want to talk about particular topics) agenda during these consultations (White *et al.*, 2022). The authors showed that, despite the fact doctors largely did not provide patients with opportunities to contribute to the agenda, patients themselves are able to deploy a variety of interactional approaches in order to achieve this, usually when the consultation is about to end. White *et al.* (2022) found that patients initiate contributions to the agenda both within a consultation activity (by sharing additional information, asking questions related to the current topic and asking for clarification) and between activities (through back tracking or raising additional concerns). The authors argued that while both patients and clinicians seem to be able to manage the agenda in telephone consultations effectively, there is still room for improvement. They recommended that clinicians could improve by explicitly asking patients to contribute to the agenda (by asking whether they have additional issues, unmet needs or other questions) particularly in telephone consultations where, according to the authors, there is a loss of space to raise additional concerns due to the lack of a physical examination.

Overall, despite its shown value, the body of CA research on primary care telephone consultations remains limited, particularly in routine in-hours contexts. The existing studies discussed in this subsection highlighted key interactional practices, involving managing agendas and patient involvement. However, these themes (in addition to managing authority) still remain relatively underexplored. The scarcity of evidence underscores the empirical need for further research to identify some of the core interactional practices of primary care telephone consultations.

2.7.2 The interactional organisation of telephone consultations

Telephone consultations are a form of institutionalised interaction that is significantly different from everyday conversations. In institutional settings, interactions are normatively structured in advance. They are organised around particular tasks or objectives, certain kinds of contributions are seen or treated as legitimate while others are not, and interactants draw on procedures and

interpretation frameworks that are specific to the institution (Drew & Heritage, 1992; Heritage & Clayman, 2010). Talk and institutional setting hold a reflexive relation: participants draw on the institutional environment to organise their turn-by-turn actions, while at the same time their actions work to reproduce that environment as an "accountable relevant social fact" (Whalen & Zimmerman, 1987, p. 172). All institutional telephone calls, including ones in a health care context, involve a distinctive organization, based around a "vaguely orderly" template (Jefferson, 2015, p. 30). This template is built upon (but possibly alternating from) the organisation or structure of traditional in-person medical consultations (Ten Have, 2001, p. 4):

1. Opening
2. Complaint
3. Elaboration, examination and/or test
4. Diagnosis
5. Treatment and/or advice
6. Closing

The opening phase, in particular, of institutional calls contrasts with that of casual telephone conversations. They differ in terms of an absence of extensive how-are-you sequences and the fact they prioritise identification over recognition (Whalen & Zimmerman, 1987). Whereas in telephone consultations there is still expected to be a greeting sequence, the next phase of the conversation will be an opportunity for the caller to display their reason for calling, which affirms the 'state of talk' between participants (Whalen & Zimmerman, 1987). By calling their GP[1], the patient has selected an organisation (or a service), rather than a specific individual. Therefore, the call taker (in this case the GP) assumes that the caller is a member of a class of callers (patients) who are contacting them with a specific purpose (Whalen & Zimmerman, 1987). These assumed institutional roles, goals and responsibilities provide a framework shaping participants' contributions to the conversation, determining which kind of contributions are

[1] In practice, it is always the GP who is calling the patient after the patient booked an appointment.

appropriate and also guiding inferences that can be drawn from them (Heritage & Clayman, 2010).

The 'complaint' phase involves the patient presenting the reason for the consultation, which sets the agenda for the subsequent interaction. Alternatively, as I will show through the analysis chapters, many telephone consultations are GP-initiated (such as medication reviews, see Chapter 5); in these calls it is the GP presenting the reason for the consultation. In both cases, this phase is interactionally significant as it establishes the further trajectory of the encounter and provides a framework for what is about to follow. In the context of a medical consultation, the patient's problem presentation is not simply the patient describing their symptoms but is also displaying an understanding of what counts as appropriate, 'doctorable' concerns, worthy of medical attention (Heritage & Robinson, 2006). In telephone consultations, examinations and/or tests are difficult (or even virtually impossible) to perform. What typically follows is some elaboration on the patient's problem presentation, consisting of a question series by the GP. These series are longer when the problem or reason for the consultation is complex. On the contrary, they are shorter when the patient already builds 'extra' information into the original problem presentation phase (Heritage & Clayman, 2010).

The subsequent phases of diagnosis and treatment advice similarly display the institutional organisation of the encounter. The GP's formulations, explanations and recommendations simultaneously establish the doctor's professional authority (as the medical expert) but also treat themselves as accountable for the evidential support of their diagnosis, thereby resisting asserting complete authority in relation to the patient (Perakyla, 1998). Finally, the closing phase, too, is organised as part of an institutional conversation. It typically involves a summary, some instructions (for example regarding what a patient needs to do after the consultation, such as picking up a prescription) and some safety-netting advice. Chapter 6 will focus on closings of telephone consultations in more detail.

The features described in this section distinguish telephone consultations as a form of institutional interaction, 'borrowing' the sequential organisation of

both ordinary telephone calls and face-to-face medical consultations, while adapting to the affordances and constraints of remote communication.

2.7.3 Communication difficulties in telephone consultations

As Sutcliffe *et al.* (2004) concluded, communication failures have been shown to play a key role in medical mishaps and can have other detrimental results, from increasing anxiety among patients to severely affecting patient safety. There is a small body of existing research focusing on common communicative difficulties in telephone consultations. A study by Reisman and Brown (2005) used case vignettes from medical telephone interactions in highlighting communication errors in these encounters. Rather than using actual recordings of telephone consultations, these vignettes are based on 'informal' and 'anecdotal' examples from their own experience of teaching telephone medicine and their clinical experience as health care practitioners. They discussed six different scenarios in which, in their experience, communication errors in telephone consultations often occur. First, according to Reisman and Brown (2005), clinicians are faced with the challenge to determine when and how (adverse) sensitive test results can be given over the phone. This is potentially challenging because a clinician is unable to see the patient's expression over the phone and is therefore unable to check whether 'bad' test results have landed well. It might be the case that the patient is unable to speak freely, for instance because they are surrounded by particular people, which is something the doctor should always check before presenting 'bad news'. When delivering 'good news', Reisman and Brown (2005) argued this seems to be less important. However, it remains unknown on what basis the authors are making this claim. They explicated that the alternative would be to book a face-to-face appointment to discuss test results, which ultimately could also lead to more anxiety among patients. Namely, this is normally inferred as meaning that the results are abnormal and the patient then has to wait some time before receiving the results. Nevertheless, this does not imply that it is necessarily unproblematic to not see the patient's expressions when delivering 'good news'. The second scenario Reisman & Brown (2005) discussed is when patients request medications such as opioid painkillers or other prescriptions over the phone, in which the challenge is to be comfortable

with denying inappropriate requests. Reisman and Brown (2005) recommended that if patients request a medicine on the telephone, they should always be checked in person first. However, they do not explicate *how* a clinician can be comfortable and how they might deal with possible patients' resistance.

Third, there is the scenario of a patient who is not sick enough for emergency care. The challenge is to recognise when a patient does not need emergency care but still needs some follow-up before a visit to the surgery is possible. Reisman and Brown (2005) indicated that it is difficult to assess on the telephone if a patient requires urgent care and that it is of vital importance to listen carefully and catch all sorts of paralinguistic cues (e.g., tone, speech patterns, pauses, pitch, etc.). They argued it is vital to not only examine whether a patient is ill enough to require urgent care, but also to assess whether a patient is listening well, is concerned, stressed, knows what to do, etc. One recommendation they explicated is to "ask the patient to repeat back instructions to ensure comprehension" (p. 961) but, again, do not continue with suggesting how doctors can do this effectively.

A fourth challenge for clinicians is to consider hidden concerns in calls that seem 'inappropriate' at first hand. Indeed, as another study by Rosen *et al.* (2022) also showed, important concerns can remain unsurfaced in telephone consultations (as well as during face-to-face consultations (Leydon *et al.*, 2018)). Therefore, clinicians should always keep in mind that there could be additional (relevant) concerns and should aim at explicitly asking for them and allowing patients to fully describe their concern(s) without too many interruptions. Whether asking a patient 'is there anything else you want to talk about?' actually leads to patients disclosing additional concerns remains unclear.

Fifth, clinicians can be faced with unintelligible patients while talking on the phone. Patients who are difficult to understand or hear are especially difficult to deal with on the phone (for instance English as an additional language speakers, patients with aphasia, hearing impairments, etc.). It is always possible to involve someone else facilitating the call, but this may have a detrimental effect on the quality of the consultation and therewith quality of the care delivery. Reisman and Brown (2005) stated that one other way to overcome this challenge is to frequently ask a patient to repeat instructions to check understanding.

Finally, Reisman and Brown (2005) concluded that clinicians should recognise the importance of speaking with the patient instead of someone speaking on behalf of a patient. According to the authors, without visual cues, the patient's words are extremely valuable and virtually the only source on which the doctor can make a sensible decision. If this information does not come directly from the patient (but from hearsay), this may have significant effects on the patient's actual safety and wellbeing, as the other person (for instance a family member) may not have the right skill set to assess a patient's wellbeing.

Overall, while Reisman and Brown (2005) identified a number of plausible challenges in telephone consultations, their analysis is constrained by its reliance on 'anecdotal' vignettes and the author's own professional experiences. As a result, it remains uncertain whether or not the difficulties they described, and the solutions they proposed, actually play out in practice and, crucially, why and how they do (not) work. Many of their recommendations might be seemingly simple to articulate (e.g., 'ask patients to repeat back instructions') but may be considerably more difficult to use in the pressured, interactionally complex setting of primary care.

More recent work by Payne *et al.* (2023) conducted a study exploring safety incidents linked to remote triage and remote consultations through a combination of case analyses, interviews with patients and health care staff, and ethnographic observations. Their findings reveal that many safety incidents arose from mismatched consultations modes (e.g., opting for telephone whilst a face-to-face visit would have been more appropriate), incomplete information gathering, neglected patients' social circumstances and, most importantly, poor communication. The study acknowledges that telephone (and also video) consultations often take place in highly pressured environments, where systems and workflows for remote care may not be fully optimised.

Although remote consultations can be valuable when integrated appropriately within a hybrid model of care (as also supported by the Royal College of General Practitioners (2021a) and Neves *et al.* (2021)), the majority of safety incidents and complaints in Payne *et al.*'s (2023) study were associated with telephone appointments. The authors identified five recurring themes contributing to these issues. First, organisational and operational (work-load)

pressures often led clinicians to use telephone consultations as a quick way to manage demand, resulting in brief, superficial interactions that increased the risk of clinical errors due to insufficient clinical information gathering. Second, communication difficulties were exaggerated in remote consultations, as clinicians were missing non-verbal cues and other sensory information (e.g., sight, touch, smell; see Lupton & Maslen, 2017), sometimes leading to an overreliance on the patient's medical history and insufficient rapport building. Third, the limited clinical information obtainable remotely made it challenging to assess patients comprehensively, particularly when making significant life-changing diagnoses without in-person assessments. Fourth, remote consultations place more responsibility on patients and their caregivers, especially for patients with complex health needs and/or limited digital access and digital literacy. Finally, Payne *et al.* (2023) pointed out significant gaps in medical education and training. Whilst out-of-hours services tended to provide some (albeit still general) instructions for remote consulting skills (for instance regarding rapport building, eliciting information, safety netting), many in-hours clinicians had received little or no formal training in effectively conducting telephone consultations.

2.7.4 Implications for communication skills training and education

Despite the increasing reliance on remote consultations in primary care and the acknowledgement of a range of corresponding communication challenges and difficulties (see previous section), formal education and training for GPs in conducting telephone consultations remain limited. Multiple studies have consistently shown that while out-of-hours services often offer structured guidance on remote consultation skills (for instance regarding building rapport, gathering information and providing safety netting advice), many in-hours clinicians reported having received minimal or no formal training in conducting telephone consultations effectively (Brooks *et al.*, 2021; Edwards *et al.*, 2021; Payne *et al.*, 2023; Smith *et al.*, 2021). The shift towards a 'digital-first' model of primary care, as encouraged by the NHS Long Term Plan (NHS, 2019) and the NHS Ten Year Health Plan (NHS, 2025a), has further highlighted this gap. Although the expectation is that GPs are competent in managing remote

encounters, existing educational frameworks and assessment tools in the UK focus primarily on *simulated* face-to-face consultations, rather than real-world scenarios, particularly in remote settings (Greenhalgh *et al.*, 2024). This risks underpreparing clinicians for the distinctive communicative and diagnostic challenges (see previous section) occurring in telephone consultations.

Recent studies have drawn attention to low confidence and limited prior experience among both trainees and established clinicians when consulting remotely. A systematic review by Wetzlmair *et al.* (2022) and the Health Education England survey (Nightingale Research, 2022) have found that many medical students and GP trainees feel significantly underprepared for conducting remote consultations before receiving particular targeted training. Greenhalgh *et al.* (2024) similarly found that there is a strong demand among medical students and established clinicians for structured and evidence-based learning opportunities regarding remote consultations.

Further research suggests that already established guidelines for clinical communication often fail to account for the nuances of delivering care remotely. Frameworks originally designed for face-to-face consultations (such as the Calgary-Cambridge model (Kurtz *et al.*, 2003)) may not adequately address the distinctive dynamics of telephone consultations, leaving clinicians uncertain (or even unqualified) about how to adapt their communication techniques to compensate, for instance, for the absence of visual and non-verbal cues in telephone consultation (Coleman, 2020; White *et al.*, 2022).

A study by Chaudhry *et al*. (2020) focused on GP trainees' experiences, perceptions and preparations of undertaking telephone consultations during postgraduate training in the UK. They used a survey (i.e., descriptive statistics) and conducted semi-structured interviews with trainees. The authors showed that while telephone consultations were viewed as an increasingly fundamental part of primary care, many post-graduate trainees felt underprepared and lacked confidence in conducting telephone consultations. Particularly, scenarios involving patients with multiple complex health conditions, language barriers, and particular 'difficult' clinical situations (such as delivering bad news) were reported as challenging. Their respondents mainly attributed their low level of confidence to insufficient formal targeted training and limited opportunities for

supervised hands-on practice with 'real' telephone consultations. Notably, reported confidence levels were higher among those who did receive targeted training or feedback, especially within out-of-hours contexts where telephone consultations contain a larger proportion of all appointments.

Broader reviews of remote care education underscored that such challenges are not necessarily unique to general practice in the UK. Including communication skills for remote consultations into medical education curricula (both within and outside the UK) remains inconsistent, and many students and trainees are unaware of the importance of developing these particular communication skills until they are required to actually use them in practice (Patterson *et al.*, 2024; Wong *et al.*, 2022; Yaghobian *et al.*, 2020). Moreover, although assessment tools based on simulated consultations have been developed to include remote communication skills training and raises awareness of its importance (Lum *et al.*, 2020; Sartori *et al.*, 2020), these often rely on video consultations, providing only partial preparation and guidance on the specific communication demands of telephone consultations. Chaudhry *et al.* (2020) reported that the introduction of audio-based clinical observation tools was viewed as a useful step towards improving feedback and learning in this area, yet students and trainees still felt that telephone consultation training within GP curricula required substantial strengthening.

Overall, the literature indicates that there is a substantial lack of structured, targeted and evidence-based education and assessments in preparation for telephone consulting. As the NHS (2019) continues to prioritise remote and hybrid models of care, there is an urgent need to include the teaching of telephone consultations skills explicitly into both undergraduate and postgraduate medical training curricula.

2.8 Summary

The context in which health care is delivered has changed dramatically over recent years. Because of the COVID-19 pandemic, various forms of remote consultations were rapidly introduced in primary care (Khan *et al.*, 2020; Krist *et al.*, 2020; Murphy *et al.*, 2021) and many general practices routinised remote

services as a tool of delivering health care (Royal College of General Practitioners, 2020). Reviews of qualitative studies, which predominantly utilise interview or focus group data, have highlighted a number of benefits and disadvantages, reported by GPs and patients after a remote consultation took place. For instance, previous studies found that phone consultations are beneficial for certain patient groups, such as diabetic patients (Krahmer *et al.*, 2021), patients with asthma (Pinnock *et al.*, 2003) and patients with mental health problems (Liberati *et al.*, 2021).

Furthermore, previous studies highlighted potential problems and risks with phone consultations. For instance, Rosen *et al.* (2022) indicated that the information exchange can potentially be inadequate in both content and tone and that the therapeutic relationship is not desirably established or becomes eroded. They also highlighted that important concerns may remain unsurfaced, which is found to be a problem for face-to-face consultations as well (see Heritage *et al.*, 2007). Moreover, studies by Majeed *et al.* (2020) and Parker *et al.* (2021) showed that remote consultations might increase inequalities as they are generally found to be more suitable for younger, working people and women and are more challenging for patients who are not technologically literate, have hearing impairment and those for whom English is not their first language. However, it remains dependent upon the reason for the consultation in determining whether telephone is beneficial (over face-to-face) or not (Wanat *et al.*, 2022).

The majority of the studies on remote (telephone) consultations focused on their acceptability and feasibility or offered guidance on what type of consultation is most appropriate in specific circumstances. However, these studies were not able to show what specifically constitutes recurring interactional characteristics of telephone consultations or how these features unfold in real-time. Only few looked at the actual turn-by-turn interaction during remote phone consultations. As a result, currently, advice and guidance about communication in remote consultations mainly concern broad communication characteristics such as checking that the audio is working well (Wherton *et al.*, 2020) or particular broad-brush communication activities such as eliciting patient concerns (Hewitt *et al.*, 2010). A gap in knowledge therefore remains regarding how telephone consultations are produced, organised, and managed

moment-by-moment. In the next chapter, I will explain the methodological foundation of conversation analysis, which is the approach I will use in examining communication in GP-patient telephone consultations. The level of interactional detail that is obtained from conversation analysis cannot be revealed from research generated by interviews, focus groups or surveys (Aguinaldo, 2022; Potter & Hepburn, 2005).

Chapter 3. Methodology

3.1 Introduction

In order to address the knowledge gap presented in the previous chapter, the method of conversation analysis (CA) will be used to explore and describe the communicative practices in GP-patient telephone consultations. This section begins with explicating the methodological foundation of CA, by particularly focusing on Goffman's (1983) *interaction order* (3.1.1) and Garfinkel's (1967) *ethnomethodological framework* (3.1.2). Next, in section 3.2, we will focus on the fundamental principles of CA as applied to everyday talk, presenting CA not just as a method but also as a theory of human sociality (Heritage, 2008; Schegloff, 1987), prior to discussing how CA has developed as a method for researching health care interaction. Finally, section 3.3 involves a brief summary and explains how the methodology of this PhD study will facilitate an original contribution to the current knowledge field.

3.1.1 Interaction as study in its own right

In his presidential address to the American Sociological Association, Erving Goffman (1983) underlined the importance of what he referred to as the *interaction order*, as a "substantive domain in its own right" (p. 2). He proposed that (especially face-to-face) interactions should be scrutinised in their own right, rather than by focusing on how external structures or pre-existing categories (such as gender, class or profession) have an effect on talk in interaction (Goffman, 1964). Instead, Goffman argued that the organisation of how people act, perceive and experience the world is maintained within face-to-face encounters. In other words, he contended that social interaction is a form of organisation that does not reside within any formal structure or set of rules, but within the interaction itself. For example, if we look at how interactants decide who speaks next during a conversation, it becomes evident that the participants themselves manage this process. There is no external agent or predetermined set of rules dictating the turn-taking. Rather, it is something which the interactants *themselves* organise, manage, deploy and can make answerable to and a vehicle

for whatever that particular group of people is doing at a particular moment in their conversation.

Furthermore, social interaction is regarded as "the primordial site of human sociality and social life" (Schegloff, 1987, p. 101). The interaction order forms the foundation for the functioning of all institutions in society and facilitates the activities that they conduct (Heritage, 2001). For instance, institutions such as education, politics, and the economy (i.e., workers speaking to each other to make the products that salespeople will sell by interacting with costumers), are all fundamentally directed and organised through social interaction. Similarly, the effective delivery of health care is achieved through, perhaps even for the most part, social interactions between medical professionals and their patients.

3.1.2 The ethnomethodological framework

Whereas Goffman's work (1964, 1967, 1983) predominantly focused on a distinct, autonomous *interaction order*, the ground-breaking work of Harold Garfinkel (1967) established the concept of *ethnomethodology* as a way of describing the routine methods or ways through which members of society make sense of the circumstances they find themselves in on a daily basis. Garfinkel was more interested in the methods of how people produce the social world and achieve mutual understanding of and in it. I will discuss how Garfinkel's (1967) seminal work demonstrated these mechanisms by focusing on the role of *accountability* in maintaining order and cooperation during social interaction (section 3.1.2.1), the *documentary method of interpretation* (3.1.2.2) and the *indexical nature of language* (3.1.2.3). Subsequently, in section 3.1.3, we will take a closer look at how ethnomethodology differed from (contemporary) sociology and how it has been (wrongly) criticised for it. I will start by discussing the origins of the ethnomethodological framework and by examining how Garfinkel was influenced by the work of Parsons (1937) and Schutz (1953, 1954).

Although Parsons and Garfinkel shared an interest in human action and the social organisation of society, they approached these issues from contrasting perspectives (Heritage, 1984a). Inspired by the works of Max Weber and Émile Durkheim, Parsons (1937) developed *structural functionalism* as a framework for

describing the mechanisms underlying the establishment of social order. According to this perspective, the actions of individuals are regulated by external rules that become ingrained through the process of socialisation. These rules are normative in the way they specify how people should behave to accomplish order in society (Murphy *et al.*, 1998). Although Garfinkel was under the supervision of Parsons, his theoretical viewpoint was not obtained from this structural functionalist conceptual system. In particular, he was dissatisfied with "the sketchy treatment of the actor's knowledge and understanding within the voluntaristic theory" (Heritage, 1984a, p. 9).

Instead, Garfinkel proposed a theoretical framework that could directly capture the processes through which individuals carry out courses of action, analyse and make sense of what is happening around them. This framework provides an understanding of social activity that is more grounded in the analysis of the organisation of personal experience and does not *a priori* neglect the individual's capacity for agency and the capability to interpret and adjust to what is going on around them within a particular context. The disparities between Parsons and Garfinkel ultimately solidify in the examination of whether the actor's perspective, and its involvement in the organisation of action, should be scrutinised and addressed through methods intrinsic to (Garfinkel), or external to (Parsons), the structure of the actor's experience (Heritage, 1984a). Ultimately, Garfinkel's work "can be usefully viewed as the product of the consistent pursuit of a single question: how do social actors come to know, and know in common, what they are doing and the circumstances in which they are doing it?" (Heritage, 1984a: 76).

A second significant influence on Garfinkel and ethnomethodology stems from Schutz's (1954) claims that an individual's experiences and interpretations of the world make sense of and give meaning to the world. In contrast to external structures, norms or rules, it is the individual agents playing a crucial role in constructing a meaningful world. For instance, identities such as 'doctor' and 'patient' are shaped by an individual's experiences (for instance with health care encounters) and how they subsequently interpret and make sense of those experiences. Schutz (1954) acknowledged that the precise meanings individuals assign to such concepts and identities remain elusive – we are not able to look

into someone's head – however, nevertheless, members of a society also heavily depend on *common-sense knowledge* in making sense of the events occurring around them. This body of common-sense knowledge encompasses both observable actions and the inferential accountable nature of these actions that individuals rely on in their daily lives. At the same time, they assume that other members of society rely on this same body of knowledge in a corresponding way. Schutz (1953) proposed that this mutual understanding, or *intersubjectivity*, is achieved through *verstehen*, involving the interpretive appreciation of the subjective reasons individuals attach to (their) actions. *Verstehen* can be utilised by social scientists to uncover how individuals understand social life and, therefore, social scientists should strive to comprehend the meaning(s) of actions from the viewpoint of the actor and to examine and describe actors' common-sense understandings.

Although Schutz's writings are predominantly philosophical and do not specify the practical application of interpretivism to scientific inquiry (Heritage, 1984a), they have significantly influenced the development of various methodologies. While interpretivism has facilitated new social science research directions and contributed to the rise of methodologies, for example phenomenology, which aims to explicate how individuals experience and perceive the world from their own perspective (Heritage, 1984a), there are, on the other hand, several challenges towards applying Schutz's philosophical ideas in practice. First, justifying the countless and ever-changing individual's understandings potentially causes social researchers to infringe the individual's perspective (Heritage, 1984a). Second, while adhering to Schutz's proposition that meaning emerges from comprehending an individual's experiences and interpretations, the resulting image is rather static (Heritage, 1984a). For instance, an interview on the effectiveness of remote consultations captures an image of what effectiveness means in that moment, but its applicability may not extend to different moments for the interviewee, let alone for other people. Third, Schutz's assertion that the intersubjective world relies on cooperation among members of society has been critiqued for not actually explicating exactly how this cooperation is accomplished *in situ* (Heritage, 1984a).

Garfinkel's contributions aimed to tackle the methodological challenges emerging from Schutz's theoretical framework as discussed above. In contrast to using *verstehen* for uncovering collective interpretations individuals assign to objects and events, Garfinkel proposed a methodology focused on understanding the processes through which order is negotiated via *intersubjectivity*:

> "how men, isolated yet simultaneously in an odd communion, go about the business of constructing, testing, maintaining, altering, validating, questioning, defining an order *together*" (Garfinkel, 1952, cited by Heritage, 1984a, p. 71).

3.1.2.1 Accountability in social interaction

Garfinkel's well-known 'breaching experiments' (1967) indicated how interactants achieve cooperation by holding each other accountable when one would transgress ('breach') the normative expectations of a social situation. For example, while playing a game of ticktacktoe, one would perform a move that is not part of the game's rule set without remarking on it, in order to see how the other player would react to it. Alternatively, Garfinkel would instruct his students to go out and bargain for fixed priced goods in a shopping mall and see how this would play out in terms of the breached social rules within that social situation. Garfinkel showed that interactants are held accountable for not adhering to the normative structure of social life and that "maintaining the 'reciprocity of perspectives' (as one of the presuppositions of the attitude of daily life) is not merely a cognitive task, but one which each actor 'trusts' that the other will accomplish as a matter of moral necessity" (Heritage, 1984a, p. 82). So, similar to Goffman's (1983) interaction order, Garfinkel's evidence of the accountable nature of social actions resolidifies that human interaction seems to have its own intrinsic set of rules and therefore should be regarded as an area of study in its own right.

3.1.2.2 The documentary method of interpretation

Garfinkel further offered empirical evidence for what he referred to as the *documentary method of interpretation* by showing how this method could be observable in real-time interactions. This documentary method entails a method

that people use in trying to understand and make sense of their social world, which is a method relied on by all other members of society as well. As Garfinkel described it, "the method consists of treating an actual appearance as 'the document of', as 'pointing to', as 'standing on behalf of' a presupposed underlying pattern" (Mannheim, cited in Garfinkel, 1967, p. 78). Garfinkel demonstrated this documentary method and its reflexive nature through an experiment within a university department of psychiatry. Students were invited to participate in what was advertised as an innovative form of psychotherapy and were instructed to outline a personal problem or concern which required advice from a counsellor. They were asked to introduce their concerns by posing a series of questions to the supposed counsellor who was seated in a separate room, communicating solely through an intercom without any visual contact. Meanwhile, unknown to the students, researchers in the separate room provided randomly generated yes/no responses to questions posed by the students, irrespective of the content of their questions or potential contradictions between answers. However, still, through their sense-making, the students retrospectively interpreted these responses as helpful and as sensible advice-giving which shows that "utterances were not treated 'literally' or at 'face value' but were understood by reference to unspoken assumptions and presuppositions that each party attributed to the other" (Heritage, 1984a, p. 94). This illustrated how individuals, in the absence of actual counselling expertise, rely on a reflexive documentary method to interpret and nevertheless assign meaning to seemingly arbitrary responses.

3.1.2.3 The indexicality of language

Garfinkel moreover highlighted the indexical nature of language, showing that the meaning of a word or an utterance depends on its context. For instance, the pronoun '*I*' refers to the person that is uttering that word, and '*now*' indexically refers to a time frame of the moment at which that word is spoken. With regards to Garfinkel's student counselling experiment described in the section above, the meanings of the words *yes* and *no* (the arbitrary responses of the assumed counsellors) were dependent on the context in which they were used. This indicated that a hearer (in this case the student) tries to make sense of the speaker's expressions by not only considering what has been said, but also by

considering who the speaker is, what their status relative to the hearer is, what has been said before and what the speaker may have been intending to imply (Scott, 2022). This real-time interpretative work that interactants do carries both retrospective and prospective implications for the unfolding interactional trajectory.

This participants' interpretative work relates directly to the concept of validity in qualitative (conversation analytic) research. According to Kirk and Miller (1986), validity concerns whether or not "the researcher is calling what is measured by the right name" (p. 69). As will be discussed in the remainder of this section, research on talk-in-interaction possesses an inherent methodological resource that other forms of qualitative research, such as studies focusing on written texts, do not offer:

> "regularly … a turn's talk will display it's speaker's understanding of a prior turn's talk, and whatever other talk it marks itself as directed to it" (Sacks *et al.*, 1974, p. 728).

In essence, it is through the subsequent progression of the conversation that interactants show their interpretations of what is happening to each other. Crucially, they demonstrate their understandings of what has occurred in the immediately prior turn in the conversation (Heritage & Atkinson, 1984). This perspective gives rise to a key validation procedure, which underpins all research within conversation analysis:

> "but while understandings of other turn's talk are displayed to co-participants, they are available as well to professional analysts, who are thereby afforded a proof criterion – for the analysis of what a turn's talk is occupied with" (Sacks *et al.*, 1974, p. 729).

This implies that every contribution to a conversation will be interpreted locally, in real-time, by each interactant in the conversation itself. Speakers convey their interpretations of prior utterances in the turns that immediately follow that interpreted utterance. Put differently, any interpretations, suggestions and hypotheses that conversation analysists may have can be assessed through this *next-turn proof procedure*, described by Sacks *et al.* (1974). Ultimately, by

examining how speakers handle turns and utterances, analysts can verify whether their interpretations align with those of the speakers.

Taking Excerpt 1 below (see Appendix 1 for transcription conventions) as an example, an analyst's categorisation of the action done in the GP's turn in lines 01-02 as a 'request for confirmation' rests not on a decontextualised interpretation but on the fact that P subsequently treats the GP's utterance as a request for confirmation: P offers a confirmation in line 04 ("I am at the moment yes"). The evidence for this categorisation is that GP subsequently does not show any problems with P's interpretation. In contrast, if a recipient displays trouble in understanding (if, for instance, P did not treat GP's turn as a request for confirmation), the first speaker (GP) can orient to this and initiate repair in their following turns (Hutchby, 2019). As can be seen in line 05, GP is not initiating any repair here.

Excerpt 1. P01GP01: 11.06

```
01      GP:  'nd once again >are you- are you< reason'bly happy on
02           ↑those medicines:,
03                (0.3)
04      P:   I am at the moment yes ↓yeah yeah (0.2) [yeah.]
05      GP                                           [Good.]
```

However, this process is often more complex than it might initially appear. Next turns may be unclear, confusing or ambiguous concerning the actions performed in prior turns of talk. For this reason, conversation analysts do not extract isolated fragments of talk; instead, they analyse data sequentially and within its original context, since actions can be clarified as an episode of interaction progresses. Nevertheless, this 'next turn proof procedure' – where speakers' next turns serve as a fundamental measure of validity – remains essential and must be used extensively in all conversation analytic research.

3.1.3 Ethnomethodology and sociology

Garfinkel developed ethnomethodology at a time when sociology, especially macro-sociology, was involved in the study of large-scale social movements and predominantly was looking at economic data and large-scale surveys. In particular, it tended to analyse social systems or populations at a high level of

abstraction, very removed from the mundane and everyday features of social life (Heritage, 2001; Heritage & Stivers, 2012). Garfinkel attempted to step away from the theoretical preconceptions that people would have to take into those studies and instead started to look at the ways in which people made sense of the social world. It appeared that this sense making was rather mundane in myriad situations and Garfinkel focused on how people would practice ordinary kinds of activities, how they would recognise it when a situation differs from 'normal' expectations (in the sense that it 'breaches' social norms and rules) and how they co-operatively carry out the 'seen but unnoticed' interpretive work that sustains their understanding of those events, in various, almost infinite, ways.

Linking back to the breaching experiments described in section 3.1.2.1, Garfinkel discovered that people made sense of 'breached' social situations not as transgressions of rules but as different social situations. The point there is that these ground level strategies for making sense of the social world turned on the head the idea that sociology could even plausibly understand what was going on in the social world by only studying macro social phenomena or by theorising about what people were doing. Garfinkel argued it is impossible to understand how people made sense of these phenomena if we do not look at the ways in which people have to rationalise what is going on around them, rather than applying some theory or abstract set of rules. Similarly, because the interactional context always differs for every single encounter, conversation partners need to apply a normative set of rules in every conversation as if for the first time. One approach that applies that same curiosity about how the rules of conversation are organised and what happens when we break them or upset normative expectations that might be applied to even the simplest things (such as simple question and answer structures), is conversation analysis, which will be discussed in more detail in section 3.2 below.

In contrast to both traditional and contemporary sociology, which focuses on *explaining* social facts, ethnomethodology is concerned with *explicating* how social facts are constituted (Ten Have, 2004). In ethnomethodology, social facts are viewed as achievements, produced in and through individuals' observable everyday actions (Pollner, 1974). This approach contrasts with the conventional sociological research tradition of *explaining*, where social facts are treated

primarily as theoretical and conceptual constructs instead of being seen as practical accomplishments (Linstead, 2006). For instance, a study by Joyce *et al.* (2021) shows how 'mansplaining' is constituted (i.e., is accomplished) through particular interactional practices. Other studies focus on specific interactional practices in responding to (and therewith resisting) particular actions speakers thereby treat as racist (Robles, 2015; Whitehead, 2015), heterosexist (Land & Kitzinger, 2005) and representing other possible -isms (Stokoe, 2015; Tadic, 2024). These studies diverge from traditional social scientific approaches to discrimination and prejudice by focusing on how these issues are actually generated, resisted, and managed in everyday interactions. Instead of attributing discrimination and prejudice mainly to individual mindsets or wider societal structures, these ethnomethodological (conversation-analytic) studies investigate their authentic manifestation and negotiation in (mundane) social settings.

Because of this divergence, since its inception ethnomethodology (and hence also conversation analytic research) has frequently faced criticism for its perceived lack of what Coser (1975), during his keynote address to the American Sociological Association, described as 'substance'. This critique, among other labels such as 'pointless empiricism', 'focusing on nothing but the text' and 'just a method in search of a problem' persisted across the following decades (Stokoe & Albert, 2024). The basis of many of these criticisms is that ethnomethodology ostensibly is occupied with doing emic microsociology (Padua, 2024) and avoids building macro-sociological theories (Alasuutari, 2023). However, social interaction is considered to be a domain where the individual and broader macro-level structures converge through people's context-specific actions and involvement in collaborative activities (Heritage, 2008; Risman, 2018; Schegloff, 2006). Social interaction serves as a stage where, for example, individual identities and overarching cultural norms are constantly performed and reinforced. As Arundale (2023) argues, the repeated forming of social actions in daily conversations provides a basis for understanding the development of features characterising intricate social systems at the macro-level of cultures and institutions. This process illustrates how micro-level interactions cumulatively give rise to the broader structures and norms that define larger societal

frameworks. For instance, taking the example of gender, interactants demonstrate their membership in gender categories using practices that both reflect and perpetuate larger organisational structures and ideologies (Pino & Edmonds, 2024). This makes the interactional level a crucial domain of social organisation where gender identities are formed, expressed, affirmed and sometimes rejected.

In other words, a macro-level social system is formed, maintained, and transformed as individuals within a wider community continuously participate in social practices linked to that macro-level system. These practices, for which individuals have previously established a shared understanding, are enacted across numerous instances of micro-level interactions dispersed over time and space (Arundale, 2023). Moreover, Mlynar and Arminen (2023) argued that taking on this point of view could also potentially offer a valuable historical perspective, enabling us to make social change (which is a fundamental matter in much social science research) in retrospect visible and investigable. In short, focusing on this interactional (micro) level has the prospect to shine empirical light on the pervasive interactional production of (social) problems, for instance of injustice and inequity, that can have individual, institutional and larger societal consequences (Stokoe & Albert, 2024).

3.2 Conversation analysis

The field of conversation analysis (hereafter CA) emerged in the 1960s through the pioneering work of the American sociologist Harvey Sacks. Through his lectures (Sacks, 1992) and seminal work (Sacks & Schegloff, 1973; Sacks *et al.*, 1974), CA was introduced as an approach to analyse talk in interaction for its orderly structured parts to uncover how interactants (successfully) 'do' things through their talk. CA was built on Garfinkel's ethnomethodological framework and followed Goffman's (1983) appeal to study social interaction as a topic in its own right (Heritage, 2001, 2008). Early conversation analysts rejected the then-popular belief that in order to understand people's linguistic or communicative competence, we should study invented (idealised) sentences, which had been proposed mainly because communicative performance was viewed as too chaotic

to study (Chomsky, 1965). Instead, together with Emanuel Schegloff and Gail Jefferson, Sacks established an inductive ethnomethodologically grounded research method, demonstrating that "there is order at all points" (Sacks, 1984, p. 22) in the ordinary situations we as speakers find ourselves in. On the one hand, conversation participants presume this 'order at all points', relying on stable and consistent practices of action and interpretation to understand each other's verbal and non-verbal cues. On the other hand, analysts also depend on this order to produce generalisations about social interactions. Importantly, this order does not exist prior or external to social interactions; rather, it is created and manifested *in situ* by interlocutors themselves (Francis & Hester, 2004). Thus, CA adopts an 'emic' approach to social interaction, concentrating on what interactants make visible and observable to each other (Koole, 2015). Consequently, conversation analysts ground their analyses in the observable and visible behaviour of conversation participants within the interaction, without making claims about the thoughts, motivations or interpretations that the participants keep to themselves.

The resulting discipline, CA, seeks to uncover and describe the principles that interactants utilise to assign, attribute and establish meaning to their verbal and non-verbal behaviour in episodes of social interaction (Sidnell, 2010, 2012). Drew and Heritage (1992) further characterised talk-in-interaction as the main method through which individuals seek to pursue practical goals and as the essential medium through which professionals carry out their everyday working activities. Thus, not only is talking inherently an action in itself, but it also serves as the primary instrument for getting things done in the social world. For instance, while speaking we invite, request, announce, blame, etc. In other words, CA is a tool to analyse talk-in-interaction for its orderly structured parts and to uncover how interactants (successfully) 'do' things through their talk.

3.2.1 Using naturally occurring data

In order to formulate *generalisable* principles that conversation participants deploy in order to assign and establish meaning in conversations, conversation analysts collect and study naturally occurring data (Sidnell, 2010). Naturally

occurring interactions involve talk-in-action from a non-simulated or non-manipulated environment. This means that the event from which the data are drawn would have occurred regardless of any researcher's presence and involvement. According to Potter (2002), naturally occurring data are contrasted with data elicited by researchers for particular purposes, for example through interviews or focus groups. Furthermore, Goffman (1967) argued that qualitative interviews are unique social interactions, each with its own distinct reality. Consequently, any knowledge generated during an interview is inherently tied to the interview itself. So, whereas it is difficult to generate knowledge about the world beyond the interview setting itself (Goffman, 1967), recording and analysing naturally occurring interaction enables a researcher to capture both verbal and non-verbal interaction and to illustrate real-world practices as they occur 'in the wild'. It allows the researcher to understand both what is going on in an episode of social interaction and how the interaction is achieved by its participants (Ten Have, 2007). It makes it possible to construct an insight into what people do and how they do it in the setting of interest (Maynard, 1989) rather than basing this insight on what they say and think they did or do (Potter, 2002; Sidnell, 2012).

In short, by examining naturally occurring data, a researcher can more precisely investigate interactional practices and reveal phenomena which could not be uncovered by exclusively depending on elicited accounts (Drewett & O'Reilly, 2023). Moreover, there is the issue that it might be very difficult (perhaps even impossible) for people to provide accurate descriptions of what they have said at what particular time during a conversation. Also, there is a potential issue of people (such as medical professionals) telling a researcher in an interview what they should do or what policies tell them they should do, rather than what they actually did or do. For instance, a study by O'Reilly *et al.* (2016) showed that professionals, in mental health consultations, believed they were routinely conducting risk assessments (which is what national guidelines instruct them to do), but that video data demonstrated that this was actually rarely the case in practice. Finally, there is also the benefit of working with recorded interaction, as a researcher is able to repeatedly view that recording in order to aid the analysis, as compared with, for instance, ethnographic observations.

3.2.2 Unmotivated looking

As mentioned earlier in this section, CA is regarded as an inductive research method, which distances itself from imposing any *a priori* determined theories or categories on the data, particularly commonly invoked sociological features such as class, gender, power, etc. It also eschews pre-specified analytic goals (Schegloff, 1996). CA advocates *unmotivated looking* at data, to see what patterns and phenomena are observable (Jefferson & Lee, 1992), which ensures that the researcher maintains an openness to all potential observations while being limited to what the conversation participants make visible and observable themselves (Sacks, 1984). Maynard (2013) characterises unmotivated looking as a defining feature of CA and describes it as an analytic stance in which a researcher sets aside, as much as possible, any preconceived ideas regarding "how a domain of human action does or could operate" (p. 18). Unlike many common traditions in the natural and other social sciences, where researchers typically begin with clearly defined hypotheses and search for evidence either accepting or rejecting those hypotheses, CA's stress on unmotivated looking positions it as an explicitly inductive research approach (Raymond *et al.*, 2024). The objective is not only to allow the possibility of identifying practices or phenomena the researcher could not have anticipated, but also to make sure that the participants' own situated actions and interpretations are prioritised over those of the researcher. By contrast, if the analyst does impose any hypotheses based on pre-existing assumptions and beliefs, "many things that actually occur are debarred from use as a basis for theorising about conversation" (Sacks, 1984, p. 25).

Now, while unmotivated looking helps in anchoring any analyses in the interaction itself and thereby minimises the likelihood of prematurely theorising about participants' actions, there are several factors why an entirely unmotivated looking approach may not be feasible under some circumstances. First, researchers often need a clearly defined research question (or a set of questions) to secure funding and access to any data, making unmotivated looking more of an idealistic approach for many researchers. Second, an analyst's experience and corresponding theoretical background (Clayman & Gill, 2004) may cause completely unmotivated looking to be impractical. Finally, especially in health

care research, there is typically a wider goal of improving practice and patient care, inevitably shaping the focus of any following analyses. However, the lack or absence of pure unmotivated looking is not necessarily problematic. Presumably more crucial than unmotivated looking is the principle of *ethnomethodological indifference*, involving the analyst refraining from making any evaluations about the value, validity or effectiveness of participants' practices (Heritage, 1984a). Such an approach still ensures that the analysis remains unbiased and grounded in the participants' own methods and perspectives.

3.2.3 Data transcription

Once the data are recorded, they are transcribed using the Jefferson (2004) system of transcription (see Appendix 1). This is the conventional method of transcription for CA-related research, and it focuses on the minute details available in the recordings, whereas no detail could be *a priori* dismissed as being irrelevant (Heritage, 1984a). Jefferson's (2004) system of transcription aims to capture the structure of conversational turns, their sequential positioning, the timing of gaps and pauses, the beginning and end of overlapping speech, as well as elements like pitch, emphasis, laughter and crying (Hepburn & Bolden, 2018). The purpose of this transcription is to capture not just what was said when, but also, as much as possible, how it was said. Arguably, transcription can even be considered as the first step in analysis. Such detailed transcriptions moreover allow researchers to extensively and frequently analyse the data (Gosen & Koole, 2017) and can ultimately be used to present and structure an analysis in a well-ordered fashion. However, transcripts are used as a *supplementary tool* for the analysis, while the audio-recordings remain the main data source. These recordings should be examined and listened to repeatedly, and the corresponding transcripts progressively refined, as there is no possibility that everything of potential relevance, especially regarding how things were said, for each stage of an analysis can be included straight away (Hammersley, 2010).

3.2.4 Generic orders of organisation in talk-in-interaction

As mentioned above, earlier conversation analytic research has pinpointed several key structures of interaction that can guide any detailed analyses. More specifically, Schegloff (2007, p. xiii) described a set of "generic orders of organisation in talk-in-interaction", which has been the focus of many of the foundational developments in conversation analytic research since the 1960s (Stokoe *et al*., 2024). Schegloff (2007, p. xiv) presents these generic orders as:

> "the various organisations of practice that deal with the various generic organisational contingencies of talk-in-interaction without which it cannot proceed in an orderly way:
>
> (1) the "turn-taking" problem: who should talk next and when should they do so? How does this affect the construction and understanding of the turns themselves?
>
> (2) the "action-formation" problem: how are the resources of the language, the body, the environment of the interaction, and position in the interaction fashioned into conformations designed to be, and to be recognizable by recipients as, particular actions – actions like requesting, inviting, granting, complaining, agreeing, telling, noticing, rejecting, and so on – in a class of unknown size?
>
> (3) the "sequence-organisational" problem: how are successive turns formed up to be "coherent" with the prior turn (or some prior turn), and what is the nature of that coherence?
>
> (4) the "trouble" problem: how to deal with trouble in speaking, hearing and/or understanding the talk so that the interaction does not freeze in place when trouble arises, that intersubjectivity is maintained or restored, and that the turn and sequence and activity can progress to possible completion?

(5) the word-selection problem: how do the components that get selected as the elements of a turn get selected, and how does that selection inform and shape the understanding achieved by the turn's recipients?

(6) the overall structural organisation problem: how does the overall composition of an occasion of interaction get structured, what are those structures, and how does placement in the overall structure inform the construction and understanding of the talk as turns, as sequences, etc.?"

Schegloff (2007) continues with stating that all these interactional problems instigate a corresponding set of generic "organisations of practice" (p. xiv), working together all the time and eventually constituting 'a conversation' and other types of talk-in-interaction (e.g., interviews, lectures, interrogations, consultations, etc.). The remainder of this section discusses each of these problems and its corresponding organisations of practice separately.

3.2.4.1 The turn-taking problem

The turn-taking problem is centred around the issue of which conversation participant is supposed to talk next and when they should take the floor. Now, one of the most fundamental components of CA is that social interaction is organised through *turn-taking* (Sacks *et al.*, 1974). This proposed system operates on the principle that usually one conversation participant speaks at a time and turns follow each other without long periods of silence or much overlap, regardless of the varying length or content of those turns. This turn-taking system exists of two components: (a) the turn-allocation component and (b) the turn-construction component. Each individual turn comprises one or multiple *turn constructional units* (TCUs). Such a unit can be a syntactically complete sentence ("I am going to the supermarket"), but also can involve one single word ("Fine", "What?", "Here"). The end of a TCU is regarded as the first possible point of completion of a speaker's turn, which could result in a change of speaker, also called a *transition relevant place* (TRP). A speaker needs to clearly project when a TCU is likely to be complete in order to ensure a smooth transition of speakership at transition relevant places. However, a speaker also has access to linguistic and non-verbal

resources to indicate that a TCU's point of possible completion is in fact not a TRP. Namely, speakers sometimes want to say more than they could do in one single TCU and hence will produce so-called *multi-unit turns* (Schegloff, 1980). So, at a TRP, whether speakership changes depends on the turn allocation component of the turn-taking system. In general, speakership can (not) change in three different ways: (i) the current speaker can select a next speaker, (ii) a recipient can self-select as next speaker and (iii) the current speaker can continue with the absence of self-selection. It is through participants' adherence to these (hierarchical and recursive) turn-taking rules that intersubjectivity and progressivity are both achieved.

As discussed earlier, turns act as vehicles for getting things done in episodes of social interaction. Namely, besides the fact that talking by itself could already be described as an activity, talk is the foremost tool for getting things accomplished. While we speak, we do not merely speak; we greet, invite, request, announce, blame, etc. A turn provides a speaker the opportunity to accomplish any of these actions, and these actions are continuously coordinated and overseen by the conversation partners (Sacks *et al.*, 1974). This means that turn-taking enables a way of sense-making between interactants by not only providing components relevant for the succeeding turns in that conversation, but also for responding to what has been said before, through intersubjectivity (Heritage, 1984; Koole, 2015; Pomerantz & Mandelbaum, 2005). As discussed in the section on the indexical nature of language and the next turn proof procedure, turns of talk display (or do not display) an understanding or interpretation of some previous turn of talk (usually of what has just been said before) through the way that present turn is delivered. For instance, a previous turn understood by a next speaker as a 'request' is subsequently answered to with either a 'granting' or a 'rejection'. Similarly, a speaker might 'accuse' someone else, and it will be perceived as an accusation based on how it is subsequently followed by an 'account' to the accusation. In this way, speakers constantly update the turn-taking system and overall structure of language in social interaction (Sacks, 1992) as a method for (dis)confirming mutual understanding (intersubjectivity) of their talk (Heritage, 2005).

Sacks *et al.* (1974) described the turn-taking model as a system with rules that is both context-sensitive and context-free. On the one hand, it contains context-sensitive tools provided to speakers by the TCU to project possible points of turn completion. On the other hand, those tools are sufficiently general and flexible to be applied in every environment over and over again, making them to some degree context-free. Furthermore, the system is neutral to every particular setting: the relevant social identities of the interactants are locally derived from the organisational state of the conversation. For instance, identities such as current, previous and next speaker are constantly locally defined and the system does not take into account what interactants could be furthermore categorised as (man/woman, employer/employee, doctor/patient, etc.). However, in interactions in institutional settings (such as the hospital), the situational identities (doctor/patient) are indeed of importance to turn-taking organisation. Therefore, the turn-taking system of Sacks *et al.* (1974) could be regarded as context-free but is not independent of the type of conversation (Heritage & Greatbatch, 1991; Mazeland *et al.*, 1995; Wilson, 1991). Namely, in many institutional settings, the turn-taking procedures (who is allowed or expected to speak at particular moments) are determined in advance, as well as what kind of activities the conversation partners are allowed or expected to conduct. This is also applicable to doctor-patient interaction (Frankel, 1990; Ten Have, 1987), for instance in primary care consultations (Heritage & Maynard, 2006). Namely, participants in primary care medical consultations take up specific identities (e.g., patient and general practitioner) and deploy specific rights and responsibilities (e.g., a patient presents their problem and the general practitioner recommends a particular treatment).

3.2.4.2 The action-formation problem

As I concluded in the previous section, CA is not solely interested in the language speakers use but focuses mainly on the actions people employ to accomplish things (Ten Have, 1999). The action-formation problem concerns how such actions are actually (successfully) recognisable by recipients as specific actions, such as granting, rejecting, requesting, etc. Now, there are certain practices,

constituting of elements within a speaker's turn, that illustrate the social action being carried out during that turn.

Heritage (2011) proposed that identifying practices through conversation analysis involves three stages. Initially, the distinctiveness of a practice must be assessed. For example, Heritage's own research on the word 'oh' (Heritage, 1984b) demonstrated this stage. He observed that the practice initially appears intriguing, warranting further exploration, even if it seems vague at first (Schegloff, 1997). The second stage involves identifying the practice's sequential placement. Heritage (1984b) found that 'oh' frequently appears at the beginning of a speaker's turn. The last stage is to uncover the practice's explication and its unique role. In Heritage's (2011) study of 'oh', he found that 'oh'-prefaced responses to questions often occur in instances where the question questions something previously stated or strongly implied, making the response largely self-evident. Additionally, 'oh' at the start of a turn signals a shift in the present knowledge state of the speaker (Heritage, 1984b). It is important to note that practices are not fixed and static components within an interaction. For a practice to be effective, the recipient must identify the intended action behind it (Sidnell, 2012). As Sidnell (2012, p. 78) stated, "for human interaction to work efficiently, a recipient must be able not only to recognise what action a practice is meant to accomplish, but also to check that his/her understanding of it is correct, or at least sufficient".

In short, the two key factors in action formation and ascription are turn location and turn design, which will be discussed in more detail in sections 3.2.4.3 and 3.2.4.5 respectively. Moreover, the context of ongoing activities and the broader institutional framework with the associated social roles of participants (e.g., doctor/patient) also play a vital role in action formation.

3.2.4.3 The sequence-organisational problem

The sequence-organisational problem entails the question of how different turns in a conversation relate to each other and are formed up to be coherent with any prior turn. As discussed multiple times already, turns can both respond to prior talk and can project further talk. Moreover, turns in conversation are also linked through specific patterns or sequences that are structurally organised, *in situ*, by

interactants themselves. This is often referred to as *sequence organisation* (Schegloff, 2007). The most basic example of a sequence is an adjacency pair involving a pair of two related actions produced by two different speakers in a particular order. By producing a particular action, the different speaker (i.e., the recipient) is expected to respond with a paired action (Sacks, 1992). For instance, a question – a 'first pair part' – is sequentially implicative (Sacks, 1992) for the production of an answer – a 'second pair part'. In other words, a first pair part makes the production of an appropriate second pair part a sequential relevant task. This, in turn, makes the production of a second pair part conditionally relevant on the production of the initiating action (the first pair part) (Schegloff, 2007). As briefly touched upon in the section regarding the indexicality of language and the next turn proof procedure (Section 3.1.2.3), adjacency pairs are essential for achieving both intersubjectivity and maintaining progressivity (Heritage, 1984b). Namely, if the producer of a second pair part is not responding with an appropriate response (or is not responding at all), then its absence is noticeable (Sacks, 1992) and often accountable (Drew, 2005).

This normative structure of talk-in-interaction lies the basis of what is known as *deviant case analysis* in conversation analytic research. As discussed, while an initial action (e.g., an invitation) typically elicits a specific set of responses (e.g., an acceptance or a rejection), this relationship is neither mechanic nor predetermined. Even when an expected pattern is not followed (e.g., an invitation is not followed by an acceptance or a rejection), speakers can still orient and respond to this "relevant absence" (Schegloff, 2007, p. 20) in various ways. Such an orientation actually serves as supplementary evidence bolstering the observed regularity (Schegloff, 1996; Sidnell, 2012) and provides a *second order validity* to the description of that regularity (Sacks, 1987).

3.2.4.4 The trouble problem

The trouble problem involves how speakers deal with trouble in speaking, hearing and/or understanding the talk so that, when trouble arises, the interaction does not come to a complete halt, the speakers still maintain (or restore) intersubjectivity and that the ongoing activity of the talk can still progress to possible completion. As I have established by now, a next speaker can

show by their response to the previous speaker's turn that (and how) they have understood the previous turn. Equally, they can also indicate that the previous turn has been misunderstood. In such cases it is important for the progressivity of the talk to solve that problem as quickly and as smoothly as possible. Similarly, a current speaker can also make mistakes, which also should be resolved as quickly as possible. Schegloff *et al.* (1977) have shown how speakers manage procedures to solve such conversational trouble, called *repair organisation*. They distinguish between who (which interactant: the speaker or hearer) makes the correction and who initiates the correction. Following this distinction, they proposed the following categories of repair:

1. Self-initiated self-repair
2. Other-initiated self-repair
3. Self-initiated other-repair
4. Other-initiated other-repair

Specifically, self-repair takes places when the speaker responsible for the trouble source fixes it within their own talk, typically within their ongoing turn, and may involve repeating talk to delete or replace a word or explicitly search for a word (Kitzinger, 2012). However, self-repair can also happen in the transition relevant place (after a TCU's point of completion) or in third position, after the recipient has produced a second pair part (Schegloff, 1997).

3.4.4.5 The word-selection problem

The word-selection problem includes how the components of a turn are selected (out of an infinite amount of options) and how that specific selection influences the recipient's understanding of that turn. Now, ultimately intertwined with the turn-taking system, sequence organisation and repair is the concept of *turn design*. In essence, speakers constantly form their turns with consideration to their position within a sequence, to the intended action of the talk, and to their specific audiences (Drew, 2012). Similarly, both speaker and hearer are attentive to various aspects of each other's turn construction to identify the moments to initiate their own contributions (Sacks *et al.*, 1974). Additionally, interactants

engage in the analysis of what a particular feature might be attempting to accomplish; speakers operate as if internally asking themselves "why that now?" (Sacks & Schegloff, 1973, p. 299). In this context, 'that' refers to a distinctive element in the preceding turn. Making assumptions about the purpose behind a particular feature in a turn provides individuals with insights into the other speaker's intentions, fostering mutual understanding and ongoing sense-making within a conversation. Additionally, Sacks (1992) formulated a number of recipient design 'rules', such as 'design your utterances for a particular recipient' and 'do not tell recipients things they already know'. Essentially, these rules show quite some overlap with the maxims of Grice (1975).

3.2.4.6 The overall structural organisation problem

Finally, the overall structural organisation problem refers to how the overall composition of an interaction is structured, what these structures look like, and how this overall structure influences the speakers' understanding of talk within that structure as particular actions, turns, sequences, etc. Most types of interactions possess some general structural characteristics. In everyday conversation, these include particular practices such as openings and closings (Sacks & Schegloff, 1973; Schegloff, 1968), where their absence can be marked and impactful. Yet, within the main part of a mundane conversation, interactions are relatively fluid and can vary according to the interactants' preferences. In contrast, a medical visit has a more defined internal structure or overall organisation, which physicians learn in medical school and with which patients become familiar through repeated experiences (Heritage & Maynard, 2006). This structure consists of several phases or activities that typically occur in a specific sequence: opening, problem presentation, examination, diagnosis, treatment, and closing. Typical GP-patient consultations, particularly those where the patient presents a new medical problem, have such a clearly structured overall organisation (Robinson, 2001, 2003).

Although this structure remains quite complex (Heritage & Maynard, 2006), the conduct of medical professionals and patients can be analysed to understand how they navigate and manage the 'boundaries' of each main activity component (Heritage, 1997). For instance, the manner in which patients respond

to history-taking questions can reveal their understanding of the questions' purposes and even the progress to a (different) diagnosis. Similarly, patients can deploy specific behaviours during problem presentation, which may indicate the transition to physical examination, diagnosis, or treatment (Robinson, 2003; Robinson & Heritage, 2005; Robinson & Stivers, 2001). In these ways, the overall structure of an encounter can serve as a resource for advancing the interaction.

3.2.5 Conversation analysis and health care interaction

While CA mainly developed by looking at ordinary conversations, its scope has now broadened into various specialised areas of interaction. These areas include educational settings, media interviews, emergency service calls, courtroom interactions and medical consultations, which differ significantly from mundane conversations, both on a social and organisational level. The contrasting focuses of these two branches of CA can be outlined as follows: studies of ordinary conversation treat the structure and function of talk itself as the primary subject, while studies of institutional talk investigate how social institutions are navigated and managed through talk (Drew & Heritage, 1992; Heritage, 1997). The fundamental assumption for analysing institutional talk is that everyday conversation is more basic and primordial compared to institutional talk. The practices of ordinary conversation tend to evolve slowly and show remarkable consistency across different settings, languages and cultures (Dingemanse *et al.*, 2015; Kendrik *et al.*, 2020). In contrast, the practices of institutional talk can adapt rapidly and are influenced by various social dynamics. For instance, the 'consumer movement' in health care has significantly altered how doctors typically deliver diagnoses (Heritage, 2001).

Since the late 1970s, conversation analysis (CA) has been utilised to study medical interactions across various settings, from homes (Heritage & Sefi, 1992) to operating theatres (Nieboer *et al.*, 2022) and from childbirth (Halvorsen *et al.*, 2025) to end-of-life care (Land & Pino, 2025). This research has delved into many aspects of health care communication, with a significant emphasis on primary care interactions. Many studies have revealed the complex routines and intricacies of medical consultations, shedding light on how these interactions actually work. CA has allowed researchers to understand, for example, how

oncologists manage miscommunication in consultations (Pino *et al.*, 2022), how GPs use web-based information during consultations (Stevenson *et al.*, 2019) and how physicians negotiate patients' treatment preferences (Landmark *et al.*, 2016).

The growing application of CA in practice has been facilitated by translating CA results into practical recommendations. This body of work focusing on *how things are done*, whether implicitly or explicitly, sets out *how things can be done*, as these analyses might reveal practices that offer valuable insights to practitioners. It is, however, essential to acknowledge that while CA aims at identifying recurrent interactional practices and their potential contingencies, such findings do not necessitate strictly causal or deterministic relationships between specific (interactional) actions and outcomes. For instance, a study by Stivers (2007) offers insights into how clinicians may either cause or avoid parents' resistance when not prescribing their children a course of antibiotics. The study showed that when a GP explicitly recommended against antibiotics ("I don't think antibiotics will be effective"), this often led to parents resisting this recommendation, potentially ultimately resulting in unnecessary antibiotic prescribing. When GPs instead affirmatively recommended a non-antibiotic treatment ("I am going to give you some cough medicine"), it was less likely to receive any parents' resistance. Stivers (2007) argued that this is because the latter approach still legitimises the medical visit and acknowledges the (importance of the) treatability of the child.

One other example of the importance of the interaction order is the principle of how small variations in language use, even on single word level, can substantially shape the trajectory of an interaction and influence recipients' subsequent behaviour. An example of this is a study by Heritage *et al.* (2007) looking at GP-patient interaction in the United States. They demonstrated that patients disclosed more additional concerns (if they had more than one concern) when GPs asked them if there are *some* other concerns they would like to address, as opposed to when GPs asked them if there are *any* other concerns. This finding shows that a small one-word variation (*some* vs *any*) can have significant consequences both for the unfolding of the interaction and for outcomes beyond the encounter as well. However, a more recent study by Leydon *et al.* (2018) on a

UK primary care setting found that this *some* vs *any* word choice made no difference. They proposed that what actually seems to be important is whether GPs solicit additional concerns at the beginning or at the end of the consultation. They suggested that soliciting additional concerns early in the consultation allows GPs to manage and prioritise patient expectations from the outset of a consultation.

Finally, another example is a conversation analytic study by Barnes and van der Scheer (2021). They looked at the different ways GPs can ask patients about any prior self-treatment. The study identified two different ways in which GPs can do this, by either using a question word interrogative ("what have you taken for the pain?") or by using a yes/no interrogative ("have you taking anything for the pain?"). They found that the first option established a normative expectation for self-treatment which some patients are unable to align with, resulting in a negative impact on the doctor-patient relationship. Barnes and van der Scheer (2021) stated that the second option is therefore likely to be a better option, as a yes/no interrogative is a less risky way of asking about self-treatment because this does not put patients in a position in which they have to account for their (non)action.

3.3 Summary

Much of the existing literature on remote (telephone) GP consultations focused on issues such as acceptability, feasibility, or the suitability of different remote consultation modes for particular (clinical) scenarios. These studies were not able to capture the interactional detail of how telephone consultations are organised moment-by-moment, nor did they describe the particular interactional practices through which GPs and patient collaboratively construct a telephone consultation. The actual turn-by-turn interaction during remote phone consultations is still highly under-researched (Seuren *et al.*, 2024), yet such an analysis offers access to the fine-grained particular interactional practices through which GPs and patients manage the business of the consultation. This level of detail regarding interactional specifics cannot be revealed from research generated by interviews, focus groups or surveys (Aguinaldo, 2022; Potter & Hepburn, 2005). Therefore, additional research is needed which directly analyses

GP-patient interaction during remote telephone consultations in order to understand how these consultations are produced in situ.

The method of conversation analysis (CA) is built on Garfinkel's (1967) *ethnomethodological framework* and took on Goffman's (1983) call for interaction to be studied as topic in its own right. It treats talk as a tool to get things done in the (social) world and sees it as the primary medium through which professionals (such as doctors) carry out their daily working activities. Central to CA is the premise that there is "order at all points" (Sacks, 1984, p. 22) in the ordinary situations we as speakers find ourselves in. Rather than existing prior to interaction, this order is produced and displayed *in situ* by interactants themselves (Francis & Hester, 2004). Accordingly, CA focuses on grounding its analysis in the conduct participants make observable to each other (Koole, 2015). It does not seek to make any claims about thoughts or interpretations that interlocutors keep to themselves. By examining naturally occurring interaction, CA aims at to reveal the practices and principles through which conversation participants organise, interpret, and make sense of what they say and do (Sidnell, 2012).

Currently, advice and guidance about communication in remote consultations mainly concern broad communication characteristics (e.g., checking that the audio is working well (Wherton *et al.*, 2020)) or that particular broad-brush communication activities are present (e.g., eliciting patient concerns (Hewitt *et al.*, 2020)). By recording interaction in health care encounters and taking a detailed approach of analysing social interaction in its sequential context, conversation analytic research has the potential to put forward evidence-based rigorous recommendations regarding what communicative practices may or may not work best to achieve a particular goal in a particular context. We considered some examples of such studies in section 3.2.5, showing that only by precisely looking at the actual interaction we could make concrete recommendations for medical professionals. In sum, by audio-recording interactions between GPs and patients during telephone consultations and by thoroughly analysing them using the method of conversation analysis, this PhD study has the potential to contribute specific, evidence-based and rigorous recommendations about some recurring interactional practices in telephone consultations.

Chapter 4. Methods

4.1 Introduction

The previous chapter introduced conversation analysis as a method for investigating how social interaction is organised and managed within its interactional context. This chapter will explain the specific methods and the particular practicalities of carrying out this conversation analytic study. The chapter begins with focusing on the preparatory work that was done to refine the research design and to enable the safe and successful collection of audio-recordings, alongside making informal ethnographic fieldnotes while being co-present in the consultation room, in a general practice setting (Section 4.2). Section 4.3 includes the aims and objectives (i.e., the research questions) of this study and in Section 4.4 I will outline the sampling approach adopted for this study (including discussing the participant inclusion and exclusion criteria), situating it within the principles of conversation analysis. Subsequently, in Section 4.5, I will describe the ethical approvals obtained for the study and briefly touch on the measures taken to deal with ongoing ethical considerations throughout the research process. Section 4.6 explains the recruitment processes for this study, describing how research sites (GP practices) and participants (GPs and patients) were identified, approached and eventually consented to take part in this study. Then, I will describe the procedures for recording and storing the data as well as dealing with issues regarding confidentiality (Section 4.7) and subsequently I will offer an overview of the data I collected (Section 4.8), including details of participating GP practices and the recorded consultations. Section 4.9 describes the analytic procedures used in the study, including transcription, collection building and the process of refining developing analyses. I will end with reflecting on my positionality within the context of this conversation analytic study (Section 4.10).

4.2 Pre-data collection activities

The initial idea for this PhD project was somewhat prefigured as an ESRC collaborative award centred around video-mediated consultations in primary

care. As established previously, despite the prominence of video consulting during the COVID-19 pandemic (Royal College of General Practitioners, 2021a), personal contact with GP surgeries and data from The Health Foundation (2025) shows that most remote consultations since the start of the pandemic until now actually take place over the telephone. This is supported by the actual distribution of appointment types in UK NHS General Practice (see Figure 1, page 1). Due to this lack of video-mediated consultations in primary care, and given the importance and relatively central role that telephone consultations currently play (and are likely to continue to play) in UK general practice, the PhD project shifted to focusing on telephone consultations instead.

As I was relatively unfamiliar with UK NHS General Practice, and with telephone consultations in general, I visited the general practice of my clinical supervisor in August 2022 and spent an afternoon in the consultation room listening in on a number of telephone appointments and seeing how the practice was laid out and organised. Engaging in ethnographic observations of the particular health care environment before commencing collecting audio-recordings helps in establishing trust with participating health care professionals and gaining insight into the work setting (Hoey & Webb, 2024), and determining how recordings can be made in an acceptable and safe manner to minimise disruption in busy health care settings (Caldwell & Atwal, 2005). As Parry *et al.* (2016) states, such preparatory observational work is also regarded in the research community as best practice. This preparatory visit also highlighted it would be beneficial to be co-present with the GP in the consultation room and collect informal ethnographic fieldnotes at the time of audio-recording telephone consultations. Namely, this enables a researcher to capture contextual details of the consultation environment (for instance, what kind of resources are displayed on the GPs computer screen) that would not be observable or audible on the audio-recordings themselves. I decided to include this in the study design.

In the process of designing, developing and executing health care related research, the active involvement of stakeholders helps in ensuring that the study is both acceptable to patients and beneficial for health care providers (National Institute for Health Research, 2021; Staley, 2009). With regards to this study, involvement of stakeholders was especially important for the collection of high-

quality recordings in a manner that was regarded as acceptable and safe and which minimised disruptions within the environment of ever-busy health care settings. Therefore, before the start of data collection, this research study was discussed with medical IT and PPI (Patient and Public Involvement) experts. In the process of designing the study, we realised that in terms of gaining consent from patients, it was not feasible to do this in-person (because these patients did not come into the practice for their consultations). I worked together with a local IT manager at one of the participating GP practices in exploring the possibility of contacting patients and seeking informed consent using the practice text message software (through TPP SystmOne). We tested using this software in sending a custom questionnaire (that would serve as the consent form), seeing what this would look like on the patient's side (on a mobile phone) and checking how completed questionnaires would return to the practice and could be stored in the patient's medical records. We ensured that this would work properly before producing the research protocol and other study documents. Furthermore, PPI is widely considered as essential for carrying out robust and valuable health care related research (National Institute for Health Research, 2021).

Growing consensus suggests that ethical PPI includes financially compensating PPI-participants (Health Research Authority, 2025a). As this study was a PhD project, I did not have access to any funding for PPI remuneration, meaning that it was not feasible to have PPI representatives involved continuously throughout the study. Nevertheless, I arranged multiple meetings with PPI experts and discussed the planned aims and objectives as well as the broader study design with them. Ultimately, these discussions contributed to the development of participant materials including patient information sheets and consent forms, and so this feedback was incorporated before the final versions were produced.

4.3 Research questions

The aim of this PhD project was to produce detailed knowledge about the interactional practices associated with and used in telephone consultations between GPs and patients, and to closely describe how these consultations are

organised through the sequential structure of the interaction. In order to produce this detailed knowledge, there were three objectives formulated before data collection and any analyses commenced:

1) Identify (some of) the core interactional practices of telephone consultations in primary health care.
2) Discover how these core interactional practices are designed and delivered.
3) Identify (some of) the key interactional affordances and challenges arising for GPs and patients during telephone consultations.

4.4 Sample

Traditional CA has typically focused on building large datasets, frequently drawing on recordings from multiple sites in order to examine interactional phenomena across several contexts. Schegloff (1999), for example, argued that observations made in one setting should be used to evaluate, refine, or even revise our understanding of a phenomenon by comparing them with data from other interactional contexts. Likewise, Sacks (1992) emphasised that if we assume interaction is orderly, then the site of data collection becomes less important – whether it is a classroom, a family dinner conversation or a GP-patient telephone call – since the analytic focus is on uncovering recurrent practices. From this perspective, the aim is often to capture a phenomenon (e.g., advice giving) in as many different interactional environments as possible, with each new setting potentially revealing "new variants" (Heritage, 1988, p. 131).

By contrast, in applied CA research, the analytic approach tends to be more tightly focused (Lester & O'Reilly, 2019). Rather than collecting data from a wide range of (everyday) encounters, the focus is on interactions situating in a particular interactional context. As a result, data collection is shaped by the specific aims of the project and the particular institutional contexts in which the interaction occurs. The primary interest is not in interaction *in general*, but in how participants organise their talk in a given institutional setting, where communicative practices are shaped by the aims and limitations of that particular setting. This PhD project fits within the latter example. Nevertheless, we decided

to include multiple GP surgeries in the study (initially aiming to recruit four but ultimately achieving participation from three). Specifically, we aimed to include both rural and urban practices, as well as practices serving patient populations with varying levels of socioeconomic deprivation. These factors were considered relevant because they are likely to influence not only access to care and the nature of telephone appointments (whether they are used routinely, mainly for follow-ups or urgent appointments, etc.), but also patients' familiarity with telephone consultations, and potentially the communicative demands placed on GPs. Including a range of different GP practices was therefore intended to produce a dataset that, while still focused on a single institutional context, captures a variety of conditions under which telephone consultations are carried out in NHS primary health care.

For CA research, when it comes to sampling, there is no set way or number. CA is neither qualitative nor quantitative in that sense. Namely, its focus is on the language that individuals use rather than the individuals using it or the texts in which it appears (Potter & Wetherell, 1987). This contrasts with other more qualitative approaches in which the number of how many people were interviewed plays an important role. In those approaches, sampling is often guided by the concept of *saturation* – the point at which no new ideas emerge during data collection (Francis *et al.*, 2010). However, this notion of sampling adequacy is not appropriate for all qualitative methods, including CA (O'Reilly & Parker, 2013). While saturation can be understood as the stage when additional data no longer provides new findings, applied CA typically has a different analytic purpose, and consequently the analytic scope can be deliberately limited to a particular setting (Ten Have, 1999). In applied CA, the emphasis is on the language-in-use, so the number of participants is generally not the primary concern (Lester & O'Reilly, 2019). Within the scope of the current PhD project, this means that the unit of analysis is not the telephone consultation as a whole but the potentially 1000s of different turns of talk that occur in them.

4.4.1 GP participants

While NHS primary care involves a range of health care professions (GPs, practice nurses, pharmacists, health care assistants, etc.) and although the title of this PhD project refers broadly to 'telephone consultations', the analytic focus is specifically on interactions between GPs and patients. GP-patient consultations constitute a central site of care delivery in NHS (primary) health care, where key activities such as diagnosis, prescribing and safety-netting routinely occur. Limiting the dataset to GP-patient telephone consultations also enables a coherent and in-depth analysis of how core communicative practices are designed and delivered through talk in a clearly defined institutional context. Moreover, because this study was a time- and resource-limited PhD project, restricting the scope of data collection to GP-patient telephone consultations also ensured feasibility with respect to gaining ethical approval and participant recruitment.

In order to maximise recruitment, any qualified GPs (meaning they must be listed on the National Medical Performers List[2] as a GP and have to be working as a GP in a GP surgery) capable of giving informed consent were eligible to participate in this study (see Table 1). GPs were permitted to take part in a maximum of eight recorded telephone consultations.

4.4.2 Patient participants

Criteria for inclusion and exclusion in the study are set out in Table 1, below. Patients could participate in this study if they were 18 years or older, without an upper age limit, and if they had booked a telephone consultation appointment with a participating GP. Moreover, the inclusion criteria for patients stated that, in order to participate, they should have the capacity and ability to give informed consent. The Mental Capacity Act (2005) states that "a person must be assumed to have capacity unless it is established that he lacks capacity". For this study, a patient's capacity was assessed by their GP.

[2] https://secure.pcse.england.nhs.uk/PerformersLists

Table 1. Participant inclusion and exclusion criteria

INCLUSION

Patients

- Age 18 years or above (no upper age limit).
- Scheduled to have a telephone consultation with a participating GP.
- Capacity and ability to give informed consent.

General practitioners

- Qualified GP (on National Medical Performers List as a GP).
- Working as a GP in an NHS GP surgery.
- Capacity and ability to give informed consent.

EXCLUSION

Patients

- Patients requiring a translator for the care encounter.
- Anyone speaking on behalf of someone else lacking capacity to give informed consent.
- Parent/Guardian speaking on behalf of children.

With regards to GPs there were no exclusion criteria.

Exclusion criteria included cases in which the patient required a translator for the care encounter (because this would substantially affect communication practices), when someone was speaking on behalf of someone else lacking capacity to give informed consent, or in cases in which a parent or guardian was speaking on behalf of children. Patients were permitted to take part in only one recorded telephone consultation.

4.5 Ethics

The study was conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki (1996), the principles of Good Clinical Practice (National Institute for Health Research, 2024), the UK Department of

Health Policy Framework for Health and Social Care (Health Research Authority, 2017) and the local University of Nottingham Code of Research Conduct and Research Ethics (2023). As is the case for any other study involving human participants, the study was reviewed by an ethics committee. Because this research studies NHS patients and staff, and their identifiable data, and because the patient participants were recruited via the NHS, this study needed ethical approval from a Health Research Authority (HRA) Research Ethics Committee (REC). The study was formally reviewed and given a favourable ethical opinion by the Yorkshire and The Humber - South Yorkshire Research Ethics Committee (REC ref. 23/YH/0249), and approval was given by the HRA (see Appendix 2 for the authorisation letter). The UoN acted as sponsor and provided public liability insurance for this study.

After we received a favourable ethical opinion and once we started recruiting patient participants, we noted a technical limitation in the GP practice text-messaging software. This prevented us from including a hyperlink to the Participant Information Sheet in the body of the text message that were sent to patient participants in the recruitment process. To ensure participants still had full access to study information prior to providing consent, we implemented an alternative approach. A hyperlink to the PIS was placed at the beginning of the digital consent form, allowing potential participants to review the document in full before deciding whether to proceed. This alternative method was tested prior to use and was found to function reliably. In all cases, participants had access to the PIS before providing informed consent, in line with ethical requirements. Because this alternative approach involved changes to study documentation, it was regarded as a substantial amendment requiring further ethical review from the same REC that has given a favourable ethical opinion initially. Approval for the changes was granted (see Appendix 3 for the corresponding approval letter), but it unavoidably caused some delays in initiating the recruitment process.

Gaining such formal ethical approval is not, however, the end of the ethical considerations and process. Orb *et al.* (2001) state that ethical research practice is ongoing and should be revisited throughout all the steps of a research study, including all stages of data collection, how the study results are written up and how they are subsequently disseminated. Moreover, as Pollock (2012) states,

much qualitative research includes a form of 'micro-ethics', requiring the researcher to navigate and respond to ethical issues as they arise whilst conducting fieldwork. These emerging ethical considerations are discussed throughout the remainder of this chapter as well.

4.6 Recruitment process

4.6.1 Research sites

The clinical supervisor provided support in identifying and facilitating contact with suitable GP practices. After identifying potential sites, the clinical supervisor sent an email (see Appendix 4) to these sites introducing the overall aim of the project, informing them that the study had received the required ethical approval and ultimately inviting them to participate in the project. This email was usually sent to the Practice Manager and/or Practice Lead GP. Where sites expressed an interest to participate, I arranged a meeting to fully explain the study and, if willing to particate, commenced the recruitment of GPs at those sites. Following GCP research guidelines (National Institute for Health and Care Research, 2022), reasons for non-participating were not sought but a number of sites provided reasons themselves. These reasons included workload pressures, staffing shortages, or difficulties accommodating (additional) telephone appointments within their rotas.

In addition, during the recruitment process I submitted an application for this study to be included on the NIHR Research Delivery Network (RDN) Portfolio. Besides confirming that the study meets high standards of quality and relevance, inclusion also brings several practical benefits for participating general practices. It provides access to national infrastructure and support for research delivery, including help with study set-up, participant identification, and recruitment through the NIHR's Study Support Service. Practices are eligible for additional reimbursement, which helps with covering staff time and the administrative burden associated with research participation. Involvement in portfolio studies also offers professional development opportunities, such as access to Good Clinical Practice (GCP) training and broader support for building research capability. Furthermore, participation can enhance a practice's

reputation as research-active, facilitate future collaborations, and contribute to improving patient access to research opportunities and innovations in care. In November 2024 the study was successfully added to the NIHR RDN Portfolio. Following this inclusion, one GP surgery that had previously expressed an interest agreed to participate in the project.

4.6.2 Research participants

4.6.2.1 Informed consent

The recruitment process and obtaining informed consent from both GP and patient participants were carried out in accordance with the HRA guidelines and Good Clinical Practice (GCP) standards (National Institute for Health Research, 2024). All participants provided written informed consent, in line with the Mental Capacity Act (2005), by completing the Informed Consent Form (see Appendix 5) prior to audio-recording their telephone consultation. Potential participants received a Participation Information Sheet (see Appendix 6 for patients' sheet and Appendix 7 for GPs' sheet), and it was made clear that their participation would be completely voluntary and that they had the right to withdraw at any time during their consultation. Throughout recruitment and consent seeking procedures, participants were given the opportunity to decline participation in the study, and, whilst informed consent was obtained prior to recording any consultation, consent was recognised as ongoing. At the start of each recorded consultation, the GPs reconfirmed that patients were happy for the consultation to be audio-recorded before starting their actual consultation. This also confirmed that the patient was actually the person who indeed was approached to participate in the study, had read the patient information sheet and completed the informed consent form.

After each individual recording, both participants were asked to complete the Optional Authorisation Form (see Appendix 8). One of the long-term aims of this PhD-project is to produce insights that can be used in communication skills training. By focusing on real-life interactions as they unfold in real-time situations, this approach offers an alternative to simulated or hypothetical encounters that may not accurately represent real-world practice (Stokoe, 2014).

For this reason, the post-recording consent process involved permission to use extracts from the recordings in data analysis sessions, presentations to other researchers and future communication skills training. Participants were informed that, if they consented, any names, place names and other identifiable features would be removed from the recording, and their voice pitch would be altered. Moreover, consent was sought for the use of the data in future research. Obtaining such permission reduces the need for repeated data collection or additional fieldwork when suitable data are already available, thereby minimising the potential burden on health care services and participants while also being cost-effective (Corti *et al.*, 2014). These optional authorisations were collected after the recording for two reasons. Firstly, patients will know more clearly after the recording what kind of data they are (not) permitting us to use in research. Secondly, the authorisations might take some time to explain and/or understand and asking participants to consider and decide on the optional authorisations before a consultation may have been burdensome and may have limited consultation time. A (part of a) recording has only been used for the indicated purposes in cases where that specific additional consent has been given by both the GP and the patient.

Furthermore, all participants were made aware through the information sheets that, if any participant believed that the recording was affecting the consultation or they wanted to discuss something they did not want to be recorded, the recording equipment could be stopped instantly. Similarly, participants could also request for the co-present researcher to leave the consultation room during the consultation. Because it is possible that audibly asking the researcher to leave the room or stop the recording would cause upset, distress or embarrassment, following feedback from the NHS REC, we implemented a visual card system whereby the GP could notify the researcher to leave the room or stop the recording by simply holding up a card (see Appendix 9).

Lastly, in order to give patients some form of warning to explain that this research study was taking place at their surgery (especially important in the cases of same or next-day appointments), I designed a poster (see Appendix 10) to be displayed in the waiting room of participating practices.

4.6.2.2 GP participants

As mentioned in the previous section, the initial invitation to participate in this study was also sent to the Practice Lead GPs and in all cases these GPs eventually also participated in this study themselves. The participating sites identified other eligible GPs and these were sent the information sheet for GP participants and the informed consent form. I subsequently arranged a meeting with interested GPs, either online or face-to-face, to discuss the study, answer any questions they had, and explain what would be expected of them if they chose to participate. For face-to-face meetings, GPs either completed the consent form at the time or took it with them to sign later and bring along when their first recorded appointment was scheduled. For online meetings, GPs either printed and signed the consent form themselves and brought a copy to their first recorded consultation, or signed it just prior to the first recording. After every consultation, the GPs also signed a separate optional authorisation form for that particular recording.

4.6.2.3 Patient participants

To minimise the risk of harm or intrusion, patient recruitment was carried out in two stages (see Figure 2 below). Firstly, a member of the GP practice team (i.e., a receptionist, research manager or GP) would approach a patient who had made an appointment for a telephone consultation to ask if they were willing to receive information about the study. This was done by either contacting them by phone or by text message. Staff were provided with a flowchart guide (see Appendix 11) to invite eligible participants. If agreeable, the patients received the patient information sheet and the informed consent form to decide whether they wanted to participate or not. In this study, there were two types of recruitment processes:

i. Textual route: the patient received an SMS (see Appendix 12) from their practice which included an invitation to participate in the study, access to the PIS and the consent form in which the patient could tick the appropriate boxes, and therewith give consent for their telephone consultation to be audio-recorded. This text message was sent using the standard TPP SystmOne practice software, enabling the opportunity to include a custom digital tick box questionnaire which directly feeds back response to the patients' medical notes. TPP SystmOne hosted the consent

form and provided the patients with a link to a webpage with the PIS. When a participant wished to complete the consent form questionnaire, the patient had to first enter their date of birth to get access to the form and, as part of the form, participants had to enter their full name as well. With regards to the optional authorisations, after the consultation, the patients received an SMS (also see Appendix 12) including a link to the optional authorisation form.

ii. Postal route: To accommodate patients without access to a smartphone or who are unable to complete the consent form in the online questionnaire format due to limited digital or technical literacy, we also implemented a postal process. As part of this process, the patient received a letter (see Appendix 13) sent by their practice, which included an invitation to participate in the study, the PIS and a consent form that the patient could complete, sign and send back to the practice, and thereby give consent for their phone consultation to be audio-recorded. Similarly, after the consultation, the patient received another letter (also see Appendix 13) with an optional authorisation form to complete, sign and send back to the practice.

Whilst participating GP practices received an allowance (£150 for overall participation and an additional £12.50 for every recorded phone consultation), we decided to refrain from reimbursing patient participants. The fee for GP practices was to acknowledge the administrative burden that was created by contacting patients with materials from the study documentation and as such it was a notional recompense for time spent on this. Patient participation in this particular PhD study did not involve any additional travel costs, any physical discomfort, or any additional time commitment beyond reading the Patient Information Sheet and deciding whether or not to participate. As such a payment could potentially be categorised as an incentive rather than a recompense. Particularly for this study, it was essential that the consultations which were recorded were as naturally as possible. By paying patients for the recording of their routine and ordinary care, there is the possibility that a) patients may be 'unduly induced' to allow their consultation to be recorded because of the

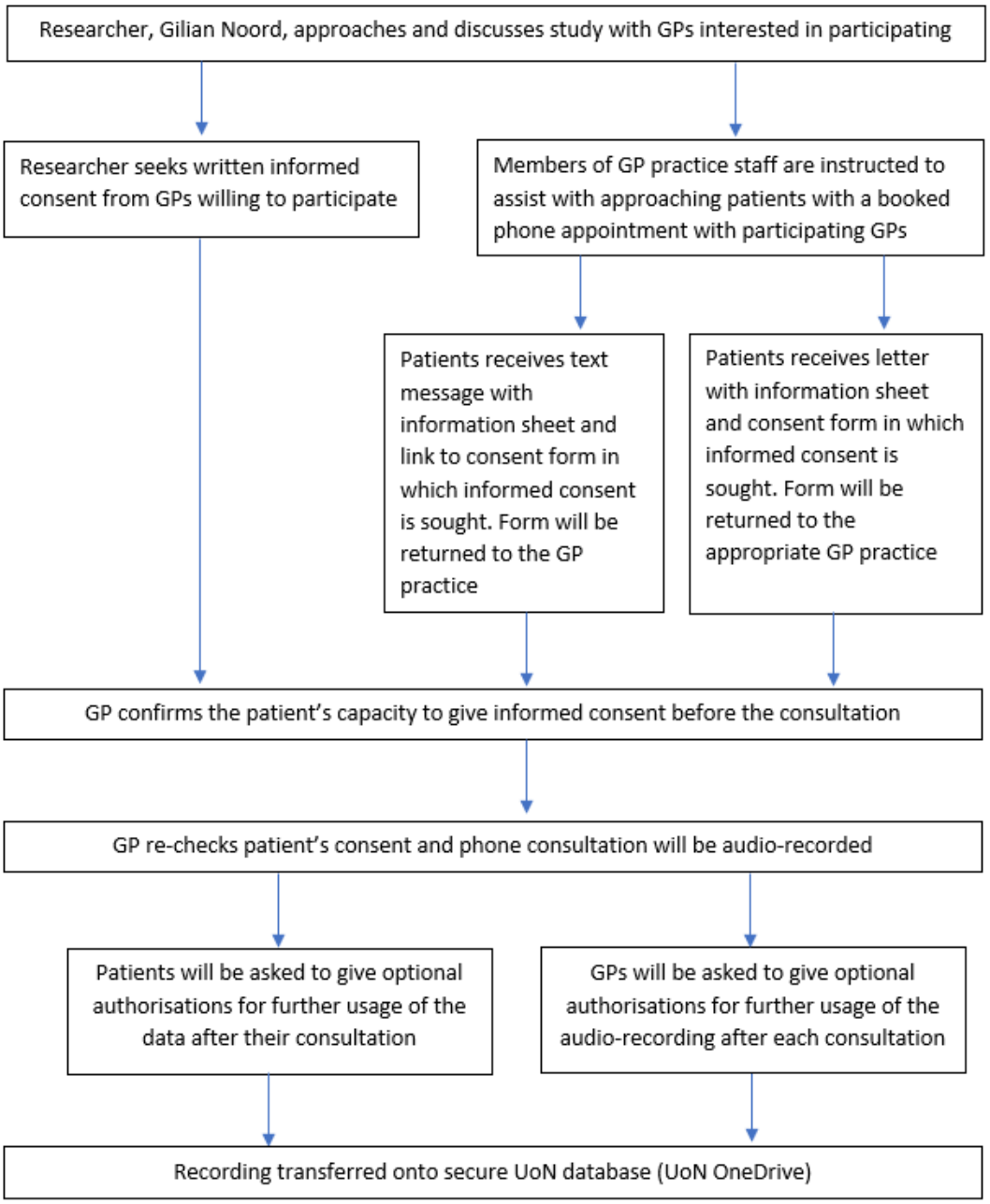

Figure 2. Study Recruitment Schematic

financial incentive (Health Research Authority, 2025b), or b) that they may feel that they need to interact differently in order to 'earn' the payment. Furthermore, in previous similar (conversation analytic) studies, including those in which members of the supervisory team have been involved, patients have not been paid where their participation has consisted of consent to record routine care. These have received a favourable ethical opinion (for example, Compassion in

Practice ref. 19/YH/0012 Yorkshire & Humber; Supporting Consultations in Remote Physiotherapy ref. 21/EM/0082 East Midlands; VOICE1 ref. 15/YH/0184 Yorkshire & Humber; VOICE2 ref. 22/WA/0023 Wales Research Ethics Committee 7 Carmarthen) and also successfully recruited patient participants without offering any reimbursements.

4.7 Data collection

As discussed in the methodology chapter, a key feature of conversation analytic research is the collection of 'naturally occurring data' (Clayman & Gill, 2004; Ten Have, 2007), meaning that the consultation would have taken place regardless of any researcher involvement. Moreover, the audio-recording need to be of adequate quality in order to be able to conduct a detailed analysis of the participants' (non-)verbal conduct (Parry, 2010; Ten Have, 2007). According to best practice recommendations, recording devices in health care contexts should be positioned as inconspicuously as possible (Parry *et al.*, 2016). The recordings were made by using an Olympus LS-10 Linear PCM Recorder. The portable (and relatively small) recorder was placed as unobtrusively as possible between the general practitioner and the telephone, ensuring that the microphone could pick up both voices as accurately as possible. The researcher was always co-present in the consultation room at the time of the consultation, to ensure the recording equipment could be quickly turned off (and on) if needed. Occasionally, the GP also informed their colleagues not to disturb them for the duration of the consultation to prevent any voice-recordings of others and any disruption of the consultation.

Alongside the audio-recordings, the researcher also made observational notes whilst sitting in the consultation room at the time of the consultation (see Appendix 14 for observation sheet). These notes included, if known, any additional information about the purpose of the consultation, if the GP and patient had seen each other before (either over the phone or in-person), any observable features of the GP's non-verbal conduct and any other information that could have been impacting the consultation. While not analysed systematically, these ethnographic notes provided contextual details regarding the consultation setting and activities occurring in the consultation, which can

contribute to and enrich the analysis of the audio-recording (Maynard & Zimmerman, 1984).

This use of observational notes alongside recorded interaction reflects a number of previous conversation analytic studies in which ethnographic methods are used to complement the analysis of naturally occurring interaction. For example, Maynard's (1984) study on plea bargaining integrated audio-recorded courtroom interactions with observational fieldnotes, interviews and court documents. These materials were used to describe the broader features of the setting, its key participants and the general proceedings, while the audio recordings and their transcripts were examined in detail to uncover the interactional practices through which plea bargaining is actually accomplished. Similarly, Whalen's (1995) study of emergency calls combined video-recordings of call-takers doing their work with extensive participant observation, including his own work as a call-taker. The analysis showed how the sequential organisation of emergency calls is closely tied to the use of computer-aided dispatch systems, which call-takers are required to use. It seems unlikely that, without the detailed, situated understanding that came from his participant observation, these practices could have been unpacked by relying solely on the video recordings. Therefore, the use of ethnographic methods alongside CA can make relevant features of the setting, particularly those not directly available in the recordings, analytically accessible and thereby support a more informed interpretation of the data (Ten Have, 2004). At the same time, their use also raises a methodological tension. Whilst ethnographic insights (such as fieldnotes) can inform analytic interpretation, they risk bringing in external explanatory resources (i.e., resources that are not observable by all interactants) which conflicts with CA's approach to grounding analyses in the participants' displayed orientations within the interaction itself. As such, ethnographic material is most appropriately used as a contextualising resource, rather than as a substitute for interactional explanatory evidence.

4.7.1 Observer's paradox

Any research that involves recording participants raises the potential issue that recording may affect the behaviour of these participants. This *observer's paradox*,

a phrase coined by Labov (1972a), involves that the observer's presence (or tools used for observation, such as recording equipment) causes research participants to behave 'unnaturally'. This could be particularly consequential for conversation analytic research, as one of its fundamental requirements is to study naturally occurring interaction (see Chapter 3, section 1.2.1). However, there is no set solution for this particular problem, as Labov (1972b) stated: "the aim of linguistic research in the community must be to find out how people talk when they are not being systematically observed; yet we can only obtain this data by systematic observation." (p. 209). Although this paradox involves a reasonable concern, it does not conclusively undermine the value of recording. For example, a systematic review by McCambridge *et al.* (2014) suggests that the observer's paradox may be overstated.

Heath (1986) proposed that if participants do not display an orientation to the recording equipment or to the fact they are being recorded, then that is sufficient evidence of the unobtrusive nature of the recording (equipment). In my dataset there is not a single instance of a participant orienting to the fact they are being recorded. However, even if that would occur, then that would not necessarily be problematic. A conversation analytic study by Hazel (2016) looked at instances in which research participants explicitly orient to the presence of a recording device. The analysis shows that the participants utilise the fact they are being observed as an interactional resource. Rather than viewing such moments as contamination of the data (see Speer & Hutchby, 2003), Hazel (2016) argues that researchers should regard even these instances as meaningful practices revealing how participants collaboratively construct the research context.

It is worth noting that previous (conversation analytic) research focusing on the observer's paradox included co-present conversations, meaning all interactants had direct visual access to either a recording device or a co-present observer. In the context of this PhD project, only the general practitioner could actually 'see' the audio-recorder on their desk and me seated in the consultation room. Nevertheless, despite the fact that patient participants did not have direct access to this, they were still made aware of the fact that they were being audio-recorded. The fact that the general practitioner, at the beginning of the consultation, was required to verify their consent to participate potentially

increased the 'risk' of the participants' awareness as research subjects. However, despite the fact I have no evidence that both GP and patient participants oriented to the recording during their consultations, this does not exclude the possibility it affected their behaviour. Previous research suggests that such a possible impact would likely only be temporarily, as research participants become used to recording equipment or to the presence of an observer (Jordan & Henderson, 1995). This would be particularly applicable to GP participants as they participated in my study for more than one consultation, suggesting that, over time, they possibly became more accustomed to my presence and to the audio recorder on their desk.

An additional relevant concern is that recording a health care encounter could have a detrimental impact on the quality of care. A literature review by Parry *et al.* (2016) concludes that most people find health care research including recording (in their case videorecording) valuable and acceptable and that existing evidence does not confirm that recording has a detrimental effect on health care delivery. Additionally, a systematic review by Themessl-Huber *et al.* (2008) states that, generally, the participants' knowledge of being recorded does not affect the length or quality of the recorded consultations. Moreover, the research participants who participated in my study were advised (through the information sheets) that recording could possibly affect their communication and that if they thought this may be the case, the recording could be stopped immediately on their request. Eventually, none of the participating GPs or patients asked for this to happen during the time of their consultations.

4.7.2 Data storage & anonymisation

Following audio recording, the data were downloaded from the recorder's internal memory to a University of Nottingham password protected laptop, at the site at which the recording took place. After I transferred the recording to a UoN OneDrive, the internal memory of the recorder was wiped out. In line with the Data Protection Act (2018), all data remained stored on password protected secure servers at the University of Nottingham and all analyses of primary data were conducted here as well. All documents pertaining to the study (i.e., the signed consent forms and completed observation sheets) were held securely, in a

locked room in a locked cabinet and were scanned to be stored on a UoN OneDrive as well. In compliance with the University of Nottingham Code of Research Conduct and Research Ethics (2023), the data will be securely retained for a minimum of seven years following the completion of all work on this study.

Each participant was assigned an alphanumeric study identity code number, for use on the enrolment log, label of the recording, optional authorisation form and on the corresponding transcripts. To ensure consistency, each audio-recording was labelled using the convention outlined below:

[ID number of patient][ID number of GP]

For example, a label might appear as follows:

P16GP03

Any other information (such as initials, date of birth, etc.) were not used in any logs or study documents, so that participants' identities remained confidential and could not be recognised from the code. Finally, recordings were stored as WAV files to ensure compatibility with a wide range of software applications.

In any or all of the processes of transcription, data analysis, and presentations of the research, it is possible, although highly unlikely, that individuals may personally recognise participants. Recognition will not necessarily be harmful but possible harms include negative communications by others about the participants and distress to observers, if for instance a relative who is now deceased is recognised. A number of safeguards were used in order to minimise these potential issues and to give participants the opportunity to consider whether they were willing to accept the possibility of these events. The audio-recordings that were used for transcription and analysis did not leave the GP practice until sensitive information (place and person names, dates of birth, and any other type of information that could identify a participant) was blanked out of the recording. Pseudonyms were used for the transcripts in written reports, and voice features were altered (e.g., modifying pitch) where consent was given for recordings to be played to individuals outside the research team.

These are regarded as standard practices in research on language and social interaction (Joyce *et al.*, 2025). When anonymized recordings were shared with other researchers, such as during presentations about the study (in closed sessions rather than open to the public), attendees were asked to avoid using participants' names if they recognised them and to refrain from referring to them in negative terms, both during the session and in other contexts outside of it. The researcher also reminded audiences to treat with respect those who have allowed their (sensitive) conduct to be observed.

Pseudonyms were assigned with attention to maintaining the original name's syllable length, stress pattern and gender, in order to minimise any impact on subsequent analyses (Saunders *et al.*, 2015). Attention was given to culturally conforming with the original name too (i.e. John Smith might become James Jones, Nilam Soni might become Najwa Patel, etc.). Similarly, the names of places, including towns and institutions (e.g., the name of a local hospital), were also pseudonymised when this was necessary.

4.8 Summary of data collected

Between April 2024 and February 2025, twenty-nine audio-recordings of telephone consultations were collected from three different GP practices in a single county in England. See Table 2 below for an overview of the demographics of these practices.

Table 2. Participating GP surgery demographics[3]

	Registered patients	*Deprivation score*[4]	*Care Quality Commission (CQC) rating*
GP surgery A	16,040	Least deprived decile	Outstanding
GP surgery B	18,487	Fourth most deprived decile	Good
GP surgery C	12,626	Fifth most deprived decile	Good

[3] Derived from Office for Health Improvement and Disparities (2025)
[4] Based on the English Indices of Deprivation (Ministry of Housing, Communities & Local Government, 2019)

The process of data collection was affected by various external factors. Data collection was suspended for over two months, as we had to wait for the REC to approve the amendment of the study documentation (due to a technical limitation in the GP practice text-messaging software, discussed in section 4.5 above). Besides the fact that recruiting GP practices proved challenging, the number of telephone consultations occurring in participating practices was lower than expected, which limited the amount of potential patient participants. However, data collection was most significantly affected by a low participation rate among patients. A large number of patients did not respond to the initial invitation, or after expressing an interest to participate did not complete the consent form. Given that GPs and practice staff could not always facilitate contact with potential participants (for example by giving them a call to remind them to take a look at the information sheet and the consent form), this also restricted the recruitment of patients causing the process to be longer than anticipated.

In total, as Table 3 shows, thirty-two patients consented to participate in this study. Twenty-five patients offered their consent by completing the online questionnaire and seven patients were recruited through the postal route. Because one patient did not attend their appointment and because in two cases the researcher was only informed of their consent after the appointment took place, these three consultations could not be recorded. Ultimately, the twenty-nine recordings were obtained from telephone consultations between six general practitioners and twenty-nine patients. The number of GPs participating differed for each surgery and the number of recordings collected from individual GPs ranged from two to seven. All patient participants participated only once.

Table 3. Summary of participant recruitment and characteristics of audio-recorded telephone consultations

	No.
Recruitment	
Patients consented to participate	32
Patients recorded	29
GPs per surgery (n=6)	
GP surgery A	3
GP surgery B	2
GP surgery C	1

Recordings per surgery (n=29)	
GP surgery A	11
GP surgery B	12
GP surgery C	6
Whether patient had previous experience with telephone consultations (n=29)	
Yes	27
No	2
Whether patient had a previous in-person appointment with same GP (n=29)	
Yes	12
No	17
Main reason for consultation (n = 29)	
Medication review	9
General follow-up	7
Acute symptoms	4
Mental health	3
Test results	3
Arranging referral	3

Based on their digital records, the vast majority of all participating patients did have some experience with telephone consultations, either with the participating GP or another member of the surgery's medical staff. The number of patients who did and did not have a previous face-to-face consultation with the same GP was relatively equally distributed.

As Table 3 shows, the recordings varied in main reason for the consultation. Because the majority of the appointments were booked in advance, the number of recordings in which patients presented 'acute' symptoms was limited; only one participating practice (surgery C) recruited patients with a next-day appointment. There was a relatively large number of consultations that were formally documented as a 'medication review' (see Chapter 5 for an in-depth discussion on this consultation type). General follow-up appointments included discussions around a wide range of topics (i.e., persisting cough, repeated skin infections, issues with new medication, allergies).

At the end of February 2025 the decision was made to stop obtaining more recordings. As I mentioned above in Section 4.4, CA prioritises the detail within over the absolute quantity of data (Sacks, 1992). Relatively small sample sizes are considered appropriate in CA research. Nevertheless, it is important to collect 'enough' data to uncover both recurring patterns and variations in interactional practices (Perakyla, 2004), and to enhance the credibility of the findings by minimising relying "idiosyncratic styles" (Drew *et al*., 2001, p. 60) of particular participants. Ultimately, the twenty-nine recordings resulted in a corpus of approximately six hours of spoken interaction, including thousands turns of talk. The length of the consultations varied between 3mins:20secs and 23mins:36secs, with an average of 12mins:23secs. In past conversation analytic doctoral research (e.g., Drewery, 2023), this dataset size has proven to be both manageable and fruitful in generating findings that contribute to the cumulative body of evidence about the structure and function of interaction practices in health care.

4.9 Data analysis

Following the verbatim transcription of the recordings, I started with familiarising myself with the data by repeatedly listening to the audio recordings, reading the corresponding transcripts, taking notes on initial ideas, preliminary observations and possible patterns. I then selected individual cases relevant to the research questions of this PhD study for more in-depth analysis. Using the transcription software DOTE, this stage of analysis involved capturing elements such as pauses, intonation, rhythm, in- and outbreath, all following the transcription conventions for conversation analytic research (Hepburn, 2004; Jefferson, 2004) (see Appendix 1). Such a detailed transcription enabled me to examine not just the actual content of the talk but also the manner in which it was delivered (Ten Have, 2007).

This study is a *collection study*. In a collection, one single interactional feature serves as the basis of multiple instances (data extracts), each of which makes this feature observable through the participants' conversational behaviour (Sidnell, 2012). When working with a collection of cases, a researcher can, on the one hand, thoroughly examine each instance by capturing its context and maintain a sense of case-specific characteristics. On the other hand, it is

possible to develop accounts that can be assessed across multiple examples (Clayman, 2024). This twofold advantage is typically absent in a single case analysis. Concentrating on a single case allows an analyst to closely examine and categorise specific interactional phenomena, yet drawing broader theoretical conclusions from such an analysis is nearly impossible. In comparison, a collection study seeks to map specific interactional phenomena (or just one phenomenon) across a range of cases, aiming to gather as many occurrences of the phenomenon as possible (Drew, 2024). This approach then allows researchers to examine and describe interactional practices in terms of their shared characteristics, moving beyond the particularities of any single case (Sidnell, 2012). Such an approach is particularly useful in relatively understudied areas, where the basic features and organisational structure (such as primary care telephone consultations) are still not well understood (Clayman, 2024).

During data analysis, initial interpretations were regularly evaluated by reviewing the data, through discussions with the supervisory team, and during *data sessions*. Data sessions typically follow a relatively consistent structure (Betz, 2024). At the start, the individual who has brought the data segment provides the group with basic contextual and background information. The participants then listen to (or view) the data multiple times, closely examining, and at times also evaluating, the corresponding detailed transcripts. This is followed by a (usually around ten-minute) period of silence during which each participant examines the transcript independently and notes down any analytic observations about the participants' talk or embodied conduct. Consequently, each participant shares (one of) their analytic observations which could potentially lead into group-wide discussion(s). The main objectives of these sessions include improving the accuracy of the transcript, producing a deeper analysis of the participants' orientations and refining the researcher's interpretations (Betz, 2024; Stevanovic & Weiste, 2017; Ten Have, 2007). As explained in the methodology chapter (Chapter 3), the core principle of CA is that any analysis should focus on the understandings and orientations that interlocutors display themselves in interactions, instead of relying on the researcher's (or participants') subjective interpretations of events. Data analysis

sessions furthermore help with making the research findings more transparent (Perakyla, 2004), thereby enhancing the overall credibility of the study.

4.10 Reflexivity

As outlined in the methodology chapter (Chapter 3), unlike other qualitative approaches, conversation analysis centres around how interactants' orientations and understandings emerge during episodes of social interaction, rather than exploring their post hoc interpretations or thoughts. The transparency of claims about these orientations and understandings is often demonstrated by simply presenting the data, typically in the form of detailed transcripts. This transparency, along with the foundational principle of unmotivated looking, might explain why reflexivity is not always emphasised in conversation analytic research. Nonetheless, as with any other qualitative research method, reflexivity remains an important aspect that should be thoroughly considered. Reflexivity concerns a researcher's awareness regarding how their role, position, perspectives and decisions affect both the research process and its subsequent findings (Haynes, 2012). It encompasses reflecting on the ways and processes through which conclusions are reached, how existing interpretations are continually compared to new insights and the ways in which these interpretations shape the ongoing research process (Grbich, 1999).

According to Gobo (2008), all researchers inevitably bring their own assumptions, opinions, and prejudices into a study. Reflexivity is therefore essential for examining how a researcher's positionality influences the knowledge that a study produces (Atkinson, 2015). Research should continuously examine how and possibly when their own held beliefs and assumptions might influence both data collection and any subsequent analyses (McDowell, 1992). Nevertheless, CA, with its emic focus on social interaction, limits a researcher from imposing any *a priori* pre-established interpretations on the data. Consequently, the analyst's focus is directed toward what participants themselves make observable and meaningful within the interaction.

As someone who originally is not from the UK, I had limited prior knowledge of the NHS and how NHS primary care services operate or are

supposed to operate. This unfamiliarity meant I approached the data without any instilled assumptions about how consultations in general but especially telephone consultations *should* take place. Moreover, this 'external perspective' may have enabled me to notice aspects of the consultations that might be taken for granted by someone more familiar with the health care system. Accordingly, rather than approaching the data with preconceived assumptions about the value (e.g., strengths and limitations) of telephone consultations, I focused on what GPs and patients treated as relevant within their interactions themselves. The next three analysis chapters therefore prioritise participants' orientations over the analyst's interpretations.

Chapter 5. "Are you happy to keep taking that?": Negotiating medication use during medication reviews in primary care telephone consultations

5.1 Introduction

In this chapter, I will examine how medication reviews actually unfold in real-time telephone consultations in primary care. This analysis examines how these reviews are organised through a GP's and patient's in-situ interactional practices (Zimmerman, 1984), what are the potential contingencies faced by both health care providers and patients, and what a detailed sequential analysis can tell us about the potential suitability of (telephone) consultations for facilitating discussions around medicine use. By examining real-time interactions, this chapter will contribute to a deeper understanding of how medication reviews are conducted and the extent to and ways in which patients are involved in these reviews.

Before turning to the findings, I will offer some background on the wider context of medication reviews (section 5.2.1), the potentially challenging and delicate nature of them (section 5.2.2), and some background on the data used for this chapter (section 5.2.3).

5.2 Background

5.2.1 Medication reviews and the problem of overprescribing

NHS primary health care providers are expected to regularly review the medications of patients on repeat prescriptions (NHS England, 2024). Usually this happens once a year, unless a GP or practice pharmacist deems more frequent reviews are appropriate for clinical reasons (e.g., patients starting on a new medication or changes in health conditions). Such medication reviews play a central role in primary health care and are intended as a core aspect of medicine optimisation (National Institute for Health and Care Excellence, 2016). More specifically, policy states that medication reviews "are designed to be a comprehensive and clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making

conversations with patients aimed at ensuring that their medication is working well for them" (NHS England, 2020, p. 1). Although they may be necessary (and in some cases even lifesaving), prescribed medications can lead to an increased risk of adverse effects, particularly in older adults prescribed multiple medications (Pocknell *et al.*, 2024).

According to a 2021 UK government report, approximately 10% of all prescribed medications are 'overprescribed', either because a non-pharmacological alternative would be better, the patient does not want or need the medication, or its potential harms outweigh its benefits (Department of Health and Social Care, 2021). Medication reviews have long been recommended as a way to reduce such potential issues (Payne & Avery, 2011) as their purpose is to "reduce the number of people who are overprescribed medication, reducing the risk of an adverse drug reaction, hospitalisation or addiction to prescription medicines" (NHS England, 2020, p. 2).

5.2.2 Challenges of deprescribing and patient perceptions

Medicines use – and polypharmacy (defined as the use of 5+ medicines) and de-prescribing in particular – are found to be delicate matters to negotiate (Pocknell *et al.*, 2024). In general, medication reviews are recognised to have the potential to be complex and delicate interactions (Swinglehurst *et al.*, 2023). Several studies showed that this is particularly the case for medication reviews with older patients who may have been on medications for a long time and who may see these prescriptions as an indicator of high-quality care (Reeve *et al.*, 2022; Sinnott *et al.*, 2015; Swinglehurst *et al.*, 2023). For example, in an interview-based study, Ouellet *et al.* (2022) showed that virtually all their patient participants indicated a preference to reduce their medicines but felt that this was not possible. In addition, they reported considering their doctor as the expert who should make these decisions. While interview-based studies provide valuable insight into how patients reflect on their medication use, they do not capture how related issues are negotiated in real-time consultations. A different perspective is offered in a conversation analytic study by Pocknell *et al.* (2024), illustrating that patients sometimes struggle with working out what exactly a particular

medication is, what it is specifically for and why it was initially prescribed to them. Perhaps more surprisingly, they also found that clinicians are equally unable to work out why a particular medication has been prescribed in some cases, such as when a medicine has been initially prescribed by a different practitioner (for example, in a secondary care setting).

This complexity is also reflected in stated policy, articulating that "the final decision to prescribe or de-prescribe must be based equally on the clinical evidence, the prescriber's experience and the patient's values, experiences and wishes" (NHS England, 2020, p. 8). In particular, guidance states that GPs should ensure that patients have received sufficient and adequate information to make a well-informed decision about their medication regimen, along with a detailed plan and a clear record of the review. Moreover, there is also some evidence that doctors in remote consultations tend to be less consistent in following clinical prescription guidelines than during comparable in-person appointments. Ray *et al*. (2019) conducted a retrospective cohort study examining antibiotic prescribing for acute respiratory infections in children. They found that remote consultations were associated with higher and less appropriate prescribing. Yet, despite specific guidance and the recognition of the complexity and delicacy in both research and policy, there still is a limited understanding of how such medication reviews actually take place, including how they unfold in practice (Pocknell *et al.*, 2024; Swinglehurst *et al.*, 2023).

5.2.3 Data

There is a significant number of formal medication reviews in my corpus of telephone consultations, as well as frequent more 'informal' instances of talk about medications. Out of the 29 recordings, nine were formally documented in practice records as a medication review and, in total, 27 include at least some talk about medications. This high proportion seems to reflect the fact that there is a perception amongst all the practices who participated in this project that these reviews can be done effectively over the phone. This frequency, and the perception that medication reviews are a suitable activity for telephone consultations, influenced my decision to make them an analytic focus of this thesis. The length of the medication reviews varied between 3:20 and 22:29

minutes, with an average length of 15:22 minutes. Most of the medication review consultations were time-consuming; only one was completed under 10 minutes and three exceeded 20 minutes. The number of medications reviewed within these consultations varied between one and eleven (with an average of approximately six discussed medications per consultation). There are no instances in the recorded medication reviews of talk about adding another medication, only of continuing or stopping existing medications. In my analysis, each reviewed medication and their corresponding discussion is treated as a separate case, resulting in a total corpus of 52 cases.

During an initial phase of data familiarisation, I noticed that almost all (50 out of 52) discussions about a particular medication resulted in the GP extending its prescription. In line with what Pocknell *et al.* (2024) concluded, (talk about) deprescribing was uncommon (with only two instances in my data set; one about reducing a medication's intake and one about stopping taking the medication completely). In order to investigate the sequential unfolding of medication reviews in practice, I have divided my analysis into three sections. I examine cases in which the discussion is about continuing taking a medication (section 5.3), about potentially reducing the dose of a medication (section 5.4), and about potentially stopping medication use (section 5.5). All extracts come from consultations formally documented in practice records as 'Medication Reviews', with this purpose reiterated by the GP (and in one instance by the patient), mostly in the opening phase of the consultation.

Through a close examination of the data, my analysis identifies a complex interplay between three key considerations that recurrently shape the discussions around medications: the medication's (i) effectiveness, (ii) tolerability, and (iii) necessity. It is important to note that these considerations were not predefined analytical categories but emerged inductively during the analysis, as participants continuously oriented to them during the consultations. In this sense, rather than assuming medication reviews to be inherently complex or delicate (as the body of literature suggests, see section 5.2.2), the aim of this analysis is to demonstrate if (and potentially how) such complexity is interactionally produced, or at times how the medication reviews proceed in relatively straightforward ways. Before turning to the analysis, it is necessary to

clarify what each of these three considerations entails. First, whether a medication is effective – that is, whether it appears to be 'working' – is typically approached as a collaborative matter. While effectiveness may be documented in the patient's medical record, for example on the basis of physiological tests, it can also rely on the patient's own knowledge, especially in the absence (or impossibility) of test results. Second, tolerability concerns whether the patient is experiencing any adverse effects, whether those effects are acceptable or manageable for them and whether the medication can with their lifestyle (for example if it affects their ability to drive). This is typically treated as residing within the patient's epistemic domain, as it relies on their subjective life-world experience (Mishler, 1984). Third, necessity involves whether the medication remains clinically justified, which is generally treated as something to be evaluated within the GP's epistemic domain. This chapter explores how these three concepts – effectiveness, tolerability, and necessity – are made relevant, and how they intersect and shift across participants during the course of medication reviews. See Appendix 1 for an overview of the transcription conventions.

5.3 Proposing to continue medication use

In this section I will examine cases of GP-patient interaction in which the discussion is about continuing taking a medication. In these instances, the GP and the patient talk considerably about the medicine's effectiveness and tolerability but, in general, the discussions do not include its necessity. The five extracts I will examine here are representative of a broader collection of 50 instances in which medication continuation is discussed. These extracts capture the most exemplary and analytically salient examples of how GPs and patients organise these discussions.

This section is further divided into two parts: discussions involving an evaluation of clinical evidence in determining medication effectiveness (section 5.3.1) and discussions lacking such clinical evidence (section 5.3.2). This distinction reflects the different epistemic domains drawn upon in these interactions. Namely, while effectiveness may be observable from the patient's medical notes, for instance based on physiological tests, it can also rely on the

patient's own knowledge, especially in the absence of such test results. These different knowledge bases are not solely interactionally relevant in and of themselves but are also consequential for the trajectory and negotiation of the discussion itself.

5.3.1 Proposing to continue medication where bio-medical clinical evidence is used

The first extract comes from the start of a medication review. The patient is on three different long-term medications and every medicine is discussed separately in the review. The excerpt starts at a minute into the 11-minute-long consultation at a point at which the GP and the patient start discussing the first medicine: atorvastatin.

Extract 1. P15GP05: 1.00-1.59

```
01    GP:   So the atorvastatin I've got down as'n eighty milligram
02          tablet (0.2) uh: one a day?
03                (0.6)
04    P:    Yes:,=
05    GP:   =Okay <an' we've go'> tha' you had a blood test done
06          in: July:, (0.5) uh:: and your- (.) >cholest'rol was
07          t' target< (0.2) a' that point:.
08                (0.5)
09    P:    .hh=It was yes:=<this is uh::> (.) a-=the other
10          doctor: (.) uh- (.) had rai:sed it becau:se >I was on
11          forty<=but he'd raised it (.) because=uh:m (0.6) uh::
12          my cholest'ol reading was: (.) too high I think.
13                (.)
14    GP:   Righ' (.) okay:, well I'm happy with this one in July:
15          tha'- tha' was fine and say tha' was to target, (0.4)
16          are you o:kay on tha' eighty milligrams or have you
17          had any side effects with pushing up the dosage?
18                (0.8)
19    P:    .hh (0.2) n-=No none that I'm aware of:=hh
20                (.)
21    GP:   No. (.) [w'll it]
22    P:              [So it  ] (0.5)(   ) be okay:.
23                (0.2)
24    GP:   Yea:h, (.) okay: uh:m (.) and ob'sly we would've
25          checked- (.) uh:m we'll just have a look but we
26          would-=should've checked your liver function test=yeah
27          tha' was done a'the same ti:me (0.4) and [that's] all=
28    P:                                             [Righ',]
29    GP:   =fi:ne.
30                (0.5)
31    GP:   Okay:. (0.2) uh:m (.) so: (.) happy wi'tha' one, (0.6)
32          uh:[m: ] (0.5) then: the tamsulosin
33    P:       [( )]
```

In lines 01-02, the GP introduces the first medicine they will talk about ("atorvastatin"), the dose the patient is on ("eighty milligram") and the frequency of taking the medicine ("one a day"). Presumably because the GP indicates that this is based on what "I've got down" – derived from the patient's medical notes rather than the GP's personal knowledge – it is offered as something to be confirmed by the patient's personal knowledge, which is indeed how the patient treats it in line 04. Now that the GP and the patient have collaboratively established the patient is indeed on the particular medication, at the particular dosage and frequency, the GP turns the discussion towards the medication's effectiveness. The GP refers to a blood test done some time before the current consultation and provides an assessment based on its results: "your- (.) >cholest'rol was t' target< (0.2) a' that point:" (line 06-07). Again, by explicating this knowledge is gained from the patient's medical notes rather than the GP's personal knowledge ("we've go' tha'", line 05), the GP offers it as something to be confirmed by the patient's personal knowledge. After a 0.5 second gap, the patient indeed confirms (and thereby agrees with) this assessment and expands the sequence by providing an account for why another doctor had initially raised the dose; because a previous cholesterol reading was "too high I think." (line 12). The turn-final "I think." softens the preceding knowledge claim by adding some level of uncertainty (Heritage, 2013), thereby positioning it as a matter of medical judgment rather than something falling within the patient's knowledge domain.

Consequently, in line 14, the GP provides two tokens of understanding ("Righ'" and "okay:") and gives an assessment of the more recent blood test in a 'well'-prefaced TCU. Here, "well" shifts the topic away to the current speaker's own topical preference, rather than expanding on the topic of the prior sequence (Heritage, 2015). In this instance the topic is shifted away from talk about a previous cholesterol reading back to a more recent one, introduced earlier in lines 05-08 as well. The GP now offers a more personal evaluation of the more recent test ("I'm happy with this one") and after that provides a more generic assessment in line 15 ("tha' was fine and say tha' was to target,"). Thereby the GP emphasises the medication's effectiveness by both a subjective ("fine") and an objective ("to target") evaluation.

Now that the GP and the patient have collaboratively established the medication is evidently working, the GP turns the discussion to whether the medication is tolerable. In lines 16-17 the GP asks if the patient is "o:kay on tha' eighty milligrams" and whether they have experienced any side effects as a result of increasing the dose. By formulating an alternative question, containing "or", the GP presents two possible answers and presupposes that only one is true: either the patient is doing well on the increased dose, or the patient has experienced side effects. This implies that asking about any side effects seems to be an alternative way of asking whether the patient is happy to continue taking the medication (i.e., if it is tolerable) at an increased dose.

The following 0.8 seconds gap, an audible inbreath by the patient, another 0.2 seconds gap and a hesitation displays potential interactional trouble (Mazeland, 2003). The patient nevertheless confirms he has not experienced any side effects and continues with a disclaimer "none that I'm aware of:" – leaving the option open that it might have caused side effects of some kind but that those were not noticeable to him. Typically, patients refrain from expressing a strong personal commitment or certainty regarding knowledge claims that might be seen to encroach on the territory of medical knowledge (Gill, 1998) and often downplay their authority in these contexts (Gill & Maynard, 2006). In this instance, the patient carefully preserves the limits of their own expertise, despite the fact that tolerability is something that patients are entitled to make knowledge claims about because that is part of their own lifeworld knowledge (Logren *et al.*, 2025).

After some overlap and unclear talk in lines 21-22, the patient seems to indicate that the increased dose is "okay:.". This is followed by two acknowledgement tokens by the GP ("Yea:h, (.) okay:") and a further objective evaluation that the patient's liver function was tested and that its results are "all fi:ne.". In line 31 the GP concludes the discussion of the atorvastatin with an assessment ("happy wi'tha' one,"). Because there is no named subject and finite verb in this assessment, it is ambiguous whether the GP herself ('I am'), the patient ('you are') or both ('we are') is/are 'happy' with taking the medication. The GP proceeds by introducing the next medicine to be reviewed during the consultation.

Notably, the GP's question of lines 16-17 (asking the patient if he is doing okay on the increased dose) is positioned at the end of a structured build-up that sequentially reinforces the importance and effectiveness of the prescribed medication. First, the GP has established a positive evaluation of the patient's blood test ("t' target", line 07), implying the atorvastatin is evidently working. This is further reinforced by the patient themself by stating that another doctor had raised the dose because a previous blood test showed an abnormal result. Ultimately, the particular design of the GP's questions in lines 16-17 is also of relevance here. The first part of the question invites a 'yes'-response and the second part a 'no'-response (Schegloff, 2007), both implying that continuation of the medication is the most appropriate course of action. In both instances, a dispreferred response would require an account or some further justification (Bilmes, 2014).

The next extract shows a similarly organised sequence of turns that constructs and projects the importance and effectiveness of a medication, although the GP addresses the patient's tolerability of that specific medication in a different way. Extract 2 comes from about halfway through another medication review. Prior to this extract, the patient and GP have discussed multiple other medicines the patient is taking, including inhalers, antibiotics and steroids. In the following extract, the GP and patient will talk about the next medicine on the patient's repeat prescription: amlodipine. Earlier on, in the opening phase of the consultation, the GP has mentioned he had a look through the patient's medical history and has already noted that the patient's "blood pressure is well controlled".

Extract 2. P20GP01: 12.41-13.00

```
01    GP:   So then if'w'go:: (0.8) ↓over_ (0.3) some oth'r things=
02          you're on- (.) amlodipine for <blood pressu:re,> (.) and
03          tha' seems t'be doin' oka:y, (.) [and] (.) is that=
04    P:                                     [Yes]
05    GP:   =[sui ]ting you as far as y'know?
06    P:     [Yeah]
07                (0.5)
08    P:    >Sorry?<
09                (0.2)
10    GP:   Is that suiting you as far as you know?
11                (.)
12    P:    Yeah no problem.
13                (0.4)
14    GP:   Grea:t,
15                (0.5)
16    P:    No' 'aving any problem with any of them <act'lly,>
17                (0.2)
18    GP:   Good. (0.6) an' then the clonazepam:
```

In line 01 the GP initiates a new topic by stating to go over "some oth'r things", framing that following activity as a collaborative project using the inclusive 'we'. Subsequently, in line 02, the GP introduces the next medicine to be reviewed ("amlodipine"), its general purpose ("for <blood pressu:re>") and an evaluation of its effectiveness ("tha' seems t'be doin' oka:y,"). Again, the first challenge for the GP here is to confirm the patient is indeed on this medication. Although the GP in this extract claims more (personal) knowledge of the patient's medication, as opposed to the GP in the previous extract, the patient nevertheless still treats it as something that requires confirmation (see lines 04 and 06) and therewith as something that also falls into their (personal) knowledge domain.

Now that the GP and the patient agree the amlodipine is working, the GP continues by asking the patient if the amlodipine is tolerable ("is that suiting you as far as y'know?"). 'As far as you know' here seems to orient to something that reasonably (or possibly) falls in the patient's knowledge domain, because, as high blood pressure does not necessarily have discernible symptoms to an individual, the patient's view will likely be limited to how she feels whilst taking the medication. Although in this extract it is the GP who is orienting to this limitation, this question is framed in similar terms of the knowledge constraints that the patient in the previous extract (Extract 1) orients to by announcing there are no side effects 'I am aware of'.

After a repair initiation (Schegloff *et al.*, 1977) by the patient in line 08 and a repetition of the GP's initial question in line 10, the patient straightforwardly

indicates not experiencing any problems with using amlodipine ("Yeah no problem."). After a positive evaluation by the GP in line 14, the patient continues by expanding her prior evaluation to "no' 'aving any problem with any of them <act'lly>". Because this claim contains a reference to something in her previous TCU in line 12 (i.e., "problem"), it is hearable as a continuation of it. Furthermore, the turn-final "<act'lly>" also treats this claim as potentially informative for the GP (Clift, 2001). The GP again offers a positive evaluation ("Good.") and, instead of elaborating on the patient's reinforced evaluation about her being fine on all her medications, nevertheless goes on to the next medicine that will be reviewed. This seems to orient to a normative process of a medication review organised around the three key components (effectiveness, tolerability and necessity) outlined earlier. Therefore, in this context, a comprehensive evaluation by the patient (i.e. indicating she is fine with all her medications) does not complete that process.

Again, like Extract 1, the GP's request for confirmation "Is that suiting you as far as you know?" in line 10 is positioned after reinforcing the purpose and effectiveness of the prescribed medication. In the opening phase of the consultation the GP has already established the that the patient's "blood pressure is well controlled" and further underpins this with a positive evaluation of those blood pressure readings ("doin' oka:y,", line 03), implying the amlodipine is evidently working well. Again, the design of the GP's request for confirmation is of relevance here as it interactionally prefers a confirmation (e.g., '*yes it is suiting me as far as I know'*). Replying with anything else than a confirmation would make an account relevant (Bilmes, 2014), again implying that continuation of the medication is the most appropriate further course of action.

The last extract in this subsection comes from another medication review. In this consultation, besides performing a medication review, the GP is also required to complete a form for assessing the patient's fitness to drive. Because the patient is also diabetic, he recently underwent a diabetic eye screening test. Prior to this extract, the GP and the patient have discussed the result of this test, which "has not detected any problems" and the extract starts with an assessment of the GP about the nature of this result: "So that's: (.) good".

Extract 3. P01GP01: 8.43-9.29

```
01    GP:   So that's: (.) good, (.) uh:m (0.3) a:nd (0.3) so wha' I'll-
02          (0.2) >do now<=I've- I've s- (.) sti-=uh=uh=the next
03          question is abou'- (0.2) medications.=so I might as well use
04          that: to:: uh- (0.5) to talk abou' your med'cines: (.) .hh so
05          before you came here >I had a little look< at uhm: (0.3) at:
06          (0.3) you- all the vari's tests an' things you've had done,
07                (0.3)
08    P:    Yeah.
09                (.)
10    GP:   And uhm: (0.3) it's all lookin' pretty goo:d (0.2) so:- (.)
11          .hh (0.2) you're on: (.) uh:m (0.2) atorvastatin, (0.2) which
12          [uhm ] (0.2) is >you know< that's for your- (0.3) cholesterol,
13    P:    [Yes.]
14                (0.2)
15    P:    [Yeh.]
16    GP:   [Uh:m] tha's aimed a' reducing: (.) risk of a heart attack
17          or s:troke?
18                (0.3)
19    P:    Yeh.
20                (.)
21    GP:   Uh: which could be slightly higher if: your- (.) go'
22          diabetes,=well .hhh (0.3) uh tha' looks like it's going:
23          (0.5) o:kay, the cholest'rol 's at'a reaso'ble level (.) uh::m
24          (.) an' are you happy wi'tha'?
25                (0.3)
26    P:    Yes: (.) yeah (.) yeh.
27                (0.2)
28    GP:   Good (0.8) then you've got: (.) uh:m (0.2) your diabetes
29          itself.=so you are prescribed this new med'cine tha's called
30          da- dapag- (0.2) gliflozin .hh
```

After positively assessing the reassuring nature of the patient's eye test in line 01, the GP in lines 01-04 formulates what the next agenda point of the consultation will be ("talk abou' your med'cines:"). He furthermore mentions in lines 05-06 that prior to the consultation he has looked into "all the vari's tests an' things" the patient completed, implying that those test results are (and will become) relevant when talking about the patient's medications. The patient's agreement token "Yeah." in line 08 seems to confirm he indeed did complete those tests and hence is aware of the tests the GP is referring to. Subsequently the GP evaluates the results of those tests collectively in line 10 ("it's all lookin' pretty goo:d") and introduces a first medication to talk about using a declarative ("you're on: (.) uh:m (0.2) atorvastatin,"). Again, similar to the previous extract, the first challenge for the GP (and the patient) is to confirm the accuracy of the patient's medical records. In overlap this is followed by a confirmation by the patient in line 13 and subsequently the GP states the overall purpose of the medicine ("that's for your-

(0.3) cholesterol,"), followed by again a confirmation (in overlap) of the patient in line 15. Despite the fact that in this extract the GP claims more (personal) knowledge (as opposed to the GP in Extract 1), the patient nevertheless still treats it as something that requires confirmation and presumably therewith as something that also falls into their personal knowledge domain.

Now that the GP and the patient have established the general purpose of atorvastatin, the GP elaborates on this by specifying the underlying rationale for taking the medicine ("reducing: (.) risk of a heart attack or s:troke"), followed by, again, a confirmation of the patient in line 19. The GP continues by stating that the risks (of a heart attack or stroke) are slightly higher for people who have got diabetes. In lines 23-24 the GP assesses that the medication seems to be working "o:kay," by referring to a blood test result: "the cholest'rol 's at'a reaso'ble level". Subsequently, the GP asks the patient about tolerability: "are you happy wi'tha'?". Now, here the "tha'" of line 24 is potentially ambiguous as it directly follows the delivery of a satisfactory test result, which is something the patient could also be happy with. This TCU does not include any other component making it apparent that "tha'" refers to taking the medication (for instance by asking '*happy to keep taking that?*'). Also, again, the GP's turn is designed to invite a 'yes'-response which the patient duly offers in line 26. The multiple repetitions of the agreement token 'yes' (and its equivalents "yeah" and "yeh") here seem to emphasise the patient's agreement and/or certainty of his response. The GP provides an 3rd position assessment ("Good") in line 28 and then shifts the topic towards reviewing another medicine for the patient's diabetes itself.

Again, the GP's question "are you happy wi'tha'?" in line 24 is positioned at the end of a structured build-up that sequentially reinforces the importance (and perhaps even necessity) of this particular prescribed medication for this patient. First, the GP establishes a generally positive evaluation of the patient's test results ("it's all lookin' pretty goo:d"), implying all the patient's medications are evidently working well. Next, the discussion of the medicine is explicitly linked to its purpose: reducing the risks of a heart attack or a stroke. The relevance of this risk reduction is heightened by the patient's medical history, particularly their status as diabetic (lines 21-22), which further amplifies the justification for continuing taking this particular medication.

By the time the GP states that the patient's cholesterol is at a "reaso'ble level" (line 23), maintaining the medication appears to be the next logical step. Ultimately, the design of the GP's question in line 24 "are you happy wi'tha?" invites a preferred affirmative 'yes'-response, thereby implicitly reinforcing the presumption that a continuation of the medication is indeed the most appropriate course of action. In this case, a 'yes'-response agrees with an implicit medical recommendation and avoids the need for offering an account.

Each extract in this subsection shows a similar sequence of actions: the GP (1) introduces a medicine, (2) checks the patient's confirmation of use, (3) discusses test results to demonstrate and affirm the medication's effectiveness, and (4) moves to assess the patient's tolerability of the medication. In each case, the GP designs their questions to prefer confirmation that the medication is both effective and tolerable, making continuation the preferred course of action. Differences appear in how GPs phrase questions about tolerability but across all extracts, the GPs sequentially reinforce the importance of the medication before asking about tolerability, making a non-confirmatory response interactionally more difficult. Interestingly, although the GP in Extract 3 strongly implies the medication's desirability, there is no overt mention of a medicine's necessity in any of the previous extracts.

However, it has to be noted that it makes logical sense to construct the sequences in this way (i.e. ask about tolerability after establishing effectiveness and necessity) in instances where the discussion is about a medication that test results can determine the effectiveness of, because that test establishes the clinical rationale for continuation. Without a clinical rationale, it would not matter if the patient is happy taking a medication or not. Similarly, a patient might respond to a question about tolerability by saying it depends on whether the medication is working or not. Equally, regarding necessity, there is no point in discussing a medication's effectiveness or asking about tolerability if the GP deems the medication unnecessary, or no longer necessary.

5.3.2 Proposing to continue medication in the absence of bio-medical clinical evidence

Whereas in the previous extracts, all the discussions included an evaluation of the medicine's effectiveness based to some degree on the clinical evidence of test results, the following two extracts do not include any mention of this.

Extract 4 is from a telephone consultation between a GP and a patient who has suffered from a presumed seizure about six months prior to the consultation. As a result, the patient lost their driving license, and the GP is required to complete some 'fitness to drive' paperwork for the DVLA for this to be possibly returned. During the opening phase of the consultation, the GP has explicated that completing this form and conducting a medication review is the overall goal of the consultation. The extract occurs approximately five minutes into the fifteen minute-long consultation. Prior to the start of the extract, the GP and patient have talked generally about what they will cover in the consultation and the GP has initiated some history taking focused on how the patient has been feeling since the seizure. The GP and the patient have discussed a letter from the hospital that says the MRI scan "was normal" and the GP has also established that a neurologist has prescribed levetiracetam to control the seizures, which the patient is currently taking. Directly before the extract begins, the patient has talked about the fact that no one has contacted him after his hospital discharge, and he ends this discussion with a complaint: "I've had to follow everything up".

Extract 4. P01GP01: 5.08-5.44

```
01    GP:   Yeah.
02                (0.2)
03    GP:   Okay:,=.hh (.) [>↑w'll look<] it's:: obvi'sly good=
02    P:                 [   (    )   ]
03    GP:   =news tha' the ↓scan was: (.) normal,=an' I
04          [think] they obvi'sly (0.2) decided tha- th-(.) uh=you=
05    P:    [Yes! ]
06    GP:   =know for someone who's had ā .hhh (0.2) a fi:rst fit:
07          where th've started them on medication: they- (0.3)
08          >p'rhaps< don't feel they need t'be doing anything
09          further unless:: uh:m (0.2) unless there's a- (0.3)
10          a problem,=.hh (.) an' as you sa:y (.) things seem
11          t'be going: (0.2) uh:m: (.) okay?=.hh [and ] are=
12    P:                                          [Yes,]
13    GP:   =you: uh:m (.) reason'bly happy on the- (0.2) that
14          medication: thē levetiraceta:m?
15                (0.5)
16    P:    I am yes: yes: [yeah] yeh.
17    GP:                  [Yep.]
```

```
18                (0.3)
19    GP:    Happy t'keep taking tha',
20                (0.2)
21    P:     >Yeah I< don't mind tha' i- uh- y'know if it's- if it-
22           if it le- if it lets me drive,=£yes, [.hh ] hh£
23    GP:                                        [Yep.]
24    GP:    .pt Okay.=that's fine:=[    .HHh    ]  [↓Uh:m ] .pt=
25    P:                           [£yeh y(h)eh£]  [(yeh) ]
26    GP:    =↑S:o: whad'I'll do is I'll jus' go through: (0.2)
27           >some'o'the:< (.) rest of the things on the
28           ↓form.=I've act'lly:=
29    P:     =Okay.=
30    GP:    =Parti'lly filled it in befo:re um (0.2) before
31           speaking to you?
```

The "Yeah." and "Okay:," in lines 01-03 confirm receipt of the patient's prior informing. Especially, the "Okay:," (line 03) simultaneously looks back to acknowledge the patient's prior informing (or complaining), while also looks forward to initiate talk that does not involve a conditionally relevant pair part (DeSouza *et al.*, 2021). Furthermore, the *well*-prefaced TCU in line 03 indeed indicates a topic shift away to the speaker's own topical preference, deviating from what might be expected as an answer (Heritage, 2015), which in this case would be a response to the patient's prior complaint (normally an account). The GP starts with a positive assessment about the result of the MRI-scan, thereby treating that as the salient issue rather than any reason why a third party did or did not contact the patient after his hospital discharge. This is followed by an overlapping agreement from the patient in line 05. Subsequently the GP offers a candidate, presumed account for why the patient did not hear anything back from a non-present third party expert, in this case a neurologist. On the one hand this reasoning is subject sided; "I'think" (line 04) and ">p'rhaps<" (line 08) in relation to the lack of contact indicate some level of uncertainty, softening knowledge claims (Heritage, 2013). On the other hand, "obvi'sly" (line 04) in relation to the MRI-scan result claims certainty and strengthens the forthcoming knowledge claim. Part of the GP's account includes explicit reference to "they" (referring to secondary care practitioners) starting the patient on a medication, which the GP has also discussed earlier in the consultation, thereby already referring to it by using its name: levetiracetam.

In line 12 the patient confirms the GP's (reported speech) assessment of the patient's current state of wellbeing of lines 10-11 ("as you sa:y (.) things seem t'be going: (0.2) uh:m: (.) okay?"), and subsequently, in partial overlap, the GP

asks whether the patient is "reason'bly happy" on the specific medication, the levetiracetam, prescribed by the specialists in the hospital. Similar to the previous subsection (5.3.1), the GP asks about tolerability after establishing that a medication seems to be effective. Whereas in the previous subsection the medication's effectiveness could be established by referring to test results, the GP in this extract does this by referring to something (using reported speech) that is outside of his knowledge domain. So, in this instance, an assessment of both the medication's effectiveness and tolerability are treated as laying within the patient's epistemic domain.

Moreover, the design of the GP's turn in lines 11-14 invites a preferred (positive) 'yes'-response (Schegloff, 2007), which the patient duly offers multiple times in line 16: "I am yes: yes: yeah yeh.". However, more specifically, a yes/no-interrogative prefers a 'yes' or a 'no' as the *first* component of a response (Raymond, 2003). Placing the agreement token ("yes:") following a partial repeat ("I am") separates the action of agreeing (which would be done by a single response token like 'yes') from the action of 'confirming' (Heritage & Raymond, 2005). So, this confirms rather than simply agrees. This is, for instance, different than the agreeing "Yes," in line 12, projecting agreement on "things seem t'b going: (0.2) uh:m: (.) okay?". Furthermore, the multiple repetitions of the agreement token 'yes' (and its equivalent 'yeah') in line 16 seem to emphasise the patient's agreement and/or certainty of his response.

The GP continues in line 19 with specifying his question of lines 11-14 by formulating a declarative with rising intonation, making it a request for confirmation (Stivers & Rossano, 2010). Namely, if the patient would be happy to continue (or "keep") taking the levetiracetam, now without the adverbial modifier "reason'bly". Again, the design of the GP's turn here invites a positive (confirming) 'yes'-response (Schegloff, 2007; Stivers, 2012). Subsequently the patient provides such a confirming response in line 21 (">Yeah I< don't mind tha") using a subordinate conditional clause ("if it lets me drive,"), implying that the latter is the main reason (or perhaps even condition) for the patient to keep taking the medicine. This is followed by (unreciprocated) laughter by the patient, orienting to some form of (interactional) trouble (Jefferson, 2015). This trouble potentially centres around the patient's ability to drive as a possibility

(dependent on the GP's further assessment) rather than a certainty at this point. The GP closes with an assessment in line 24: "Okay.=that's fine:". Although this response seems to be ambiguous (i.e. it could implicitly grant the patient's condition to drive again), this turn here seems to function as topic closure and could be better understood in terms of assessing the patient's willingness to continue taking the medication. The GP treats the topics of driving and medication as distinct topics, to be discussed separately. In lines 26-31 the GP consequently continues on a different topic by announcing what will be the next step and phase of the consultation.

The next extract includes another discussion around a medicine for which its effectiveness cannot be evaluated based on a test result. In terms of how the GP designs his request for confirmation and how the patient orients to the extent as to which he can be certain about the medication's effect (in this case framed as helpfulness), it shows quite a number of similarities with the previously discussed extracts. Extract 5 involves the discussion of a painkiller medication. Prior to this extract, the GP and patient discussed and reviewed another painkiller medicine (amitriptyline) the patient is currently on. This discussion ends with the GP postponing a decision to continue, reduce or come off this medicine until a next appointment. Directly following that, the GP (in line 01) introduces the next painkiller medicine that is about the be reviewed: pregabalin.

Extract 5. P19GP01: 13.51-14.12

```
01    GP:   And then you're on (.) pregabalin (.) >which is also<
02          for:=uhm (0.5) .pt=well [it is] for (0.9) pain (.) supposed=
03    P:                            [(   )]
04    GP:   =t'b'for (0.2) neuropathic pain (0.3) do you find
05          that helpful?
06                (0.6)
07    P:    Uh:m (0.5) it seems to be. (.) [but ] (.) I'm on the:
08    GP:                                  [Yeah]
09                (0.3)
10    P:    Maximum dose of tha'.
11                (.)
12    GP:   Yeah. (0.2) yep.
13                (0.2)
14    P:    (first thing) in the morning one at night.
15                (0.2)
16    GP:   Yeah. (0.2) okay:. (0.6) fi:ne.
17                (1.5)
18    GP:   >So look<=so: (0.4) <tha' all looks:> (.) okay:
```

In line 01 the GP introduces the next medicine to be reviewed using a declarative ("you're on (.) pregabalin") and states the overall purpose of the medicine ("supposed t'b'for (0.2) neuropathic pain"). Subsequently the GP asks the patient: "do you find that helpful?" (lines 04-05). Again, this interrogative question design prefers a 'yes'-response (Schegloff, 2007), but as opposed to the previous extract the GP is not questioning if the patient is 'happy' with taking the medication but is eliciting an evaluation of the medicine's helpfulness, without offering such an assessment about its effectiveness himself. Here, no clinical evidence (i.e., a test result) is available to assess the medication's effectiveness. This is reflected upon by the GP stating the medication is *supposed to be* for (reducing) neuropathic pain. Now, it is helpful to note that pregabalin is an atypical painkiller, commonly used in cases where other drugs have not worked and also may not be effective for all patients. It is a particular case where the patient's experience with taking the medication is important. As a result, the GP leaves the evaluation fully within the patient's knowledge domain.

In line 07, after an "Uh:m" and a 0.5 seconds pause, the patient responds to the GP's question with a non-type conforming answer (Raymond, 2003), by assessing "it seems to be.". Typically patients refrain from expressing a strong personal commitment or certainty regarding such knowledge claims (Gill, 1998) and often downplay their authority in these contexts (Gill & Maynard, 2006). However, when patients express uncertainty, this does not necessarily always indicate an 'actual' lack of understanding. Instead, such expressions can function as conversational devices to display that they do not claim the right to possess certain kinds of knowledge (Drew, 1991). In this instance, the patient again carefully preserves the limits of their own expertise, despite the fact that the patient is entitled to make such knowledge claims about such life-world events (Logren *et al.*, 2025).

In overlap with an acknowledgement token ("Yeah") of the GP in line 08, the patient elaborates on his evaluation of the medication by stating he is on the maximum dose of pregabalin. One possible reason for this statement is that it averts any suggestion or discussion about increasing the dosage. Because the patient indicates he is not entirely certain if the medication is helpful, a proposal by the GP about raising the dose could be anticipated to follow. Such a proposal

indeed remains absent, and the GP offers two acknowledgement tokens in line 12. Besides the fact that one possible reason is to avoid such a discussion, another explanation might be that it further orients on the (un)helpfulness of the medication; the patient indicates some uncertainty about the medication's effectiveness ("it seems to be."), but any evaluation might even be irrelevant because the dose cannot be increased anymore (i.e., there is nothing else that can be done to improve the working of the medication). In line 16 the GP ends this medicine's review with two acknowledgement tokens ("Yeah. (0.2) okay:.") and an overall evaluation using the adjective "fi:ne.". Consequently, without mentioning issues regarding the tolerability of this specific medication, the GP offers a more general evaluation of all the medications discussed previously in the consultation ("<tha' all looks:> (.) okay:"). After the extract, the GP initiates talk about the logistics of reauthorising all the patient's medicines and booking a future follow-up medication review.

5.4 Proposing to reduce medication use

This section focuses on a case in which the outcome is medication reduction, which is the only instance of this kind in my data set. The next extract comes from the start of a consultation where the GP introduces a discussion of a medicine (lansoprazole) used to lower stomach acid. In contrast to the previous extracts, the GP and the patient do not explicitly address the medicine's effectiveness. Instead, the GP questions the medicine's tolerability and subsequently its necessity. Just prior to this extract beginning, the GP has reconfirmed the patient's consent for the consultation to be audio-recorded.

Extract 6. P13GP03: 0.33-1.50

```
01    GP:   So I see: that you're on lan:soprazole (.) fifteen
02          miligrams once every day.=is that ri:ght?
03                (0.7)
04    P:    Yeah tha's righ' yeh.
05                (0.5)
06    GP:   And how are you getting on wi'tha'?
07                (1.0) ((GP typing on keyboard))
08    P:    I've been fi:ne (.) been a- I- been okay.
09                (1.2)
10    GP:   So you started that back in two thousand and one at
11          fifteen miligrams:, (0.4) have you for[gotten] any=
12    P:                                          [Yeah  ]
```

```
13    GP:   =doses:?
14                (1.5)
15    P:    No I've not forgott'n any doses no.
16                (0.8)
17    GP:   And uh: (.) do you think you still nee:d it?
18                (1.5)
19    P:    Yeah I'm- I'm seem t'b'do- I'm seem >t'be doing< all
20          righ' I'm- I am watching what I'm eating etcetera,
21                (.)
22    GP:   Yes: (0.7) so- (0.2) sometimes people do try reducing
23          it by going to >ev'ry other day< and then see if they
24          (then) can come off it: (0.5) uh:m (.) but [lots] of=
25    P:                                               [Yeah]
26    GP:   =people do stay on it for quite a long time as well:?
27          (0.7) uhm (.) it's up to you really (.) I c'n see
28          you've had an endoscope done- (0.4) back in twenty
29          sixtee:n, (0.3) have you had any endo[scopes] done=
30    P:                                         [Yeah  ]
31    GP:   =since then:?
32                (1.3)
33    P:    I've not had any done since then but hon- on- honestly
34          I've been fi:ne. (0.2) I've not been [(bad) at all.  ]
35    GP:                                        [So you're hap- ]
36          you're happy to jus' carry on as you are:?
37                (1.2)
38    P:    Yea:h an' like you say i- (.) I might try that you know
39          like miss a dose:
40          [every other day and see how I go on with tha']
41    GP:   [Yes: you could just try that and see         ] (.)
42          uh: because (.) you know obvi'sly if you're taking
43          an unnecessary medicine (0.4) uh:m you don't have to
44          take a medicine if you don't need it (0.5) so I'll just
45          extend [your  ] prescription just no:w so: (.) your=
46    P:           [Righ:']
47    GP:   =birthday's in Ma:rch: so (.) I'm gunna make i' (0.5)
48          for another s:::ix months:
```

Similar to what happens in the previous extracts, the GP in lines 01-02 starts with producing a declarative including the medicine the patient is on ("you're on lan:soprazole"), the dose the patient is on ("fifteen milligrams") and the frequency of taking the medicine ("once every day."). "I see:" (line 01) indicates that what is about to follow is, again, derived from the patient's medical notes rather than from the GP's personal knowledge. Furthermore, the GP ends his turn with a request for confirmation ("is that ri:ght?") which is provided by the patient in line 04: "Yeah tha's righ' yeh.".

Now that the GP and the patient have collaboratively determined the patient is indeed taking the specific medication on the particular dose, the GP continues by eliciting an evaluation regarding the medication's tolerability. In contrast to what the GPs in the previous extracts do, the GP in this extract asks an open question regarding how the patient is "getting on" (line 06) with the

medication. In line 08 the patient provides a type-conforming answer (Raymond, 2003) to the open question ("I've been fi:ne") and subsequently strengthens that ("I- been okay.").

After a 1.2 seconds gap, the GP produces another declarative about the time and the dosage the patient started on this specific medication, which again is followed up by the patient with a token of confirmation ("Yeah") in line 12, again treating it as something primarily located in the patient's knowledge domain. Subsequently the GP asks if the patient forgot to take any doses since then. The turn design in this instance prefers a 'no'-response (Schegloff, 2007) which is duly offered by the patient using a partial repetition of the question design in line 15: "No I've not forgott'n any doses no.". This question from the GP is complex and providing an honest and accurate response here is particularly challenging when reflecting on a period spanning over more than two decades. However, it is perhaps intended to topicalise a discussion of any consequences of missing doses, in order to subsequently consider intentionally missing doses (i.e., reducing the medication). If the patient indeed had forgotten any doses and did not experience any difficulties as a result, then that could have eased the way for the GP for introducing the idea of reducing the dose.

In line 17 the GP continues with another question, now directly questioning the medication's necessity: "do you think you still nee:d it?". Despite the fact this question design prefers a 'yes'-response (Schegloff, 2007), the word 'still' adds another layer to the GP's question. It implies the patient in the past indeed needed this particular medicine but that its usage in the present is now being scrutinised. Moreover, as opposed to what happens in the previous extracts, the GP here does not offer or elicit any specific evaluation or assessment of the medication's effectiveness – although the general question "how are you getting on wi'tha'?" could also be interpreted as questioning both the medication's effectiveness and tolerability. It could be argued that even only by virtue of scrutinising the necessity of taking a medicine already implies the patient might not need to take the medication anymore (i.e., there is no point in asking it if the GP deems the medication absolutely necessary).

Now, one possible reason for asking this question ("do you think you still nee:d it?") could be to invite the patient's perspective on their treatment plan,

acknowledging the patient's role in their own health care decisions, and offering him some form of agency. The use of "think" here offers the patient a way to express their thoughts without directly challenging a medical assessment, and it acknowledges the likelihood of a level of uncertainty or subjectivity in the patient's point of view. Nevertheless, the patient's knowledge about the clinical necessity of the medication may not be as informed as the GP's. The patient seems to orient to this as well by not providing a definite 'yes'-answer (which would indeed be the preferred response) but by providing an account for that: "I'm seem >t'be doing< all righ" (lines 19-20). Again, the patient refrains from expressing a strong commitment to his 'doing all right' and downplays his (medical) authority. This aligns with Pilnick's (2022) argument that expertise is an interactional achievement which is collaboratively negotiated between parties rather than something which is imposed by GPs (or other health care practitioners). Subsequently, the patient then expands his account by considering lifestyle issues ("I am watching what I'm eating etcetera,"), describing how he actively manages his condition in addition to taking the medication.

The GP continues by stating that "sometimes people do try reducing it", thereby implying the patient should or could also consider reducing (and eventually coming off) the lansoprazole. This is met by a confirmation of the patient in line 25. The GP continues his turn by stating that "lots of people do stay on it", prefaced by "but", which immediately offers the possibility of staying on the medication. Most interesting here is the "it's up to you really" in line 27 which explicitly offers the patient (full) autonomy. As Landmark *et al.* (2015) show, different choices regarding treatment options (in this case either to continue with or stop taking a medication) are rarely presented as completely equipoised. Furthermore, as Toerien *et al.* (2013) demonstrate, doctors' presentation of different options may operate less as an explicit invitation to choose but more as a means of endorsing a particular course of action. However, rather than waiting for a response from the patient, the GP subsequently shifts the topic away from the medication to the patient's history with endoscopes, which seems to be the only potentially available clinical evidence for the medication's effectiveness. Subsequently the patient does reject this shift away in line 34 by focusing on their

wellbeing (both regarding taking the medication and the unnecessity of undergoing a new endoscope): "I've been fi:ne (0.2) I've not been (bad) at all.".

The GP in lines 35-36 then does what we have seen in the previous extracts. He produces a polar yes/no-declarative ("you're happy to jus' carry on as you are:?") which is designed to prefer a 'yes'-response, which the patient offers in line 38. However, the patient does then continue by adding to it he might try reducing the dose and the GP overlaps by confirming that and by providing an account for why the patient might want to consider that, before announcing he will extend the patient's prescription for the time being. The sequential position of the GP's account for reducing the medicine ("you don't have to take a medicine if you don't need it") is of interest here as well as it is presented after the patient's suggestion they might try and reduce it rather than before it.

This instance, then, shows a notable absence of an explicit discussion regarding the medication's effectiveness, with tolerability only addressed as an upshot of questioning the medication's ongoing necessity. The topic of tolerability arises not in its own right but rather as part of a broader evaluative trajectory. Effectiveness, meanwhile, remains unspoken but still is ingrained in warranting the medication's necessity; if the patient deems the medication still necessary, then its effectiveness is automatically assumed as well.

5.5 Proposing to stop medication use

This section considers talk about potentially stopping taking a medication. The extract presented here is the only instance of this kind in my data set. Although there is talk about potentially stopping a medication in the previous section (5.4), the outcome is still to first reduce the dose and, moreover, it eventually seems to be the patient's decision to do so. The next extract starts about halfway through the same medication review as Extract 1. Prior to this extract the GP and patient have already discussed two other medications (atorvastatin and tamsulosin) and have now arrived at reviewing the third, and final, medicine the patient is currently taking: aspirin.

Extract 7a. P15GP05: 6.56-10.25

```
01    GP:   And then the ↑final one (.) uhm (.) is aspirin seventy
02          five miligrams: (.) uh one a day.
03                (0.8)
04    P:    Yes that's right hh=yes:: I've had that since I had
05          >a bit of a< sca:re=*uh:* (0.4) like a heart (.)
06          problem .hh (0.2) a::nd=uh-=uh the hospital advised
07          that (.) and so I've kept on with that >ever since
08          really,<
09                (0.7)
10    GP:   ↑O:kay=>now< (.) can I just clarify:, (0.3) w:hen you
11          had this heart ↓sca:re=did they think you ha:d-
12          =act'lly had (0.4) uhm (0.3) either a heart attack or
13          angi:na?
14                (0.9)
15    P:    .hhhh ↓no ↓no they to-=uh=the- they took (0.2)
16          <blood tests>='nd they said I'd not had a heart
17          attack.
```

Similar to previous extracts, the GP in lines 01-02 starts by formulating a declarative including the medicine the patient is on ("aspirin"), the dose the patient is on ("seventy five milligrams:") and the frequency of taking the medicine ("on a day."). The subsequent 0.8 seconds gap invites the patient to confirm this, thereby treating this as knowledge locating within the patient's personal knowledge domain. In line 04 the patient indeed provides a confirmation ("Yes that's right") and provides an unsolicited account for why he is prescribed the aspirin and who initially prescribed it.

In response to the patient's account, the GP seeks clarification with a pre-request ("can I just clarify:,") and recontextualises the patient's vague formulation (of lines 05-06) into more medically recognisable categories ("a heart attack or angi:na"). It also begins the process of assessing whether taking the aspirin is still necessary; if the patient was indeed diagnosed with either of those it would make clinical sense to keep taking the aspirin. Subsequently the patient rejects these diagnoses (or at least the diagnosis of a heart attack) using reported speech, and refers to blood test results, lending his response a strong degree of certainty.

After a stretch of intervening talk (omitted in the extract), during which the patient talks about possible explanations for his heart scare (e.g., he did some heavy labour in his garden at the time) and why the hospital put him on aspirin as a preventative medicine, the extract continues as follows:

Extract 7b. P15GP05: 6.56-10.25 (continued)

```
34    GP:   O:kay↓ (.) .hhh (.) uhm: (0.5) do you ge' any, (0.2)
35          indigestion or heart burn with-=with taking that
36          at all,
37                (0.8)
38    P:    .hh (.) no I don't seem t'do, I us'lly take it with
39          breakfast cause- (.) u- s- so it's with (.) >you know
40          some-< I'm eating something,
41                (0.2)
42    GP:   Ri:ght okay↓ (.) .hhh (.) it's [just]
43    P:                                 [No I] don't (.) have
44          any indigestion,
45                (0.2)
46    GP:   N:o:↓ (0.2) uh:m (0.3) >I mean that's good< (0.2)
47          grea' (.) I just think- (.) >if it's all right with
48          you< I'd like to clarify (.) with the cardiologists=if
49          they (0.6) uhm: (0.2) act'lly intended this going on
50          long term: or whether they intended it to be: (0.4) a
51          sho:rt term: (0.4) uhm: (0.4) treat- (.) ment
```

In lines 34-36, the GP turns the discussion towards the tolerability of taking the aspirin by asking if the patient experienced any side effects ("indigestion or heart burn"). Again, similarly to the previous extract (Extract 6), any discussion of the medication's effectiveness is absent. As in the previous extract, this shift towards evaluating the medication's tolerability may serve a dual function. On the one hand it helps determine whether potential side effects provide a reason to stop the medication. On the other hand, it also paves the way towards potential deprescribing without directly proposing that.

In line 38, the patient responds in a similar fashion as we have seen previously above, by refraining from expressing a strong commitment to not experiencing any side effects: "I don't seem t'do". The patient downplays his medical knowledge and upholds the limits of his own expertise, despite the fact that experiencing side effects is something that patients are entitled to make knowledge claims about because that is part of their own lifeworld knowledge (Logren *et al.*, 2025). Subsequently, the patient continues with telling when he usually takes the medication and why he does so, which could function as a possible account of why he is not experiencing any adverse effects. In line 42 the GP acknowledges that, before tentatively initiating some continuation ("it's just"), which is overlapped by the patient confirming the tolerability of the medicine.

After the GP offers a positive assessment of the patient not experiencing any indigestion, she introduces the possibility of medicine discontinuation. Rather than unilaterally (Collins *et al.*, 2005) suggesting stopping the medication,

the GP proposes to consult a secondary care specialist, thereby locating both expertise and authority regarding the decision outside of herself. Her proposal is heavily mitigated, marked by softeners ("I just think-", line 47) and hedging (">if it's all right with you<", lines 47-48). In another omitted stretch of talk, the GP continues talking about the possibility that a cardiologist initially put the patient on aspirin to exclude a recurrence of heart issues before then ruling out the patient did suffer a heart attack. The extract ends as follows:

Extract 7c. P15GP05: 6.56-10.25 (continued)

```
94    GP:   =>But as I:< will just take some advice as to whether
95          (0.4) m-=m-
96                (.)
97    P:    I need [to carry on with th-]
98    GP           [You should be       ] having it at all (0.3)
99          yeah
100               (.)
101   P:    Yeah (0.2) 'kay (.) that'd be ↑great=yeah
102         thank you very much then doctor.
```

In the closing lines of the extract, the GP rephrases her intended course of action and now, for the first time, explicates the reason for seeking the advice (i.e., to determine whether the patient should continue taking the medication or not). The GP downgrades the course of action with the use of a minimiser ("just"), which displays this proposed course of action as less intrusive for the patient (O'Brien *et al.*, 2020). Interestingly, in overlap, the patient displays an anticipatory understanding of this implicit trajectory. Namely, before the GP explicitly formulates the issue as one of medication necessity (line 98), the patient produces a similar formulation ("I need to carry on with th-", line 97). This shows the patient orienting to and affiliating with the emerging implication that continuing the medication may not be required, thereby 'relieving' the GP of the delicacy involved in proposing potential discontinuation. Therewith the patient also demonstrates both understanding and acceptance of the GP's line or reasoning. The extract ends with the patient showing his appreciation to the doctor for carrying out the intended course of action in lines 101-102.

5.6 Discussion

In this chapter, I have examined how medication reviews unfold in real-time telephone consultations in primary care. The analysis focuses on how these reviews are interactionally (locally) organised by participants, and on how GPs and patients navigate the interactional delicacy involved in balancing clinical necessity with patients' experiences of their medication(s). Through a close examination of the data, the analysis identifies a complex interplay between three key considerations that recurrently shape the discussions around medications: the medication's (i) effectiveness, (ii) tolerability, and (iii) necessity. The focus, therefore, is on how and when both GPs and patients make relevant these three considerations in their discussions about continuing (section 5.3), reducing (5.4), or stopping (5.5) medications.

The findings demonstrate that GPs frequently use declarative statements to establish the patient's current medication intake, often followed by confirmation-seeking questions. The extracts consistently show that GPs treat this as something not definitively known by them, but as derived from medical records and as something located within the patient's personal knowledge domain. So, one of the first challenges in all of these reviews is that the nature of contemporary primary care makes it unlikely that the person doing the review will be the person who initially prescribed the medication(s) – even if they were initiated in the same (primary care) practice.

A recurring feature across the extracts is the use of polar yes/no-interrogatives when discussing medication (dis)continuation. These questions are systematically designed to prefer an affirmative response, thereby reinforcing the presumption that patients will continue their prescribed treatments and maintain the status quo. At the same time, recent conversation analytic work cautions against treating such interrogatives as inherently 'tilting' towards an affirmative response. Couper-Kuhlen *et al.* (2023) and Robison and Heritage (2023) showed that the responses these questions elicit are also shaped by their sequential placement and the action they include. From this perspective, the preference for responding with an affirmative 'yes' or 'no' is not necessarily a fixed property of the question design as an interrogative (alone) but unfolds in relation to how the question is fitted in the local course of action. In the presented

analyses, in most instances the GP's questions 'are you happy with that' or 'are you okay on that dose' function not only as a request for patient input but also as an implicit expert endorsement of treatment continuation. Patients, for their part, often respond with mitigated or non-type conforming answers (e.g., "it seems to be [helpful]" in Extract 5), which downplays certainty and refrains from expressing a strong personal commitment (Drew, 1991; Gill, 1998). Such responses do not necessarily indicate an 'actual' lack of understanding or uncertainty but orient to an acknowledgment they may not have the right to possess certain kinds of (medical) knowledge (Drew, 1991; Pilnick, 2022).

When GPs invite patients to consider reducing (see section 5.4) or stopping (see section 5.5) a medication, this can create an epistemic tension as it implicitly questions the necessity of an ongoing treatment (by virtue of a medical expert questioning it) while simultaneously treating the patient's assessment as essential for that decision. The GP's subsequent talk, such as 'it's up to you really' may overtly include the patient in the decision-making process but it may also induce uncertainty or anxiety, especially if the patient feels ill-equipped to make a judgment about the necessity of the medication. The analysis suggests that in offering patients more control over their treatment, GPs must ensure that patients feel supported and informed in their decision-making process. In line with previous studies (Landmark *et al.*, 2015; Toerien *et al.*, 2013), it is exactly this expert support and (clinical) informing that potentially places patients in a complex and tangled position. This finding aligns with previous CA work (Pilnick, 2022) in raising important questions about how shared decision-making or patient-centred care is realised in practice, particularly in the context of long-term medication use.

So, these findings complement and nuance prior interview-based studies of (de)prescribing (e.g., Ouellet *et al.*, 2022; Reeve *et al.*, 2022; Sinnott *et al.*, 2015) which report that both GPs and patients regard medicine use (and polypharmacy and deprescribing in particular) delicate matters to talk about. The present analysis shows that, whilst medication reviews are seemingly structured and routine, they actually involve delicate negotiations between medical authority and patient autonomy, particularly when it comes to decisions about continuing or discontinuing medication. As previously discussed in the introduction section,

policy guides state that "the final decision to prescribe or de-prescribe must be based equally on the clinical evidence, the prescriber's experience and the patient's values, experiences and wishes" (NHS England, 2020, p. 8). However, the analysis shows that the sequential position of involving the patient in the decision-making process (by for instance asking 'are you happy to keep taking that?'), after establishing the medicine's effectiveness (regardless of basing it on clinical evidence or not), implicitly reinforces the presumption that continuation of the medicine is indeed the most logical appropriate course of action.

Overall, these findings contribute to a deeper understanding of the interactional practices that underpin medication reviews during telephone consultations. They point to the complex interplay between discussing a medicine's effectiveness, its tolerability and ultimately its necessity. They highlight the delicate balance between (i) medical expertise and patient autonomy (i.e., GPs have to rely on their professional expertise to assess medication use while also orienting to patients' subjective experiences with them); (ii) the role of patient agency in treatment decision-making (i.e., while policy guidelines advocate involving the patient, in practice this results in patients displaying uncertainty and carefully avoiding claiming medical expertise); and (iii) the interactional practices involved in discussing medication (dis)continuation (i.e., the design and timing of involving the patient in the decision-making process). At the same time, the analysis also suggests three implications for best practice:

1. Consider the impact of particular question design. For example, polarised interrogatives as 'are you happy to keep taking that medication?' prefer an affirmative response and may implicitly direct patients towards treatment continuation.
2. Attend to the sequential positioning of involving the patient in decision-making. Inviting patient input after establishing the medication's effectiveness may implicitly reinforce medication continuation.
3. Be mindful that involving the patient in treatment decision-making does not necessarily lead to autonomy. Namely, it may put patients in a complex position, particularly when they feel unable to evaluate the implications of

medication (dis)continuation. Articulating what aspects of the decision rely on clinical evidence and what aspects require the patient's experiential input may help in avoiding overloading patients with evaluative work they may feel unable to undertake.

While these suggestions are not necessarily direct recommendations, they emphasise some areas in which greater awareness of various interactional practices may help practitioners in ways that take into account both the clinical objectives (and guidelines) of medication reviews and patient's experiences and preferences regarding their medications.

A final point for consideration is the suitability of conducting medication reviews over the telephone, as opposed to traditional face-to-face consultations. In my corpus of telephone consultations there is a relatively high amount of formal medication reviews (9 out of 29) and virtually all consultations include some form of talk around medicine use. This seems to point to a perception amongst participating practices that medication reviews can be done effectively over the telephone. This is understandable as it may seem to be redundant to physically see a patient in a context where presenting symptoms are not the reason for the consultation. I have previously described the research suggesting that while telephone consultations provide an acceptable (and sometimes beneficial) alternative to face-to-face, they may also cause some limitations. GPs are unable to observe most non-verbal cues, such as body language or facial expressions, which could be instrumental in checking the patient's understanding (for instance about the purpose of a particular medication) and in evaluating their level of comfort (for instance in cases of discontinuing medications or reducing doses). Despite the fact the practitioners deem medication reviews can be done successfully over the telephone, this chapter shows that these discussions are perhaps more complex and interactionally delicate than might be assumed at first glance.

Chapter 6. "Is there anything else I can do for you today?": Exploring the closing phase of primary care telephone consultations

6.1 Introduction

In this chapter, I examine how closings actually unfold in real-time telephone consultations in primary care. A main problem in these consultations is how both parties – particularly patients – know when they both have accomplished everything they intended to and therewith are both ready for the consultation to end. This is a crucial issue, as unaddressed or unresolved matters may leave patients feeling confused, burdened, neglected, or otherwise unsatisfied after the consultation (Frigaard *et al.*, 2025; Heritage *et al.*, 2007; Murphy *et al.*, 2022). Despite the fact that health care consultations are theoretically time limited encounters (NHS GP appointments are usually 10 minutes long (NHS, 2023)), the specific time allocated to an appointment does not necessarily dictate when or how that appointment will be ended (West, 2006), hence there are other means interlocutors need to rely on in order to appropriately close a consultation.

A significant challenge in primary care is that patients often bring multiple concerns to a consultation (Leydon *et al.,* 2018; Salisbury *et al.*, 2016), yet the evidence suggests that many of these additional issues remain undiscussed (Heritage *et al.*, 2007). This can lead to patient dissatisfaction, potential worsening of health issues, and system inefficiencies due to the need for follow-up appointments (Barry *et al.*, 2000). Because consultations typically progress as doctor-governed, question-answer driven interactions (Frankel, 1995; Heritage, 2010; Maynard, 1991; Mishler, 1984), the consultation's closing phase is one of the few opportunities for patients to raise any remaining concerns or questions (Nielsen, 2012; White *et al.*, 1997). This makes the closing phase a crucial point within the consultation.

This issue may possibly be intensified in telephone consultations. An interview-based study by Rosen *et al.* (2022) showed that one of the associated risks of remote consultations is that a lot of concerns indeed remain unsurfaced. Besides the fact that researchers have found that telephone consultations are typically shorter than face-to-face encounters (Hammersley *et al.*, 2019; Hobbs *et*

al., 2016; Jiwa *et al.*, 2002; McKinstry, 2002; McKinstry *et al.*, 2010; Pinnock *et al.*, 2003; Totten *et al.*, 2019), the limited amount of existing empirical evidence suggests that telephone consultations tend to be even more doctor-driven, with the doctor maintaining greater control over the conversation and patients adopting a more passive role (Agha *et al.*, 2009). Moreover, most visual cues are not directly observable (Rothwell *et al.*, 2012) and since physical examinations do not occur, there is a loss of opportunity for patients to raise additional concerns that routinely occur around this examination phase (Stivers & Timmermans, 2020). In face-to-face encounters, moments of non-speech co-occurring with activities such as dressing after a physical examination, or doctors visibly writing up notes or prescriptions may afford opportunities for patient to bring up further concerns. Equally, in face-to-face consultations, research has found that patients are able to raise another concern on their literal way out of the door, also known as the 'doorknob phenomenon' (Nielsen, 2012). These opportunities, again, are largely absent in telephone consultations.

Previous conversation analytic studies have explored the closing phase of in-person primary care consultations, including West's (2006) and Robinson's (2001) work in U.S. primary care, Heath's (1986) analysis of embodied practices during closings in UK general practice and Nielsen's (2018) and Edwards *et al.*'s (2019) work on safety netting during the closing phase. However, to date, no study has explicitly focused on how the closing phase unfolds in primary care telephone consultations. This chapter uses conversation analysis to examine the closing phase of 29 audio-recorded GP-patient telephone consultations in NHS primary care. It focuses on how these closing phases are organised through GPs' and patients' in-situ interactional practices (Zimmerman, 1984), and explores what the potential contingencies faced by both GPs and patients are, particularly when patients do attempt to raise new concerns or questions. In doing so, this chapter contributes to a deeper understanding of how telephone consultations are conducted and provides some evidence-based insights into the interactional work involved in closing telephone consultations.

Before turning to the findings, I will offer some background on the general organisation of closings in (ordinary) conversation (section 6.2.1), how this

relates to closings in primary care (telephone) consultations (section 6.2.2), and some further background on the data used for this chapter (section 6.2.3).

6.2 Background

6.2.1 Closings in (ordinary) conversation

Schegloff and Sacks (1973) identified two key 'problems' that speakers are faced with when bringing a conversation to a close. The term 'problem' here does not mean the speakers have to actively think about a solution, but rather as something that requires (interactional) work to accomplish. The first problem is ensuring that their conduct is observationally (for the other) oriented towards ending the conversation. Merely stopping talking will not be sufficient for this purpose; according to the normative rules of turn-taking in conversation (Sacks *et al.*, 1974), a period of silence may be interpreted as a pause or gap, rather than as an indication that the conversation has ended. In such a case, the other participant may take the silence as an opportunity to take the floor and continue speaking. In order to manage this, participants often engage in which what Schegloff and Sacks (1973) term a *terminal exchange*, as per the example below:

1) Schegloff & Sacks, 1973, p. 318
   A: *Bye* bye
   B: Bye

The second 'problem' lies in ensuring that all participants have the opportunity to introduce any outstanding topics before the conversation reaches its end. Such topics (also named *unmentioned mentionables*) can be matters participants wanted to discuss but were unable to fit into the ongoing flow of the conversation. Given that conversational topics are typically organised turn by turn, an abrupt attempt to initiate a terminal exchange precludes the other from raising anything else (i.e., initiating a new topic) they still wish to address (Schegloff & Sacks, 1973). In order to accommodate this, speakers often initiate a recognisable *possible preclosing* sequence, during which they hand the floor to the other

without introducing a new topic. This can involve an exchange of turns including items as 'so', 'well' or 'okay' (including downwards intonation):

2) Schegloff & Sacks, 1973: 317
   A: O.K.
   B: O.K.
   A: Bye Bye
   B: Bye

In the example above, each 'O.K.' serves as a possible preclosing, displaying that neither party has any further business to pursue and thereby paving the way for the terminal bye-bye sequence. According to Schegloff & Sacks (1973), a well-formed closing typically includes at least a possible preclosing and a terminal exchange. However, in practice, as I will also show in the analysis sections of this chapter, closings are far more complex than this. The potential for extensive further talk following a preclosing remains an often-observed contingency.

Possible pre-closings are typically placed after the close, or the closing down, of a topic. Button (1987) described several techniques speakers deploy in shutting down conversational topics and therewith moving towards closing the conversation. These include referencing back to items discussed earlier in the conversation, displaying appreciation (see also Antaki, 2002) and explicating the reason for the call (in case of a telephone conversation). Particularly making *arrangements* for future activities is a usual way to work towards closing (Button, 1987). In suggesting, or referring to, a future meeting, speakers can imply that the current conversation is reaching an appropriate endpoint, and that any additional matters can either be 'reserved' until that future encounter or are no longer necessary to be addressed at that particular moment. Interlocutors can also bring a current topic to a close by *reintroducing arrangements* made earlier in the conversation (Button, 1991). Another technique hearable as topic closing is by *summarising* the topic-in-progress (Button, 1991). Usually this entails the one party providing a summary and the other providing an affirmation of it. By affirming, the hearer thereby displays their orientation to the topic as possibly closed.

As West (2006) described, the closure of any conversational topic makes relevant the following set of contingencies:

[Topic closure]
↓
Okay} Preclosing
Okay}
↓
Goodbye} Closing
Goodbye}
[End of conversation]

In short, normally a topic needs to be brought to a close before the initiation of preclosing; preclosing moves are generally completed before the initiation of the closing; and the terminal exchange must usually occur before the conversation ends. However, at any stage in the closing process – including even the initial turn of a terminal exchange – speakers can engage in alternative activities such as extending, delaying or moving out of the closure (Button 1987; 1990; 1991; Jefferson, 1984).

One way of moving out of the closure is through *Topic Initial Elicitors* (Button, 1987). An example of this would be a GP asking a patient 'is there anything else you want to talk about today?'. Such elicitors indicate an opportunity for a new topic to be introduced in the conversation but generally they do not specify a particular topic (or range of topics) for the other participant to take up. Such turns are especially sensitive during closings because they can sharply shift the interaction away from closure whilst still acknowledging that the conversation is indeed approaching its end. In short, they occupy a turn that could otherwise be used to produce a closing component (e.g., the first fair part of a terminal exchange) and make conditionally relevant a presentation of a new item/topic or a decline (instead of second pair part of a terminal exchange). There is an overall 'preference' for a topic initial utterance over a decline (Button & Casey, 1984). However, in case of a decline, closing remains relevant.

6.2.2 Closings in primary care (telephone) consultations

Medical consultations are typically mono-topical conversations (Raymond & Zimmerman, 2007), constructed around one primary medical issue. Once this issue is treated as resolved, both participants treat the closing of that topic as the point at which the closing phase of the entire conversation is initiated (Schegloff & Sacks, 1973), regardless of the possibility of patients bringing more than one concern to the consultation. This mono-topical nature is reinforced by the doctor-led, question-answer nature of health care interaction, which further constrains patients' opportunities to raise additional concerns. In general, it is difficult for interlocutors to change the trajectory of a conversation once the main action has been accomplished. Therefore, once the main action (the reason for the consultation) has been addressed, it is equally difficult for patients to change the trajectory of the remainder of the consultation.

Heath (1986) noted that patients are typically the ones who physically leave the room in face-to-face consultations, but because medical consultations are doctor-governed, it is usually the doctor who initiates the closing. However, how this translates to telephone consultations is an empirical question, given the parties do not occupy the same physical space. Nevertheless, the GP remains the party 'controlling' the consultation, responsible for initiating the closing of the consultation (Heath, 1986; West, 2006; White *et al.*, 1994). This is reinforced by the mono-topical organisation of health care encounters and the institutional expectation (frequently now explicitly underlined in UK primary care services) that patients will refrain from bringing up previously unmentioned complaints (West, 2006).

Previous research showed that doctors often initiate pre-closing sequences by offering treatment recommendations (Nielsen, 2012), summarising the discussion (White, 2015), or proposing future arrangements (West, 2006). These actions make understandable the completion of the primary business and serve to legitimise closing the consultation in a medically appropriate and accountable way. As Nielsen (2012) noted, patients often wait until the doctor has moved to close the main concern before attempting to raise additional matters (if they raise them at all). This dynamic makes the closing phase in medical consultations particularly consequential: once the doctor initiates consultation

closure, patients may interpret the opportunity to raise further concerns as constrained or no longer appropriate. Relatedly, safety-netting practices, which involves offering guidance on what to do if a patient's condition does not improve, worsens, or new symptoms emerge after the consultation, often form part of these closing sequences (Edwards *et al.*, 2019; Hewitt *et al.*, 2010), further solidifying the trajectory toward closure and making late-stage topic initiation by patients even more interactionally delicate.

Doctors often initiate the closing phase of consultations by asking whether there is 'anything else' the patient wants to discuss. However, as West (2006) showed, the question 'anything else?' does not automatically mark the start of the closing. Rather, only when it follows an analysable end of a topic (Schegloff & Sacks, 1973) – particularly after treatment plans and other arrangements have been proposed and agreed upon – then 'anything else?' works to elicit a warrant for treating the consultation as possibly closed.

Importantly, the wording GPs use when asking patients about additional concerns can play a crucial role in shaping how patients respond. Subtle differences in wording can significantly influence consequential answers, with certain words either associated with a positive or negative frame of reference (Cohen-Cole, 1991; Lipkin *et al.*, 1995; Marvel *et al.*, 1999). The word 'any' is commonly associated with a negative frame of reference and not with a positive frame (Heritage, 2010; Heritage *et al.*, 2007; White *et al.*, 1994). For instance, people tend to say "I don't have any symptoms" instead of "I do have any symptoms". In contrast, 'some' typically appears in positive constructions (Heritage, 2010), such as "I have some symptoms" and not in utterances as "I don't have some symptoms". This difference in *polarity* may have far-reaching consequences in medical interactions. Words like 'any', which are negatively polarised, may limit patient responses during consultations and thereby discourage them from bringing up further concerns. Namely, negatively polarised questions (such as "is there anything else you want to discuss?") prefer a negative 'no'-response (Schegloff, 2007). On the other hand, positively polarised words like 'some' might make patients more inclined to bring up additional concerns (Heritage *et al.*, 2007), because positively polarised questions prefer a positive 'yes'-response (Schegloff, 2007).

To explore this, Heritage *et al.* (2007) conducted a randomised control trial study in U.S. family medicine clinics, randomly assigning doctors to use one of two question formats after the patient had presented their main concern. Doctors either asked, "Is there *anything* else you want to address in your visit today?" (the negatively polarised form), or, "Is there *something* else you want to address in your visit today?" (the positively polarised form). They found that, if patients had multiple concerns, patients in the *some*-group were significantly more likely to mention more than one medical concern than patients in the *any*-group (90% vs. 53%). Moreover, they found no significant increase in appointment time or patient satisfaction. Another similar study by Leydon *et al.* (2018) focused on a UK primary care context and found no difference in raised concerns between the *some* and *any*-group. Instead, they underscored the importance of the timing of the solicitation within the consultation. Leydon *et al.* (2018) suggested that GPs should invite patients to raise additional concerns during the opening phase of the consultation. This is because addressing additional concerns at the end of the consultation can cause challenges for time management and may lead to those concerns being insufficiently explored or resolved. Eliciting additional concerns early on allows GPs to prioritise issues and manage expectations from the beginning of the consultation.

However, more recent conversation analytic work sheds another light on this account. A study by Couper-Kuhlen *et al.* (2023) argued that affirmative polar interrogatives with 'any' (e.g., "is there *anything* else you want to talk about today?") do not inherently 'tilt' towards a negative ('no') response. Instead, the preferred response is shaped by the particular action the question is doing, its sequential position, and what type of response would advance the ongoing course of action. In this sense, 'any' is not best understood as negatively polarising the question, but as facilitating responses by making even minimal contributions (i.e., raising even minimal additional concerns) interactionally acceptable. This suggests that the interactional consequences of 'any'-questions in medical consultations cannot be reduced to polarity alone but have to be analysed in relation to their sequential positioning and action formation. Further refining our understanding of these interrogatives, Robinson and Heritage (2023) also demonstrated that identical 'anything else' polar interrogatives can elicit

different response types depending on their sequential context. In particular, when such questions occur following an initial 'open solicitation' of the patient's problem (e.g., "what can I do for you today?"), they can function to renew that prior action (i.e., soliciting reasons for the visit), thereby enabling patients to introduce additional concerns without first producing a 'yes/no'-response. In short, these findings have important implications for the present analysis. Rather than treating 'anything else'-questions as inherently discouraging further concerns, their action has to be analysed in relation to their sequential placement and the activity in which they are situated. Accordingly, the analysis that follows in this chapter examines how these interrogatives function in their context, and how patients orient to this in their responses.

In the UK, specific guidance and communication training on how to close (remote) primary care consultations is remarkably slight. The most widely used model in UK GP training (endorsed by the RCGP) is the Calgary-Cambridge model. However, the model is criticised for not being able to deal with multiple conditions that are brought up in a primary care setting (Royal College of General Practitioners, 2021b). In short, closing a consultation, according to this model involves summarizing the session, confirming the plan of care, checking for understanding, and addressing any remaining concerns (Kurtz *et al.*, 2003). Particularly the last point is of interest here. The model, or any other related guidance, lacks detail regarding exactly *how* to do this. It is predicated on the assumption that asking for any remaining concerns in any shape or form is the important thing, and that asking will elicit remaining concerns, if patients have these. Equally, in the US, Heritage *et al.* (2007) reported that unmet concerns are a known issue and that medical school curricula encourage doctors to ask for additional concerns, however with the 'Is there anything else'-question. In both cases, the communication guidance does not acknowledge the importance of the details of question (and sequence) design from a conversation analytic perspective.

In response to the commonly formulated question 'do you have anything else you want to talk about today?', empirical research suggests patients do not generally respond by openly introducing new topics/concerns. Instead, they treat introducing further concerns as an accountable matter, displaying a shared

orientation to a mono-topical model of medical consultations. Robinson and Heritage (2015) described that patients' answers to the 'is there anything else'-question (in their case in up-front agenda setting) indeed often appear to be self-contradictory. Namely, in their responses to physician's agenda-setting questions, patients often initially offered nonvocal and/or verbal 'no'-type responses, seemingly claiming they had no further concerns to talk about, but then nevertheless proceeded to raise additional concerns.

6.2.3 Data

Every recording in my corpus of telephone consultations included a closing phase (i.e., no call was ended abruptly due to, for instance, a technical issue). Out of the 29 recordings, there were two instances in which the GP asked the patient to re-confirm their consent for the call to be recorded at the end of the consultation, just before the terminal exchange. Because these instances not only caused a 'distortion' to the interaction but also made these closings less naturally occurring – as these moments would not have arisen in the absence of a recording – they have been excluded from the analysis presented in this chapter.

In the remaining 27 recordings, I observed that there are broadly three ways in which the consultation is brought to an end (i.e., how the participants make observable to each other that they are ready for the consultation to end). Section 6.3 examines cases in which patients indicate they have no further concerns to raise. Then, Section 6.4 includes instances where the use of confirmation-seeking tags project and negotiate consultation closure. Lastly, Section 6.5 analyses 'anything else'-questions initiating consultation closure.

6.3 Patients indicating having no further concerns to raise

This section presents two extracts from the final phase of different telephone consultations, illustrating how patients initiate closing sequences through strong expressions of gratitude and satisfaction and how GPs subsequently expand beyond these turns with additional clinically relevant talk. Both extracts show how strong appreciation tokens (e.g. 'thank you so much') and high grade assessments (e.g. 'amazing', 'lovely') are used by patients as possible pre-closings,

implying that their concerns have been (more than satisfactorily) addressed and no further issues need to be raised.

The first extract comes from the end of a telephone consultation that lasted seven minutes and fifty seconds. The patient has reported dealing with mental health concerns, due to work-related stress. After the problem describing phase, the GP proposes a number of actions to be undertaken by both parties: for the GP to write a 'fit note' for return to work; for the patient to call a mental health helpline phone number; for the patient to call the Citizens Advice Bureau clinic, and also to explore the option of private therapy. Towards the end of the call, the GP starts to send the patient separate text messages including information on how to do these things. Just before the extract reproduced here, the GP has sent the patient a text message on how to contact a mental health helpline. The extract starts with referring to the most recent text message, about contacting the Citizen's Advice Bureau.

Extract 1. P12GP03: 7.14-7.50

```
01    GP:   A::nd then (.) I'm going t'send you the information on
02          the Citizen's Advice↑ Bureau clinic:.
03                (3.7)
04    GP:   That's the next text coming throu:gh:, (.) and then I'm
05          going t's:end you a ↓website where you c'n explo:re the
06          option of private therapists::.
07                (0.9)
08    P:    Ama:zing.=that's- (0.2) uh=you've b'n- (0.2) so helpful=
09          that's >really lovely<=thank ↓ya.
10                (.)
11    GP:   If you do find your thoughts are worsening an' you feel
12          you can't keep yourself safe::, (.) uh: specially if
13          there are thoughts of harming yourself: or ending your
14          life you must call for'n >emergency appointment the
15          same day,< (0.4) or ring [>one ] one one< if we're=
16    P:                             [Yeah.]
17    GP:   =closed or we can't fit you ↓in (0.5) there are
18          [people] to ↓he:lp.
19    P:    [Okay. ]
20                (1.3)
21    P:    O- (.) ↓kay (.) -ell ama:zing=thank you so mu:ch=
22          =[thank you]                    [really do appreciate-]
23    GP:    [All right]=thank you Abigail [and I hope things im ]=
24          =prove for ↓you.
25                (0.9)
26    P:    ↑Thank you [you take care thank you=>bye bye.<    ]
27    GP:              [°All right ↓then take care°=>bye bye.<]
```

The GP's utterance in lines 01-02 presents some activity (sending information) and after a 3.7 seconds gap the GP indicates the activity has been completed (i.e.,

the information has been sent to the patient). Subsequently announcing "and then I'm going t's:end you" (line 04-05) projects further upcoming activity, indicating the GP is still in the process of providing the patient with all the relevant information discussed earlier on in the consultation. It includes an upshot formulation of what has been discussed and decided earlier on in the consultation. After a 0.9 seconds gap, the patient offers a high grade assessment (Antaki, 2002) token: "Ama:zing" (line 08). The patient unpacks her appreciation twice: first with "you've b'n- (0.2) so helpful", and then again with "that's >really lovely<". The patient concludes her turn with a downward intonation on "thank ↓ya.", further orienting to a topic closure initiation (Button, 1987). Particularly, the patient's "you've b'n- (0.2) so helpful' indicates there is no evidence that there are other unaddressed issues or concerns. Especially the past tense ('been') includes some work to close the sequence; it implies that the patient's agenda has been (more than sufficiently) addressed. The extensive gratitude and positive evaluation of the GP's help so far seems to suggest satisfaction with the consultation outcome, further establishing the interactional move towards closing the consultation. On that basis, it could be hearable as a possible preclosing move.

Despite the patient's affiliative, appreciative and closing-oriented turn of lines 08-09, the GP expands past the patient's strong appreciation and initiates a safety-netting sequence (Edwards *et al.*, 2019) in lines 11-18. The turn is formulated in the conditional tense ("If you do find" – line 11, "If there are" – lines 12-13) and uses a modal imperative ("you must call" – line 14). The patient responds with a downward intonation "Okay." in line 16, displaying understanding and acceptance of this.

After 1.3 seconds (line 20), it is the patient who takes the floor again. In line 21, the patient reorients to closing the consultation with a high grade assessment token: "ama:zing". Such assessments are typically found after the other speaker (in this case the GP) has inserted something into the closing sequence (Antaki, 2002), in this case an inserted safety-netting sequence. Using a high grade assessment token such as 'amazing' (re-)claims ownership of the close down sequence and reinforces that there are no additional concerns to be raised. Furthermore, the patient (again) upgrades her appreciation ("thank you

so mu:ch=thank you" and "really do appreciate-"). The fact that this is a (partial) repetition and an upgrade of lines 08-09 makes it even more hearable as a resumption of the closing phase; it makes immediately expectable a return to the suspended closedown of the consultation (Antaki, 2002). In overlap, the GP responds to the patient's thanking of line 21 with "All right" and a reciprocated 'personalised' thanking in line 23. He continues his turn with expressing his hope the patient will improve, followed by a "↑Thank you" of the patient in line 26. The consultation ends with an overlapping but aligned closing/goodbye sequence in lines 26-27.

Extract 2 comes from the end of a telephone consultation lasting just under eleven minutes. The main reason for the consultation is to perform a medication review, which involves reviewing what medicines the patient is taking, discussing their effectiveness and tolerability, and making sure they are still appropriate for the patient's needs (see Chapter 5 for an extended discussion on medication reviews). The extract starts at the end of a discussion of the final medication (aspirin), in which the GP and patient have discussed why the patient is currently taking the medication. The GP has already proposed she will contact a cardiologist (who initially prescribed the medication) to ask if the prescription was meant as short or long term. After the patient himself notes that long term usage of aspirin could cause stomach issues, the GP says that because of the patient's age this is not something to be worried about and continues by referring back to the proposal to contact a cardiologist: "I: will jus' take some advice".

Extract 2. P15GP05: 10.22-10.50

```
01    GP:   =>But as I:< will jus' take some advice 's to whether
02          (0.4) m-=m-
03                (.)
04    P:    I need [to carry on with th-]
05    GP:          [You should be       ] havin' it at'all.
06                (0.3)
07    GP:   ↓Yeah.
08                (.)
09    P:    Yeah.
10                (0.2)
11    P:    'kay (.) that'd be ↑great yeah
12          [thank you very much] then doctor.
13    GP:   [O:kay↓             ]
14                (.)
15    GP:   No problem=so what I'll do is I'll update all your
16          meds <as is: for no:w:,> (0.2) okay, and reau:thorise
17          them >but then if-< (.) if uhm- (.) if I ge' a message
18          back to say (.) no it's okay you can stop the asp'rin
```

```
19          then I'll obv'sly let you ↓know.
20                (0.7)
21    P:    .pt (.) lovely.
22                (.)
23    P:    Okay.
24                (.)
25    P>    .hhh (0.3) that's- that's lovely=thanks very
26          [much for    ] your ↓call.
27    GP:   [>↑Brilliant<]
28                (.)
29    GP:   O:kay and I'll see you at some point t'check on the
30          prosta'.
31                (0.5)
32    P:    Yes I'll make an appointment.
33                (.)
34    GP:   Per[fect.]
35    P:        [Thank] you very ↓much.=
36    GP:   =All righ' (.) >take care th'n.<
37                (0.3)
38    GP:   Byebye.
39                (.)
40    P:    ↑Byebye:.
```

In this extract, the GP's utterance in line 01 (">But as I:< will jus' take some advice") functions as a reformulation of what has been previously discussed and decided. Therewith it is hearable as both a summary/repetition and as a transitional move that effectively closes the activity/topic of (medical) decision-making. The patient self-selects in line 04 with a candidate completion of the GPs ongoing turn ("I need to carry on with th-"), but the GP subsequently overlaps in line 05 by stating the actual completion of the turn initiated in line 01: "You should be havin'it at'all". Despite the fact that both formulations are slightly interactionally misaligned, both speakers subsequently display an affiliation with a mutual 'Yeah' (lines 07-09). After a topic closure, such stand-alone acknowledgment tokens produced with a downwards intonation could indicate a possible preclosing sequence (Schegloff & Sacks, 1973). The patient then continues with producing a closing-relevant turn in lines 11-12. This turn not only strongly displays appreciation (similar to Extract 1) but also further orients towards a possible closing through explicit reference to the institutional role of the GP, as "doctor". This seems to be an overt orientation to this institutional encounter to be (almost) over. However, similarly to what happens in the previous extract, the GP expands past the patient's strong appreciation and does not (yet) treat the consultation as complete at this point. In lines 15-19 the GP announces an action plan, displaying what will happen at this point ("I'll update

all your meds") and what could happen in the future ("if I ge' a message back to say … then I'll obv'sly let you know").

The patient's turn in lines 25-26 is, similarly to the previous extract, explicitly appreciative, affective, and strongly (re-)orients to closing the consultation. Again, there is a turn-initial high grade assessment after the other speaker has inserted something (in this case an action plan/arrangement setting) into a closing sequence. The "lovely." in line 25 takes (or reclaims) ownership of the close down sequence (Antaki, 2002) and stipulates that the patient has no additional concerns that need to be raised before the end of the consultation. It implies the patient's agenda has been sufficiently addressed and it sequentially warrants a lack of need for any follow-up questions from the GP. Therefore, this turn, like in Extract 1, further (re-)establishes an interactional move towards closing the consultation. The GP aligns with this move by overlapping with an affiliative ">↑Brilliant<" (line 27). Yet, instead of closing, the GP adds a final step in lines 29-30 ("I'll see you at some point t'check on the prosta'."), referring to the fact the GP and patient agreed previously during the consultation that the patient should book a follow-up appointment with the GP for an in-person prostate examination. The patient subsequently confirms this which is met with a third-position evaluative assessment of the GP in line 34: "Perfect." Subsequently, the patient initiates the final pre-closing sequence in lines 35, again by displaying (strong) appreciation and lines 38-40 include the terminal exchange phase of the consultation.

In both extracts in this section, the patients' strongly appreciative turns, including high grade assessment tokens, serve as interactional moves towards closing the consultations. In both instances, it is the patient who is initiating the pre-closing 'thank you'-'thank you' sequence (see Sikveland & Stokoe, 2017), thereby treating a service as complete. These turns imply that the patients' concerns have been sufficiently addressed and that no further issues remain to be raised, meaning that it does not warrant a question from the GP asking for any additional concerns, and thus functioning as possible pre-closings. In each extract, however, the GP expands past these closing-initiation turns by inserting additional talk; safety-netting advice in Extract 1 and an action plan/arrangements in Extract 2. Notably, after each GP's expansion, the patient

returns to the suspended closedown, again through strongly appreciative, affiliative turns that reclaim ownership of the closing sequence (Antaki, 2002). These extracts suggest that while patients may attempt to initiate closings through strong displays of gratitude and satisfaction, GPs retain interactional control of the consultation's trajectory by inserting clinically relevant actions (such as safety-netting), before collaboratively moving into a recognisable closing phase.

6.4 Confirmation-seeking tags to project and negotiate closing

This section includes two extracts from the final phase of two (GP-initiated) telephone consultations. It focuses on the use of confirmation-seeking tags ('okay?' and 'all right?') in managing the transition of the consultation into closing. The extracts show how these tags function not only as requests to confirm specific next steps (e.g. arranging a referral), but also to project and check a mutual 'readiness' to close the consultation. As the analysis will show, when patients respond with an agreement or appreciation, these sequences are indeed followed by a collaborative and orderly closing of the consultation.

Extract 3 comes from the end of a GP-initiated telephone consultation, lasting just over nine minutes. The patient needs to undergo a repeat bone density scan (a DEXA), which is a common follow-up for patients who have previously received breast cancer drug treatments. As part of ordering the DEXA

Extract 3. P05GP04: 8.57-9.15

```
01    GP:   So that's a:ll sorted for you Caroline an' I'll take
02          care *o'the rest* ↑okay?
03                (0.5)
04    P:    Yeah I've put ↓dow:n (.) I've put it on the calendar=I've
05          jus' put it on the diary. ((papers rustling))
06                (1.5)
07    P:   O:kay ↑then?
08                (0.3)
09    GP:  £A:ll righ'£ you take ca:re,
10                (0.7)
11    P:   And £you:£,
12                (0.6)
13    GP:  £Bye bye::.£
14                (0.5)
15    P:   Bye:.
```

– which will be carried out in a secondary care setting – the GP is required to complete an electronic form, which is the main reason for the consultation. Prior

to the scan, the patient needs to undergo a blood test as well. The GP has booked in an appointment for that blood test just before the next excerpt starts.

In line 01 the GP closes the activity of booking in a blood test for the patient, using an extreme case formulation "a:ll" (Pomerantz, 1986), implying there is nothing else expected or required from the patient at this moment in time. Subsequently this is strengthened by the GP stating that she will take care of whatever else there is to do – presumably checking the result of the blood test and informing the patient about its result. By referencing to the reason for the call (sorting out a referral to a DEXA scan), the GP establishes the relevancy of closing initiation (Schegloff & Sacks, 1973) because it displays that no further new material for the conversation is being introduced (Button, 1987). She ends her declarative turn with a confirmation seeking "↑okay?" (Raymond, 2010). In line 04 the patient fittingly provides an agreement token ("Yeah") and consequently seems to demonstrate that agreement, by stating she has written down the time and date for her blood test appointment (potentially even twice). The patient therefore displays an understanding that attending that appointment is the only action currently required from her side.

What follows is a 1.5 seconds gap, which CA research has suggested is nearly the 'standard maximum silence' for telephone conversations, at which point interactants commonly initiate some activity designed to resolve the 'problem' (Jefferson, 1989). Due to technological latency in the context of telephone interaction this may still seem small (although it is significantly longer than the other inter-turn gaps in the extract and in the rest of the consultation), but it is nevertheless hearable as a gap between speakers and could indicate a lack of uptake or further talk from both patient and GP. As Hoey (2018) shows, such lapses (instances in which no speaker self-selects as next speaker) can be treated as closure-implicative, projecting the conversation is reaching its end.

In line 07 the patient takes the floor again and further moves the consultations towards closing: "O:kay ↑then?". Interestingly, it is the patient here who checks if the GP is 'on board' regarding closing the consultation – something the GP already has done in line 02. On the one hand this could be because this consultation was initiated by the GP; the patient therefore checks if the GP has covered everything she intended. On the other hand this could be because of the

lack of visual cues together with the hearable sound of rustling papers on the patient's side of the connection; it acknowledges that the GP is unable to see whether the patient is 'actively' waiting for the GP to take the floor again. In both cases, the 1.5 seconds gap and the patient's turn in line 07 imply that the patient has nothing else to add to the agenda. Namely, such a closing indicator (see Goldberg, 2004) displays a 'readiness' to transition the conversation into the next relevant action (Beach, 1993) (i.e., bringing the consultation to an end). The patient's confirmation seeking "O:kay ↑then?" is followed by the GP in line 09 by an agreement token ("£A:ll righ'£") and subsequently the GP initiates the final closing sequence(s) of the consultation: "you take ca:re,". After this is returned by the patient ("And £you:£"), the GP initiates the terminal 'bye-bye' closing sequence of lines 13-15, before terminating the call.

Extract 4 comes from the end of a 21.5-minute long consultation. The consultation is also a medication review, in which the GP and the patient have reviewed 11 different medications that the patient is currently taking. Just before the extract starts the GP has proposed the patient will send a picture of her foot and has sent her a text message including instructions on how to do so. The extract starts with a summary by the GP of what the consultation included, what the outcome is and what will happen after the consultation ends.

Extract 4. P20GP01: 21.07-21.29

```
01    GP:   Okay so look we've been throu:gh and we done your
02          medication re[view:] and uh:: we're keeping ev'rything=
03    P:                  [Yes. ]
04    GP:   =The same except we're taking off: the: (.) uh- (.)
05          <parac:etamo:l> (0.4) [uh:m ] (.) I've given you a=
06    P:                          [Yeah.]
07    GP:   =further <Trimbow::> (0.4) uh::m:
08                (.)
09    P:    Thank [↓you.]
10    GP:         [A:nd ] uhm (.) an'I'll do that referral ↓for
11          you (0.2) ↑all right?
12                (0.7)
13    P:    Thank you very much [indee:d,]
14    GP:                       [Grea'   ] (.) nice to speak to you,
15                (0.3)
16    P:    And you (0.2) take care.
17                (0.2)
18    GP:   >Byebye.<
19                (.)
20    P:    Byebye.
```

In lines 01-02, the GP offers a summary formulation ("We've been throu:gh and we done your medication review:), thereby indicating that the primary activity of the consultation (the main reason for the call) is now complete. Similar to Extract 3, such a reference to the reason for the call and providing an upshot formulation of what has been decided previously is closing implicative (Button, 1987). This is met with a confirmation by the patient ("Yes.") in line 03. The GP continues with outlining/summarising the three main outcomes of the consultation. Firstly, the GP states that paracetamol is the only medication that will be taking off from the patient's repeat prescription, met with a confirmation of the patient in line 06. Secondly, the GP announces he has prescribed the patient another inhaler, met with a token of appreciation of the patient in line 09. Similarly to Extracts 1 and 2, it is the patient who initiates a pre-closing 'thank you'-sequence, implying that for the patient no further topics are relevant (Sikveland & Stokoe, 2017). However, consequently, the GP does not respond to and/or return the patient's 'thank you'.

Thirdly, the GP indicates that he will sort out a referral for the patient, presumably after the consultation has ended, followed by a confirmation-seeking tag "↑all right?" in line 11. This is a key action here. Although it appears (syntactically) to confirm just the referral, its prosodic design (the sharp rise in pitch and sharp rising intonation) and placement (at the end of listing the general outcomes of the consultation) also potentially functions more generally to seek confirmation/approval to close the consultation. Like the turn-final "↑okay?" in Extract 3, it provides the patient with a space to raise any additional, remaining issues or questions. The patient, however, does not take up this space by providing new or remaining concerns, but responds with a non-conforming (Raymond, 2003), appreciative and closing-implicative "Thank you very much indee:d,". Following the patient's strong display of appreciation of line 13, the GP produces an evaluative "Grea'" and further advances the closing trajectory by saying "nice to speak to you,". This is reciprocated by the patient in line 16 following a first farewell "take care." Lines 18 and 20 eventually include the terminal exchange sequence before the call is ended.

Taken together, these two cases illustrate how GPs can deploy turn-final confirmation-seeking tags ("↑okay?" in Extract 3 and "↑all right?" in Extract 4) to

not only invite patients to confirm just-prior specific actions (e.g. arranging a referral) but also, implicitly, a 'readiness' to move towards closing the consultation. Their placement, design, and prosodic shape offer patients a final opportunity to speak, while also projecting the imminent end of the consultation. However, requests for confirmation prefer a confirmation as their response (Schegloff, 2007), and when such confirmation is delivered – either through an agreement token or appreciation – it further moves the conversation towards its end. In other words, it implies closing (or at least a move towards it) as the most appropriate next step of the consultation. As such, "↑okay?" and "↑all <u>right</u>?" function not only as vehicles for seeking confirmation but also as subtle yet powerful resources for steering the consultation towards a recognisably collaborative and orderly endpoint.

6.5 'Anything else'-questions to initiate consultation closure

This section examines five cases of GPs asking patients if there is 'anything else' they want to bring up during the closing phase of the consultation. This way of eliciting additional concerns is the most common way in my dataset (14 out of 26 closings) of initiating and projecting consultation closure. It is also the only observed way in which GPs ask patients about additional concerns or questions. The section is further divided into two parts. Section 6.5.1 includes patients providing a 'no'-response, resulting in no further formulated additional concerns or questions. As Robinson and Heritage (2015) describe, patients' answers to 'anything else'-questions can be self-contradictory. Also in my dataset there are instances of patients providing a 'no'-type answer – which seem to convey "I do not have additional concerns" – but then nevertheless proceeding to raise additional concerns. These instances are discussed in section 6.5.2. There is only one example of a 'yes'-type answer in my dataset, which included an unrealistic request for the GP (finding the patient an NHS dentist), involved reciprocated laughter and consequently was not treated as a 'serious' additional concern.

6.5.1 'No-response' and no additional questions or comments

This section examines one instance of how a closing is managed in a telephone consultation following a GP's use of a Topic Initial Elicitor (Button, 1987), specifically a question designed to elicit any remain concerns (an 'is there anything else'-question). The extract here illustrates how a patient responds negatively to such a question but continues with expanding on this response, providing an account and expressing a high degree of satisfaction. The analysis shows that this follow-up talk does not severely disrupt the progressivity of the closing phase, rather it emphasises the relevancy of imminently closing the consultation.

Extract 5 comes from the end of 15.5-minute long telephone consultation. In this consultation, besides performing a medication review, the GP has also been required to complete a form for assessing the patient's fitness to drive; he has told the patient that he will assess this positively. Prior to this extract the GP and the patient have agreed that the patient should wait to hear back from the DVLA (Driver and Vehicle Licensing Agency) before he starts to drive again.

Extract 5. P01GP01: 14.56-15.20

```
01    GP:   Uh::m:
02               (0.7)
03    GP:   ↑Okay >are there any other things that you'd like ↓to-<
04          (.) bring up t'da:y?
05               (0.6)
06    P:    I don't think so: ↑no: you've- (0.2) cov'rd what I)
07          was:: (0.5 I w's wantin' or::.
08               (0.7)
09    GP:   Great.=
10    P:    =( ) (0.2) °O-° (.) y'know what I asked for yes yeah
11          yeah (so) I'm quite fine wi'that:.
12               (0.8)
13    GP:   ↓Grea'.
14               (.)
15    GP:   Okay well thanks very much: and [uh:  ]
16    P:                                  [Okay.]
17               (0.2)
18    GP:   All righ' (0.2) all the ↓best.
19               (0.3)
20    P:    Okay=>thank you very much sir< ↑thank you:=
21    GP:   =B- (.) >b'bye.<
22               (0.3)
23    P:    Bye:.
```

After a hesitation and a 0.7 seconds gap, the turn-initial "↑Okay" of the GP in line 03 indicates a willingness or readiness to move into the closing phase of the

conversation (Button, 1990; Schegloff & Sacks, 1973). The GP continues with a Topic Initial Elicitor (Button, 1987): "are there any other things that you'd like ↓to-< (.) bring up t'da:y?". This yes/no-interrogative of lines 03-04 is negatively polarized, projecting a preferred 'no'-response (Heritage *et al.*, 2007), which the patient duly offers in line 06: "I don't think so: ↑no:". However, more specifically, a yes/no-interrogative prefers a yes or a no as the *first* component of a response (Raymond, 2003). Whilst that is not produced here, the initial hedge "I don't think so:" softens the forthcoming knowledge claim ("↑no:") by adding some level of uncertainty (Heritage, 2013). This might also orient to an expectation that, whilst the GP's question design prefers a negative response, the patient should have at least something extra to bring up. And, indeed, in cases of Topic Initial Elicitors, there is also a preference of a topic initial utterance over a decline (Button & Casey, 1984). Importantly, the patient expands with an account for why there is nothing further to bring up: "you've- (0.2) cov'rd what I was:: (0.5) I w's wantin'". This account furthermore orients to the potential face implications (Goffman, 1955) that being unable to bring up anything else may have.

The GP's "Great." in line 09 positively evaluates the patient's previous talk. This is followed by the patient expanding on his prior assessment, continuing to display his satisfaction by essentially rewording his prior talk of lines 06-07 and ending with an explicit assessment: "I'm quite fine wi'that:". In line 13 the GP, again, acknowledges the patient's expansion with a "↓Grea'.". In case of a decline following a Topic Initial Elicitor, as here, closing remains relevant (Button, 1987) and, indeed, the GP subsequently initiates a possible pre-closing in line 15: "Okay well thanks very much:". The turn-initial "Okay", again, indicates a readiness to further move into the closing sequence(s) of the consultation (Button, 1990; Schegloff & Sacks, 1973). Furthermore, "well" shifts the topic/project away to the current speaker's own topical preference, rather than expanding on the topic of the prior sequence (Heritage, 2015). This pre-closing is followed by an overlapping acknowledgement token ("Okay.") by the patient in line 16, projecting alignment regarding moving towards closing the consultation. In line 18 the GP indeed initiates the closing of the consultation with a first farewell greeting "all the ↓best.", to which the patient responds with a strongly

appreciative ">thank you very much sir< ↑thank you:". The consultation ends with a terminal exchange in lines 21-23 before the call is ended.

In short, this extract illustrates how, even when the GP's 'is there anything else'-question is followed by a negative 'no'-response, the interaction may still include some brief follow-up talk. Here, the patient expands on his 'no' by offering an account as some form of facework (Goffman, 1955). Despite the patient's expansion on his 'no'-response, the GP continues treating closing the consultation as the next relevant step, swiftly initiating another pre-closing and collaboratively bringing the consultation to its end.

6.5.2 'No-response' but following additional questions and comments

This section examines four other instances of GP asking patients if there is 'anything else' they want to bring up during the closing phase of the consultation. This section particularly focuses on instances in which the patient provides a 'no'-type answer to the GPs question but then nevertheless, eventually, does present (an) additional concern(s). More specifically, there are two different types of talk emerging after the 'no'-type response (i.e., there are two types of concerns) that will be discussed separately. First, two instances including questions and concerns regarding previously discussed business are examined in section 6.5.2.1. Then, section 6.5.2.2 examines two other instances including questions and concerns regarding additional concerns not previously discussed (i.e. relatively 'new' concerns).

6.5.2.1 Questions and comments related to main business of call

This section includes two instances where a 'no'-type response is followed by subsequent questions and comments related to the main business of the call. In Extract 6 this entails the patient checking his understanding of what the GP has previously instructed him to do after the consultation. Extract 7 shows an example of a patient subsequently underscoring the doctorability of her concern (Heritage & Robinson, 2006), implying that the main business of the consultation has not yet been satisfactorily dealt with.

Extract 6 comes from the end of 6.5-minute telephone consultation. The consultation is about discussing an adverse blood pressure reading result and during the consultation the GP and patient agree on starting a new blood pressure medication (amlodipine). Therefore, the GP instructs the patient that three weeks after the consultation, he should take more blood pressure readings at home and send the results to the practice. He then needs to contact the practice to check that it is okay to keep using the new medication. Just prior to the extract, the GP has concluded that if the blood pressure readings are fine the patient should be able to continue on the amlodipine long term and if not, he should speak to a clinician again.

Extract 6. P16GP03: 4.57-6.25

```
GP:   ↓Yeah that's ev'rything, (.) uh:m (.) the ↑amlodipine
      we shouldn't need t'check your- (.) y- (0.2) kidney
      blood test: (.) in a wee- (.) in a month: (0.4) uh:: i-
      (.) i' shouldn't affect your kidneys so it should be
      okay::,
            (0.9)
P:    Yeah,
            (0.2)
GP:   .pt (0.2) uh::m (.) and ↓so: (.) uh- if you have any
      side effects or problems obvi'sly then book an
      appointment t'talk to us about it.
            (0.8)
P:    Righ': (.) ↓yeah (.) no problem.
            (0.6)
GP:   All: righ' then, (0.2) have you go' any [questions?]
P:                                           [Okay then?]
            (1.8)
P:    Uh:: (.) n- hhh. (.) no I don't think so, (.) [uh:]
GP:                                                 [All]
      righ' then.
            (.)
P:    >So'f I'm gettin' this righ' then:,< (0.5) I c'n (0.2)
      pick the:se up (0.2) later on tonigh', (0.4) this
      afternoo:n,
            (.)
GP:   Yes:_
            (1.4)
P:    A:nd three weeks ti:me, (1.3) I:: do a- (.) a wee:kly
      (.) av'rage (0.6) uh:: (0.3) pre- (0.2) blood pressure
      test yeah,
            (.)
GP:   Yeah.
            (1.8)
P:    An'then I bring it into the:: doctor's surgery.
            (.)
GP:   Yeah that's correct. (.) an' don't stop [taking  ]=
P:                                           [(Yeah)  ]
GP:   =these tablets until you've spoken to us (.) unless
      there's a problem.
            (1.6)
```

```
41    P:    (   ) will you ring me up?
42               (0.6)
43    GP:   If it's no:r[mal you might] not be contacted,
44    P:                  [(Should I be)]
45               (0.2)
46    GP:   And so that's why: (.) give us a couple of wee:ks (.)
47          an'then: (.) ring [up   ] and check (.) if it's normal=
48    P:                      [Yeah,]
49    GP:   =or no'. (0.2) ↑if it's normal [then you need] to ask=
50    P:                                   [All/Oh righ'.]
51    GP:   =them to renew the prescription: (0.5) so you c'n carry
52          i' on long term:.
53               (0.9)
54    P:    Righ'. (0.3) right, (.) okay: then?
55               (0.6)
56    GP:   All right then [thank you very much then,]
57    P:                 [I'll try an' remember    ] all tha'
58               (.)
59    GP:   [Huhuh (0.3) if you forge' you c'n just] ring reception=
60    P:    [((laughter))                          ]
61    GP:   =they'll be able to ask us if they need ↓to.
62               (0.9)
63    P:    Righ::'. (0.2) o- okay,
64               (0.5)
65    GP:   All right then >thank you very much then:.<
66               (.)
67    P:    (   )
68               (0.4)
69    GP:   [Okay.]
70    P:    [Right] thank you very much too yeh:.
71               (.)
72    GP:   Byebye::.
73               (0.5)
74    P:    Byebye:.
```

In lines 01, the GP produces a conclusive "that's ev'rything," and therewith initiates a possible topic closure. However, the notably rising intonation might nevertheless display an orientation to some further elaboration. The GP continues with commenting on the lack of need of performing a kidney test as the new medication should not cause any adverse kidney effects, concluding his turn with a reassuring evaluative ("it should be okay::,"), further orienting towards topic closure. The patient aligns with this in line 07 through a minimal response token ("Yeah,"), thereby contributing and moving forward the closing phase of the consultation. The GP continues with initiating a safety-netting sequence in lines 09-11. His turn is formulated in the conditional tense ("if you have any…"), includes an imperative ("then book…") and presents this safety-netting advice/imperative as something straightforward and well-known ("obvi'sly").

The patient acknowledges this advice in line 13 by both indicating an understanding and acceptance of the advice.

Following a 0.6 seconds gap, in line 15 the GP produces an "All righ' then," which could function as a closure-implicative device (Button, 1987). However, after a brief (0.2) seconds pause, the GP opens up the closing by producing a Topic Initial Elicitor (Button, 1987): "have you go' any questions?". In overlap, the patient nevertheless continues with orienting to closing with "Okay then?" (similar to what the patient in Extract 3 does). This is not taken up by the GP and after a relatively long 1.8 seconds gap, it is the patient who takes the floor again. Despite the fact his turn includes multiple features of a dispreferred turn (Mazeland, 2003): delay, hesitation ("Uh::"), cut-off speech ("n-"), a sigh ("hhh.") and hedging ("I don't think so,"), it does include a preferred type-conforming negative 'no'-response (Heritage *et al.*, 2007).

Following the patient's response, the GP continues with formulating a possible preclosing: "All righ' then.", opening up the closing phase of the consultation again. This is not taken up by the patient who, instead of further orienting to closure, starts by producing a series of requests for confirmation in order to check his understanding of what is expected from him. These are related to when to pick up the newly prescribed medication (lines 22-24), when to do new blood pressure readings (lines 28-30) and consequently what to do with those readings (line 34). All these turns are followed by a confirmation from the GP (lines 26, 32 and 36) and eventually an elaboration of the GP in lines 36-39. All of these entail upshot formulations of what has been previously discussed and decided in the consultation, implicitly summarising the main business of the call. Because of some unclear talk in line 41 it is unclear if the patient displays an understanding of the GP's elaboration of lines 36-39. He continues his turn by formulating another follow-up question regarding if he will be contacted or if the patient himself should ring the surgery to ask for the result. In lines 43-52 the GP explains the patient should do this himself and what do to in case of a normal result.

In line 54, the patient acknowledges the GP's prior instructions ("Righ'.") and subsequently opens up the closing again ("Okay: then?") in a similar way to his previous turn in line 16. In line 56, the GP closes this preclosing sequence ("All

right then") followed by a display of appreciation ("thank you very much then"), typically found in closing phases (Antaki, 2002; Button, 1987). Instead of progressing towards the terminal exchange, the patient (in overlap) implicitly references the amount of the prior instructions. The GP responds with a chuckle and a follow-up instruction, thereby acknowledging the complexity and quantity of the previous instructions.

In line 63, the patient acknowledges the GP's prior follow-up instruction ("Righ'.") and opens up the closing again ("o- okay,") in a similar format as line 16 and 54. The GP responds in an identical manner as line 56 and thereby again closes the preclosing sequence. In line 64 the GP initiates the final preclosing sequence ("Okay."), followed by an acknowledgement token ("Right") and a reciprocated thanking ("thank you very much too yeh.") from the patient. The GP issues a terminal "Byebye::.", reciprocated by the patient before the call is terminated.

Extract 7 includes the closing of another telephone consultation with a different patient. It is a patient-initiated call in which she has expressed her concern over recurring skin infections due to insect bites and her worry of taking too many courses of antibiotics. Earlier on in the consultation, the GP has proposed a follow-up plan - he will write to a secondary care specialist (an immunologist) to ask for advice - and the patient has agreed with this. Just prior to the extract below, the GP says that a cause of frequent skin infections cannot always be identified. The extract starts with the GP continuing on this turn by saying that he will write to the specialist anyway:

Extract 7. P07GP03: 6.35-7.30

```
01    GP:   But I will write a letter to the: immunology specialist to see
02          if they've got anything else to suggest.
03                (1.2)
04    P:    All right then no ↓worries.
05                (0.3)
06    GP:   Is there anything else you'd like to discuss toda::y?
07                (1.3)
08    P:    No I just don't want these insect bites cause it's
09          gonna- (0.3) it's gonna be one insect bite >it's gonna
10          get< that ba:d (0.6) I: don't want t'go into anaphylaric
11          shock↓.
12                (0.4)
13    GP:   Su:[re so- ]
14    P:       [because] (anaphylaxis)
15                (0.2)
16    GP:   [Yes:]
17    P:    [It  ] was so: so: bad.
18                (0.4)
19    GP:   So if: any:- (0.2) skin becomes <red hot swollen or
20          tender> especially if it's spreading (.) you do need a
21          same day review:, and if we can't fit you in [you need]=
22    P:                                                 [Yeah.   ]
23    GP:   =t'call >one one one,<
24                (0.6)
25    GP:   Anaphylactic shock is a different problem and tha'
26          is due to an a:llergy (0.5) wha' you're describing
27          doesn't sound like an a:llergy it sounds like infection
28          of the bites: (0.5) uh:m but the [>im'nologist<]=
29    P:                                     [Okay         ]
30    GP:   =obvi'sly I'm gonna write to them anyway↓ (0.6) .hh.pt
31          uhm but I can't [see] anything treatable that we can=
32    P:                    [Yeh]
33    GP:   =change at the momen' compared to what we've talked
34          abou:t↓ (0.8) .hh uh bu' [of course that's why I'm ] writing=
35    P:                             [all right then no worries]
36    GP:   =for advice:.
37                (1.3)
38    P:    All right then no w'rries.=thank ↑you.=
39    GP:   =Awright thank you bye ↑Sarah.
40                (0.5)
41    P:    Thanks byebye.
```

In lines 01-02 the GP repeats what he will do after the consultation regarding the patient's concern. This is an upshot (re)formulation of what has been discussed already and, together with the downward intonation, has been identified as a technique to shut down conversational topics (Button, 1987). By affirming and accepting this upshot in line 04, the patient thereby displays their orientation to the topic as possibly closed (Button, 1991). Subsequently, in line 06, the GP moves out of the closing phase of the consultation with a Topic-Initiating Elicitor

(Button, 1987): "Is there anything else you'd like to discuss toda::y?". The patient subsequently offers a negative, preferred, 'no'-response in line 08.

Directly after providing the 'no'-response, the patient continues with explicating (and restating) the reason for the consultation. Using such an 'I just'-construction is a way of downgrading what has been said before or what will follow (Pomerantz, 1984), in this instance emphasising that what is about to follow is all she wanted to talk about during the consultation today. The patient expands on this by providing an account justifying her worry over the insect bites: "I don't want t'go into anaphylactic shock" (lines 10-11). Essentially, the patient here raises the stakes of her problem as potentially leading to a medical emergency, and justifies her ongoing concern as a doctorable problem. A doctorable problem is one deemed appropriate for medical attention and worthy of consideration as a possibly significant medical condition (Heritage & Robinson, 2006). However, in the consultation prior to this, the doctor has strongly implied that there is not much to be done; the proposal to contact the immunologist has not been framed as likely to be productive (note the negatively polarised "anything else" in line 02). What follows here seems to be an attempt from the patient to make her problem more doctorable than the GP has originally treated it as.

So, what follows after the patient's initial 'no'-response here is not necessarily 'anything else' – it is the same problem and tied to the main business of the consultation. However, there still seems to be an orientation to the fact that producing a relatively straightforward 'no'-response here (as in Extract 5) effectively means the consultation will be over. The patient's upgraded account for the reason for the call is met by the GP with two acknowledgement tokens ("Su:re" in line 13, and "Yes:" in line 16) and in lines 19-23 the GP initiates a safety-netting sequence (similar to the one in Extracts 1 and 6). Again, this turn is formulated in the conditional tense ("if: any:- (0.2) skin becomes…", "if it's spreading" and "if we can't fit you in") and conveys necessity to potentially carry out a particular action ("you need t'call"). The patient responds with an overlapping "Yeah." in line 22, displaying understanding and acceptance of the safety-netting advice.

In lines 25-28 the GP explains what anaphylactic shock is and states that this is not in line with the symptoms the patient has described previously. In his description, he makes a clear distinction between "an a:llergy" and an "infection". The patient responds with an overlapping acknowledgement token ("Okay") in line 29. The GP continues with restating he will write to a secondary care specialist ("the >im'nologist<") twice (line 30 and lines 34-36). By repeating the upshot formulation of lines 01-02, the GP re-initiates topic (and therewith consultation) closure.

After a 1.3 seconds gap, in line 38 the patient repeats her prior turn of line 35 and latches a "thank you" to the repetition. Such displays of appreciation are indeed routinely observed in the context of closings (Antaki, 2002; Button, 1987). However, the tone and abruptness of the patient's talk displays that she is not necessarily treating the problem as satisfactorily resolved. Nevertheless, by not taking up the previous 1.3 seconds gap as a space to elaborate on anything any further and by repetitively projecting topic-closure, she chooses not to persist, presumably because this persistence (and also the fact that this is not the first consultation about this issue) has not apparently got her anywhere further in resolving her problem at this point. Therewith, the patient displays an orientation towards closing the consultation. The GP aligns with this, reciprocates the 'thank you' in line 39 and initiates the final exchange of lines 39-41, before terminating the call.

Taken together, both cases illustrate how patients nevertheless proceed to ask additional questions or provide additional comments following a 'no'-type response to the GP's 'anything else'-question. Both extracts demonstrate an orientation by the patient that the 'anything else'-question initiates the closing phase of the consultation (West, 2006), thereby recognising that moment as the final opportunity to initiate other actions such as checking their understanding (Extract 6) or emphasising unresolved concerns (Extract 7). Nevertheless, the patients refrain from formulating a straightforward 'yes'-type response to the GP's initial question.

6.5.2.2 'New' questions and comments

This section includes two instances where a 'no'-type response is followed by subsequent questions and comments which are less explicitly related to the main reason for the call. In Extract 8 this involves asking something about the consequentiality of non-adherence to a previously recommended over-the-counter medication. Extract 9 includes an instance in which the patient makes an additional suggestion as to what could be the cause of her presented problem. Both examples illustrate the accountable nature of raising additional issues at this point in the consultations, despite the fact those additional issues are formally elicited by the GP. They also underscore the importance of the sequential placement of the 'anything else'-question, which is consequential for the patient's subsequent interpretation.

Extract 8 comes from the end of a 4.5-minute-long GP-initiated call. The main reason for the consultation is discussing a blood test result. The consultation starts with the GP informing the patient her iron level is low and that he will write to a secondary care specialist to decide whether the patient requires any follow-up care. Just prior to this extract the GP has informed the patient their immunoglobulin A and M levels are also bit low but that this is not something to be severely worried about. The extract starts with an upshot formulation of what has been decided previously in the consultation, namely that the GP will inform a secondary care specialist who has been treating the patient of the result and ask them for advice. After a safety-netting sequence, the GP asks the patient the 'anything else'-question.

Extract 8. P03GP03: 4.01-4.34

```
01    GP:   So I'think the ↑best thing is if I send it a:ll through
02          to mis- doctor Fletcher.
03                (0.6)
04    GP:   But [if     you:- ]
05    P:        [That's it    ] yeh.=
06    GP:   =If you a:re unwell you must let u:s (.) o::r their::
07          (.) nurse (.) prac[titioner ↓know.]
08    P:                      [Yeah:    I-    ] I know: what ↓t'do:
09          (.) yeah hh. huh
10                (0.2)
11    GP:   Is there [anything] el- (.) else=
12    P:             [Yeah.   ]
13    P:    =Yes:?=
14    GP:   =That you >wanted't'discuss< toda::y?
15                (0.7)
16    P:    No no that's fi-=>I mean e-< (.) ev'rything: to do:
```

```
17          I- I'm ta:king a- (0.6) well I'm supposed to take two
18          Adcals=↓but (.) quite honestly they're horrible=so I
19          jus' [take one]=but (0.5) I'm ↑trying to have plenty of=
20    GP:         [I ↓see:.]
21    P:    =calcium [fo'the] rest of my diet=↓yeh.
22    GP:            [Goo:d.]
23                 (0.2)
24    GP:   I often think with [things] like tha' is you- you try=
25    P:                     [okay  ]
26    GP:   ='nd do what you ca:n:, (.) and if you can't [take] the=
27    P:                                               [Yeh.]
28    GP:   =full dose: (.) at least you're getting some ↓benefi'.
29                 (0.9)
30    P:    Yeah absolutely: (.) yeah (.) that's fine.
31                 (0.2)
32    GP:   All right then=>thank you very much then Claire<=
33    P:    =A:ll right [thanks] very mu:ch=
34    GP:               [Okay  ]
35    GP:   =Byebye=
36    P:    =Okay: (.) byebye (.) bye.
```

In lines 01-02 the GP reformulates what he will do regarding the patient's blood test result and thereby initiates closing the topic. The patient in line 05 provides an aligning "That's it yeh.". Before the patient has completed the topic closing sequence, the GP initiates an overlapping safety netting sequence. This turn is formulated in the conditional tense ("If you a:re unwell") and uses a modal imperative ("you must let u:s … ↓know."). The patient responds with an overlapping acknowledgment token ("Yeah:") and displays and explicit understanding of the safety-netting advice: "I know: what ↓t'do:".

In line 11-14, the GP moves out of the closing phase of the consultation with a Topic-Initiating Elicitor (Button, 1987): "Is there anything el- (.) else … that you >wanted't'discuss< toda::y?". The patient duly produces the preferred 'no'-response (twice) in line 16 before nevertheless introducing a new concern. The hedging and delay here are typical features of a dispreferred turn (Schegloff *et al.*, 1977). The issue raised is about non-adherence to 'sufficiently' taking an over-the-counter calcium supplement (Adcal). Instead of raising the issue as an interrogative (e.g., 'is it okay if I only take one?'), it is introduced as a declarative ("I jus' take one") preceded by an account ("they're horrible") and followed by a mitigation of having plenty of calcium for the rest of her diet, compensating for the lower dose of calcium gained by the supplement. The GP provides two minimal acknowledging responses ("I see:." and "Goo:d.") and offers a

'generalising' formulation in lines 24-28, implying that partial adherence to taking things like calcium supplements is nevertheless beneficial.

Consequently, the patient acknowledges the GP's stance on 'try and do what you can' and agrees with the GP that partial adherence is anyway still beneficial: "Yeah absolutely:". The patient ends her turn in line 30 with an evaluation ("that's fine."), in which the falling intonation seems to align with the projected closing of the consultation. After that the consultation smoothly and unambiguously moves into closing. There is a reciprocated "all right" and a reciprocated 'thanking' in lines 32 and 33, a reciprocated "Okay" in lines 34 and 36 indicating a mutual readiness to further move into the closing phase of the consultation (Button, 1990; Schegloff & Sacks, 1973) and the consultation ends with a terminal exchange in lines 35-36.

Extract 9 comes from the end of a telephone consultation that lasted nine minutes and 19 seconds. It is a patient-initiated call in which she presents her symptoms of what she proposes may be a sinus infection. Instead of prescribing a course of antibiotics, the GP has proposed to bring the patient in for an in-person appointment in a few day's time. Just before the extract begins, the GP has confirmed the day of that appointment and mentioned that if the patient's symptoms have not improved by that time, then they can start thinking about prescribing antibiotics.

Extract 9. P26GP06: 7.52-9.19

```
01    GP:   Uh:m I'll book you in fo:r eleven thirty jus'to: (0.2)
02          >have a look in/and-<
03                (0.2)
04    P:    O:kay,
05                (0.4)
06    GP:   An' o'vi'sly (.) between now and then if you cough up
07          <any more bloo:d,> (0.6) uh::m (0.2) that w'd be a
08          >little bit< worrying so I w'd (0.3) jus' get straigh'
09          back in touch an' (.) we may need to o'vi'sly review
10          things a bit soo:ner,
11                (0.8)
12    P:    Okay.
13                (0.9)
14    GP:   Was: there: (0.2) any:- (.) are you- (.) allergic to
15          any antibiotics at'all?
16                (0.5)
17    P:    ↓N:o:: (.) nothing.
18                (0.8)
19    GP:   °Mkay° (.) and was there anything else tha' you:- (0.7)
20          needed t'let me kno:w?
21                (0.6)
```

```
22    P:    Uh:- ↓no: that's it ↑thank you:.
23                (0.4)
24    GP:   N'you- (.) so you're not allergic t'↓penicillin,
25                (0.6)
26    P:    No:.
27                (1.2)
28    GP:   Brilliant.
29                (0.3)
30    GP:   Uh:m (.) yeah. (0.9) let's just observe >for the next<
31          few days: (.) uh::m (0.3) I'll see you on the twen'y
32          forth:: (.) we'll have a look at back of the
33          throa' (.) ears (0.5) an::d'[uhm]
34    P:                                [Uhm] I ↑do have a really
35          quick question:, (.) uhm: (0.4) I use a cee pap machine:
36          (0.2) uhm: (.) for sleep apnoea.
37                (0.4)
38    GP:   M[yeah]
39    P:     [Uh:m] and- (0.4) it's >giving me like< blisters on my
40          nose: (.) would tha' be causing me like any other kind
41          of:- (0.4) problems (.) like is the mask- (.) is- is
42          too tigh' or it's not fi'ing around my nose would that
43          be causing me: (0.3) do you think like any of these
44          ↓symptoms as well or like-

      ((30 lines omitted in which GP explains this shouldn't cause
      sinusitis and GP proposes to put some padding on the mask. GP
      also proposes that the patient gets some nasal spray to reduce
      her nasal inflammation))

74    GP:   Yeah (.) are you getting lots o' nasal ↑congestion as
75          well?
76                (0.9)
77    P:    I' just feels very blocked.
78                (.)
79    GP:   Jus' feels block- yeah, (0.3) I would try the: (.) the
80          nasal ↓spray: (0.2) do that as a- (.) bit of symptom
81          relieve and I'll see you on the Monday.
82                (0.7)
83    P:    Okay. (.) thank you.
84                (.)
85    GP:   Take care: (.) bye.
86                (0.3)
87    P:    Thanks (.) bye:.
```

In line 01-02 the GP refers to a future appointment in which the patient will come to the practice for a physical examination. By referring to a future meeting, the GP implies that the current conversation is reaching an appropriate endpoint, and that any additional matters can either be 'reserved' until that future encounter or are no longer necessary to be addressed at that point (Button, 1987). After the patient produces an agreement token in line 04 ("O:kay,"), the GP initiates a safety-netting sequence. In line 12 the patient acknowledges and accepts the safety-netting advice/imperative and therewith closes this preclosing sequence.

In line 14 the GP opens up the closing by a yes/no-interrogative, seemingly functioning as a last-minute check question. It seems likely that the cut off talk ("Was: there: (0.2) any:-") was an attempt to produce the 'is there anything else'-question (which consequently is offered in line 19). Instead, the GP asks the patient if she is allergic to antibiotics, touching on the fact that they may still consider starting on a course of antibiotics following the follow-up appointment. After the patient provides a type-conforming 'no'-response in line 17, the GP continues by offering the 'is there anything else'-question ("was there anything else tha' you:- (0.7) needed t'let me kno:w?"), inviting the patient to bring up any final topics. This question design prefers a negative 'no'-response (Heritage *et al.*, 2007), which the patient duly offers in line 22. The patient continues with announcing "that's it", explicating there is nothing left on the patient's agenda and displays appreciation ("↑thank you:."), further shutting down the topic and moving towards closing the consultation (Button, 1987). However, instead of initiating another possible preclosing sequence, the GP initiates another question-answer sequence, asking specifically about being allergic to a particular kind of antibiotic (line 24). This is followed by another type-conforming 'no'-response by the patient (line 26) and a third position evaluative by the GP in line 28.

Subsequently the GP offers an upshot formulation of what has been previously discussed and decided in the consultation ("let's just observe") and reintroduces the arrangement made earlier in the extract. Before the GP is able to complete his turn, the patient interrupts by announcing she does have "a really quick question:,". The patient's question entails a suggestion that an issue with her sleep mask may be the cause of her symptoms. Most interestingly, this question is placed after the GP initiated topic/consultation closure and it seems to be the case that the patient recognises the end of the consultation is near. However, instead of formulating this question after the GP's 'is there anything else'-question of lines 19-20, the patient does it here. It might be that there is an orientation towards line 19-20 not necessarily opening the consultation's closing (which is the case in Extract 5-8) but as tied to the preceding question. In that case, the 'is there anything else'-question is not treated as asking about other concerns, but more about related concerns such as other factors that could

influence the patient taking a course of antibiotics. This might be the reason why the patient does not ask her question about her sleep mask here. And indeed, West (2006) shows, the sequential placement of the 'anything else?' question is vitally important. Namely, after the (re-)formulation of treatment plans and other arrangements have been proposed and agreed upon (as is the case in Extracts 5-8), only then 'anything else?' works to elicit a warrant for treating the consultation as possibly closed.

The phrasing "really quick question:" (as opposed to simply 'a question') is also meaningful here. The question is presented as a minimal time imposition (as "really quick"), implying the delicate nature of reopening the conversation at a dispreferred moment, (i.e., after the GP has already initiated closing the encounter). It suggests an orientation to the closing as already underway, and simultaneously works to justify the insertion by categorising the question as brief and non-disruptive.

In line 74, the GP initiates a further follow-up question after already having proposed that the patient should get an over-the-counter nasal spray which may ease symptoms. The patient responds with a non-type conforming response, implicitly confirming the GP's previous yes/no-interrogative. The GP continues with reformulation his advice ("try the: (.) the nasal ↓spray:") and, again, reintroduces arrangements made earlier in this extract, thereby bringing the current topic to a close (Button, 1991). The patient aligns in line 83 with a minimal response and appreciation token ("Okay. (.) thank you."). The GP then initiates the terminal exchange in line 85, followed by a display of appreciation and a reciprocal "bye:." from the patient.

Taken together, both cases illustrate how patients nevertheless proceed to ask additional questions following an initial 'no'-type response to the GP's 'anything else'-question. Again, similarly to the previous subsection (6.5.2.1) both extracts demonstrate an orientation of the patient that the 'anything else'-question initiates the closing phase of the consultation (West, 2006) but additionally also indicate the importance of the sequential placement of the 'anything else'-question within the closing phase, as well as how it is actually formulated. Both examples also show an orientation to the accountable nature of bringing up additional concerns, despite them being explicitly elicited by the GP.

6.6 Discussion

In this chapter, I have examined how closings unfold in real-time telephone consultations in primary care. The analysis focuses on how these closings are interactionally (locally) organised by the participants, and on the contingencies that emerge as GPs and patients collaboratively bring about these closings over the telephone.

The analysis of patients implicitly indicating no further concerns to raise (section 6.3) reveals how expressions of gratitude and high-grade assessments are used by patients as interactional resources to initiate closing sequences. These findings demonstrate that such turns are not merely displays of appreciation from the patient but also suggest their concerns have been sufficiently addressed such that no further issues remain. This aligns with previous work on the interactional structure of closing sequences in conversation (Antaki, 2002; Button, 1987). While previous research has found that doctors typically initiate closings (West, 2006), these findings offer a more nuanced view. However, although patients may take the first interactional steps toward closing, GPs retain an element of control over the trajectory of the consultation by inserting clinically relevant sequences (such as safety-netting or arrangement-setting) before aligning with patient-initiated closings.

The use of turn-final confirmation-seeking tags (Section 6.4) demonstrates how these tags (e.g., 'okay?' and 'all right?') serve a dual purpose in the closing phase of the consultation. Not only do they invite patients to confirm agreement with or acceptance of just mentioned specific actions (e.g. arranging a referral) but also, implicitly, a 'readiness' to move towards closing the consultation. This finding aligns with and extends prior work on closing-initiating actions (Button, 1987; Schegloff & Sacks, 1973) by showing how these tags function as vehicles for seeking confirmation but as well as devices to move the consultations towards a recognisable and orderly close. However, requests for confirmation prefer a confirmation as their response (Schegloff, 2007), meaning that closing (or at least a move towards it) is the most appropriate next step of the consultation. Whereas, at first glance, these confirmation-seeking tags may seem to be offering patients the final opportunity to raise additional concerns, in practice these tags subtly encourage both acceptance of what has just been

mentioned (e.g., a treatment plan) and an acceptance of the consultation reaching an appropriate endpoint.

Section 6.5 focuses on 'anything else'-questions as a means to initiate consultation closure. Consistent with prior research on the closing phase in medical consultations (West, 2006), this question emerges as the most frequently employed device by GPs to elicit any remaining questions or concerns before closing the consultation. This section highlights the preference organisation (Schegloff, 2007) of the 'anything else'-question, structurally eliciting a negative 'no'-type response (Heritage *et al.*, 2007). In short, this question design not only invites patients to confirm they have no additional questions or concerns to raise but also invites patients to confirm a 'readiness' to close the consultation. Even in seeming straightforward 'no'-responses (as in section 6.5.1), patients still perform additional interactional work (e.g., offering an account as some form of facework (Goffman, 1955)), further emphasising their 'readiness' to move into the closing phase. Namely, despite the 'anything else'-question preferring a 'no'-type response, the question could also imply that the patients should have something else to bring up and if that does not happen then the patient should offer a reason (an account) for this lack of uptake.

Moreover, the analysis shows that 'no'-responses are frequently followed by further talk that can relate either to the main business of the call or to additional, relatively 'new' questions or concerns. This finding supports what Robinson and Heritage (2015) described as the self-contradicting practice of appearing to claim not having additional concerns but subsequently proceeding with presenting additional concerns. One possible reason for this could be that patients treat 'anything else' as referring to something that has not been discussed in the consultation *at all*.

Supporting Button's (1987) claim that Topic Initial Elicitors are sensitive in the context of closings, the analysis presented in this chapter confirms that the 'anything else'-question (a Topic Initial Elicitor) can indicate that an interaction is approaching its end, whilst also having the potential to delay this ending. These findings also reveal an interesting contradiction in the normative nature regarding replying to a Topic Initial Elicitor during the closing phase. Namely, as discussed above, the question design prefers a negative 'no'-response (Heritage

et al., 2007), however, simultaneously, it also prefers a topic initial utterance (i.e., a 'yes'-type response) over a decline (Button & Casey, 1984). This might explain why providing a straightforward 'no' is still treated as an accountable matter (see, for instance, Extract 5), despite a 'no'-response actually being the preferred response. This might also explain why patients often provide self-contradicting responses (Robinson & Heritage, 2015) to the 'is there anything else'-question.

Taken together, the findings of this chapter illustrate the limitations of current UK GP training models, such as the Calgary-Cambridge model (Kurtz *et al.*, 2003) which provide only a broad-brush approach to closing consultations, particularly in their recommendation for "ensuring appropriate point of closure" (p. 806), without specifying exactly *how* this activity might be initiated or sustained. The analysis points to four possible considerations for clinical practice:

1. Recognise that closing-related questions, such as turn-final confirmation tags ('okay?', 'all right?') and 'anything else'-questions, do not solely ask for additional concerns but also convey the consultation is reaching its end.
2. Be mindful of the sensitive question design of closing-related questions. Particularly 'anything else'-questions interactionally prefer a 'no'-response, which may require patients to do additional interactional work if they wish to raise additional concerns or may cause them not disclosing these.
3. Consider the sequential placement of closing-related questions. Related to the first consideration, such questions might encourage patients to accept both what has just been mentioned (e.g., a treatment plan) and that the consultation is reaching an appropriate endpoint.
4. Attend to the possibility for patients to understand 'anything else' in multiple ways. Patients may either see it as something related to the main business of the consultation or as something that has not been discussed in the consultation at all. A possible solution to this is to separate out 'questions about that?' in relation to the matter previously discussed and then ask about other concerns.

Although these considerations are, again, not prescriptive recommendations, they highlight areas where greater sensitivity to various interactional practices may assist practitioners in (collaboratively) bringing telephone consultations to an end. In short, this chapter underscores the critical role of question design and sequential placement for the effective elicitation of additional concerns, especially in remote consultations where nonverbal cues are limited (Rothwell *et al.*, 2012) and where there already is a less favourable spatial environment to raise these concerns (Stivers & Timmermans, 2020).

Chapter 7. "I'll just do a few clicks on my computer": Unpacking silences during GP's background tasks in primary care telephone consultations

7.1 Introduction

This chapter examines how silences in the context of general practitioners' *background work* emerge and are managed in real-time primary care telephone consultations. Unlike face-to-face consultations, where patients are able to see and orient to general practitioners' embodied conduct, the absence of visual cues in telephone consultations requires its participants to produce, orient to and interpret silences differently. Despite their pervasiveness, these silences are an underexplored aspect of primary care telephone interaction.

Previous research (Frers, 2009; Greatbatch, 2006; Nielsen, 2016; Pasquandrea, 2011; Robinson & Stivers, 2001; Stevenson et al., 2019) has shown that, in their face-to-face interactions with patients, doctors accomplish a range of tasks (e.g., speaking, reading, writing prescriptions, recording data on the computer, etc.). They do so through the combined use of diverse multimodal resources, such as speech, gesture, gaze, body posture, the use of objects, etc. Many of these tasks are performed quietly, without speaking, and could even be described as 'favouring silence'. Empirical evidence suggests that, in face-to-face consultations, patients orient to this, for example by suspending the production of spoken talk when they can visibly see the doctor writing a prescription (Greatbatch, 2006). However, the telephone constrains or changes how these embodied modalities may be used as resources for interaction. Yet, the study of multi-activity (Haddington *et al.*, 2014; Mondada *et al.*, 2015) in telephone consultations remains relatively underexplored.

The relative absence of visible bodily conduct compels participants to orient to and interpret silences differently. Within popular psychology, 'silence' is often treated as an idiomatic or affective phenomenon – an "awkward silence"[5],

[5] https://aeon.co/essays/whats-so-awkward-about-an-awkward-silence

as something that makes people uncomfortable[6] or nervous[7]. In the context of health communication guidance, it may be glossed as a clinician 'saying nothing' (Kaye et al., 2023). However, such interpretations risk presenting silence as a static, empty, and often negative state. In addition, within the field of linguistics, silence is generally described as marking the limits of language itself. As Vlăduţescu (2013) explains, Wittgenstein's idea of the *linguistic silence* is rooted in the recognition that while thought may be infinite, language is not. He suggested that silence is not a failure of communication, but a necessary and meaningful boundary, where what cannot be logically expressed through words is instead left unspoken. In this sense, silence is not just a pause within language, but also a way of acknowledging what lies beyond it and 'cannot be described'.

This chapter will show that, using a conversation analytic approach, there is no such thing as silence in a purely physical or inert sense. Accordingly, this chapter approaches silence not as absence but as an inextricable core to interactional organisation; one that is closely tied to the multi-activity nature of primary health care and to the communicative constraints of the telephone medium. By analysing how GPs and patients orient to and manage silences, this chapter seeks to show that silence has to be produced, maintained and, like every other component of interaction, is doing something.

Before turning to the findings, I will offer some background on the general multi-activity organisation in (ordinary) conversation (Section 7.2.1) and how this relates to primary care (telephone consultations (Section 7.2.2). I will then discuss the organisation of silences in (ordinary) conversations (Section 7.2.3) and, again, relate this to the context of primary care (telephone) consultations (Section 7.2.4). I will end this section with some further background on the data used for this chapter (Section 7.2.5).

[6] https://www.psychologytoday.com/gb/blog/mind-matters/202502/why-are-we-so-uncomfortable-with-silence
[7] https://www.bbc.co.uk/worklife/article/20170718-the-subtle-power-of-uncomfortable-silences

7.2 Background

7.2.1 Multi-activity organisation in (ordinary) conversation

Although social actions can be sequentially organised in a relatively linear manner (e.g., Schegloff, 2007), interactants often also coordinate – using both talk and embodied conduct - multiple activities at the same time (Haddington *et al.*, 2014; Mondada *et al.*, 2015). The body of research on 'multi-activity' examines how participants manage the timing and ordering of two or more streams of action (both verbal and embodied/non-verbal), particularly emphasising on how these activities become interwoven and co-relevant in interaction (Haddington *et al.*, 2014; Mondada, 2011, 2014). For instance, Mondada (2011) demonstrated that multiple activities may be coordinated in various ways: (i) they may be ordered in parallel, such that one activity does not disrupt the progress of another; (ii) they may be embedded, such that they are carried out simultaneously but complement each other; and (iii) they may be exclusive, such that one activity is temporarily or permanently stopped.

Interactants are able to manage overlapping courses of action by establishing a hierarchy of relevance between them. This involves momentarily postponing one activity in order to commit more fully on another. Mondada (2012) explained this by using the example of the multi-activity organisation in the car. A car driver could drive and talk to a passenger at the same time but can also prioritise one of these activities over the other. In practice, this means that one activity may be *backgrounded* (for instance, talking) while another activity is *foregrounded* (such as driving), for example when the car is entering a busy street. In that case, the driver treats both activities as *exclusive*: one activity (talking) is temporarily or permanently stopped. Another example is a study by Vatanen & Haddington (2023). They discussed examples of parents suspending the conditionally relevant and preferred next action (in their case during a turn after a request from their child) by verbalising their involvement in another activity as the reason for not immediately granting the child's request. Through their accounts (e.g., let me do X before I do Y), they demonstrated the need to advance an already initiated course of action. In doing so, they negotiated the relative

significance of intersecting (and potentially overlapping) activities, organising them in terms of priority and hierarchy.

7.2.2 Multi-activity organisation in primary care (telephone) consultations

In their face-to-face consultations with patients, doctors routinely engage in multiple (simultaneous) tasks (Frers, 2009; Greatbatch, 2006; Nielsen, 2016; Pasquandrea, 2011; Robinson & Stivers, 2001; Stevenson *et al.*, 2019). For instance, they speak, check electronic records, listen, write prescriptions, read, make notes, etc. They do so by drawing on a range of multimodal resources such as talk, gaze, gestures and body posture. Much of this activity is carried out with little or no accompanying talk and may even be characterised as 'favouring silence'. Patients typically adjust their own conduct accordingly, for instance by suspending their talk when the doctor is visibly occupied with writing a prescription (Greatbatch, 2006). Over the telephone, however, many of these embodied modalities are inaccessible for the patient.

Previous research has consistently highlighted the importance of nonverbal communication in GP consultations, not only to present (physical) symptoms but also as a means through which patients can express dissatisfaction or underscore the intensity of their concerns (Heath, 1984; Larsen & Smith, 1981; Little *et al.*, 2015). However, telephone consultations rely mainly on spoken interaction alone. A study by Humphrey *et al*. (2025) highlighted how the absence of visual and nonverbal cues in telephone consultations can be particularly challenging for patients, particularly for patients from marginalised groups (e.g., vulnerable migrants, people facing homelessness and individuals with substance or alcohol dependence). Drawing on ethnographic observations and interview accounts, their study showed that without access to embodied resources such as gestures and facial expressions, patients often struggle to convey symptoms and (mental) health concerns and sometimes attempt to intensify their verbal expressions. The loss of nonverbal cues was also reported to create a sense of disconnection or invisibility, with patients feeling less heard or 'taken seriously' by their GP. While this work sheds light on the potential difficulties *patients* may face when nonverbal communication is largely unavailable, the ways in which *GPs*

manage this absence, particularly when they are simultaneously engaged in background tasks, remains less well understood.

The role of the computer is particularly salient. The computer not only plays a central part in contemporary general practice (Fisk, 2024), but in telephone consultations, the absence of visual cues means that patients are not able to see when doctors are orienting to their computer, whether to check records, open letters or issue prescriptions. For example, we know from video-based research on in-person consultations that, in the opening moments of a face-to-face consultation, doctors may continue looking at their computers while greeting the patient and asking them how they may help them, before signalling their availability to listen by visibly shifting their attention away from the screen (Heath & Luff, 2000; Robinson, 2006). My own ethnographic fieldnotes for this study note that GPs spend the vast majority of the consultation oriented to their screen(s) (displaying patient records, copies of letters, prescriptions software, etc.), while only occasionally glancing at the telephone as a 'substitute' for the patient. Thus, the telephone more or less both foregrounds the centrality of the computer and obscures it from the patient's perceptual field. This means that clinicians may have to indicate to patients that they are about to review electronic medical records or other computer-based documentation. To date, however, there has not been a systematic examination into, whether or not, and how doctors make such actions explicit.

7.2.3 Silences in (ordinary) conversation

Previous empirical research suggested that interactants are highly sensitive to timing. For example, if there is a noticeable gap after a question, it may suggest that the respondent is experiencing some difficulty in answering it, for example because they are uncertain about how to answer or they find it difficult to answer in the affirmative (Levinson & Torreira, 2015). A substantial amount of research has examined how extended gaps or silences function in so-called *dispreferred* responses, which are responses that do not align with the preceding turn's proposed action (Pomerantz & Heritage, 2013). Levinson and Torreira (2015) indicated that pauses lasting 0.7 seconds or more tend to occur with dispreferred actions, and that, in the case of invitations, gaps longer than the standard (over

0.3 seconds) reduce the likelihood of an outright acceptance while increasing the chance that a response, whether accepting or rejecting, will take a dispreferred form (for instance, "Yes, but…"; Kendrick and Torreira, 2015). An experimental study by Roberts *et al.* (2011) of inter-turn silence across speakers of English, Italian and Japanese similarly shows that gaps of 0.6 seconds or longer prompt listeners (first-pair part initiators) to draw such negative inferences already themselves. Furthermore, Jefferson (1989) proposed a one second standard maximum of silence for face-to-face conversation, at which point interlocutors begin some activity designed to resolve this 'problem', unless that silence is visibly accounted for. So, importantly, embodied conduct (i.e. gaze, posture, bodily orientation, engagement with objects) provides participants with an interpretative framework for recognising what others (co-conversationalists) are doing during periods of non-speech (Goffman, 1963). However, the telephone limits such a framework. In telephone interaction, it follows that this standard maximum is slightly longer, around 1.6 seconds (Jefferson, 1989).

Research on silence in everyday conversation has long emphasised that silences are not empty absences or inert suspensions of time, but socially meaningful events whose interpretation depends on their sequential and contextual location (Hoey, 2015, 2018, 2020; Jefferson, 1989; Sacks *et al.*, 1974). A basic distinction within CA research is often drawn between *pauses* (silence within a speaker's turn), *gaps* (between turns, following possible completion), and *lapses* (when the conversational turn-taking structure breaks down and no participant self-selects as next speaker). While, according to Hoey (2015), within-turn pauses are typically attributed as belonging to the current speaker and therefore do not constitute a problem, gaps and lapses can be more interactionally delicate. They risk being heard as 'someone not responding' (Schegloff & Sacks, 1973), which may pose difficulties due to reasons related to preference organisation and the maintenance of social solidarity (Clayman, 2002; Pomerantz, 1984; Sacks, 1987).

Hoey (2015) further identified three ways in which lapses in conversation acquire meaning through speakers' orientations. Firstly, interlocutors interpret lapses as the relevant cessation of talk, as "silence where silence should be" (Hoey, 2015, p. 448). This is for example the case when someone is entering a theatre

and after greeting the ticket attendant at the entrance is handing a ticket to them. The attendant inspects the ticket and subsequently offers some instructions on how to get to the correct room or to the correct seat. Both interactants collaboratively project the relevance of 'inspecting the ticket' as the relevant next-thing-to-do and thereby treat such a lapse as now-relevant for the development of their interaction. Secondly, speakers treat lapses as the allowable development of non-talk, when, for example, interlocutors are watching television, studying, driving/passengering, and after some talk they resume their ongoing primary activity. Thirdly, speakers see lapses as the conspicuous absence of talk, as "silence where talk should be" (Hoey, 2015, p. 442), which can invite self-selection to speak. In this way, lapses may be treated as closure-implicative (the lapse projects the conversation is reaching its end), as opportunities to extend prior talk, or as slots for introducing a new topic (Hoey, 2018).

7.2.4 Silences in primary care (telephone) consultations

In health care contexts, silence is often described as a therapeutic instrument. In such a way, it offers patients the opportunity to pause, reflect, connect with their emotions and continue with their line of thought (Hill *et al.*, 2003). At the same time, these moments of silence provide clinicians with the space to observe, to consider how best to respond and move on with the consultation and to regain focus if needed (Ladany *et al.*, 2004). In a similar way, Kaye *et al.* (2023) described that silence can give patients time to process information, to formulate their feelings and to foster trust and solidarity within the clinical/therapeutic relationship. Such silences emerge when a patient's turn comes to a possible point of completion and after the clinician formulates a continuer (e.g., "hm hm"). A conversation analytic study by Knol *et al.* (2020) focused on such silences in psychodynamic therapy sessions and shows that such silences are not merely a therapeutic instrument but are co-constructed by speakers and are assigned meaning by adjacent turns of talk. They showed that such post-continuer silences have the potential to become interactionally meaningful. This chapter continues this work by showing how this would work for silences in a different (sequential) environment, namely during GP's background work.

A study by Hewitt *et al.* (2010) focused on silences in GP-patient consultations (both face-to-face and over-the-phone). They argue that, unlike in face-face-face consultations where moments of silence naturally occur during activities such as physical examinations or prescription writing, telephone consultations lack these silences, which would otherwise offer opportunities for patients to raise additional (medical) concerns. However, it seems that 'silence' here is formulated in a normative, rather than an interactional way. A GP who is writing a prescription (which is visually observable in face-to-face consultations) is not 'silent'. The analysis presented in this chapter will show that GPs, in a context where this is not visually available, orient to this lack and so produce formulations of their actions for the benefit of patients.

For GPs, many routine activities – checking medical records, consulting prescribing software, writing notes, reading letters, issuing prescriptions – might be described as 'favouring silence'. A systematic review conducted by Rivera-Rodriguez and Karsh (2010) has shown that (interactional) interruptions are a common occurrence across all health care settings. Previous research on such interruptions have shown that interruptions are potentially disruptive and may prevent clinicians from carrying out and completing their work activities effectively (Brixey *et al.*, 2007; Carayon *et al.*, 2005; Drews, 2007), causing interruptions to be a likely factor in emerging medical errors. Now, in a face-to-face setting, patients are able to see the doctor attending to routine tasks, so associated absences of talk are largely unproblematic as interruptions are less likely to occur. For instance, a conversation analytic study by Stevenson *et al.* (2019) showed that it was evident for patients that GPs search for (online) information during the consultation. As mentioned previously, over the phone many activities are unobservable, risking their interpretation as unexplained gaps or conversational lapses. As McKinstry *et al.* (2009) argued, the absence of visual cues places greater reliance on verbal and prosodic resources to compensate for this.

7.2.5 Data

Every recording in my dataset of telephone consultations contained moments in which the GP appeared to engage in some form of concurrent or 'background' activity while talking to or listening to the patient. For the purpose of the analysis presented in this chapter, and in line with the emic approach of conversation analysis I described in Chapter 3, I selected cases in which such background activity was *observable* or *treated as such* by the participants. This includes instances where the GP's conduct was made relevant through talk (for example, announcing an activity such as "let's have a look") or through the patient's orientation, as evidenced by them refraining from speaking, indicating that the GP was momentarily engaged in some form of concurrent activity. Across these cases, a consistent observation was that virtually all of these moments involved periods of non-speech or complete silence.

To explore this phenomenon in more detail, Section 7.3 examines instances in which GPs' material activities (for example, audible typing or handling paperwork) were made hearable and therefore provided patients with resources to interpret periods of non-speech. Section 7.4 focuses on cases where GPs verbally announced such activities (for example, "I'll just do a few clicks on my computer"), thereby prospectively accounting for upcoming silences and maintaining the progressivity of the consultation. Lastly, Section 7.5 analyses instances in which GPs verbalise the otherwise unobservable *silent* activity of 'looking'.

7.3 Gaps accounted for by hearable 'material activity'

This section examines how silences in telephone consultations can be made meaningful through hearable 'material activity' such as paper handling or keyboard typing. Drawing on two extracts, it explores how GPs and patients treat gaps that occur while the GP engages in these background tasks, showing how the audibility of such activities allows participants to interpret extended periods of non-speech not as lapses in talk but as part of the ongoing projects of the consultation. The analysis highlights how, in the absence of visual cues available

in face-to-face encounters, sound becomes the primary resource for displaying these periods of non-speech as purposeful and orderly.

The first extract comes from a consultation in which, besides performing a medication review, the GP is also required to complete a form for assessing the patient's fitness to drive. The DVLA has sent this form to the GP who is required to complete it and send it back by post. During the entire consultation, the GP has this form in front of him on his desk and fills it out by pen. The GP has informed the patient at the start of the consultation that he is asked to complete this form and that he already filled out parts of it. Prior to this extract the GP and the patient have discussed the patient's current alcohol intake.

Extract 1. P01GP01: 6.56-7.13

```
01    GP:   ↓Great.
02               (0.2)
03    GP:   >Okay righ' I'm just going t'jus:t uhm:< (0.7) just (.)
04          double check the:se uh:m: (0.5) the- these questions.=so::
05          (0.4) you said (.) it is the:: uh:m-
06               (1.6) ((papers moving/folding))
07    GP:   it's the: (0.3) only (0.3) f:it or anything like a fi'
08          ((papers moving)) that you've- (.) you've ever ha:d,
09          (0.2)
10    P:    Yeah. yeah.
```

In line 01 the GP produces a "↓Great.", treating the previous topic of the patient's current alcohol intake as over. With the "Okay righ'" in line 03 he shows a further readiness to move the consultation further by starting a new activity. Subsequently, in lines 03-04 the GP prefaces the upcoming silence with a pre-pre announcement ("I'm just going t'jus:t … double check … these questions."), which works as a floor-claiming device (Schegloff, 1980). By projecting an upcoming action of 'double checking some questions', the GP marks the silence not as a disruption of talk but as part of the ongoing activity. The repeated use of *uhm* (lines 03–05), but especially the "uh:m-" at the end of line 05, similarly seems to have a floor-holding function (Tübben & Landert, 2022), mitigating the risk that the patient might treat the upcoming absence of talk as problematic or as a possible transition relevant place.

The most prolonged silence in this extract occurs in line 06 (1.6 seconds), but it is co-occurring with hearable paper handling. The audibility of this non-verbal activity is crucial: in the absence of visual cues (unlike in face-to-face consultations), the GP produces *hearable evidence* of ongoing work. This

transforms what might otherwise be a conspicuous silence into an interactionally accounted-for absence of talk (Jefferson, 1989). In face-to-face interaction, silence during note taking or record checking is visibly accounted for and thus potentially less unproblematic; in telephone encounters, sound becomes the only available resource for presenting such silences recognisable as meaningful (cf. Hoey, 2015).

In line 07, the GP resumes talk by recycling part of the earlier turn ("it's the:"), again demonstrating that the intervening silence was indeed a temporary suspension within the GP's turn of talk. The patient's minimal acknowledgment in line 10 ("yeah yeah"), following only a 0.2s gap (line 09), further shows that the silence of line 06 was not treated as problematic, but instead as an orderly continuation of the consultation's activity.

Extract 2 comes from a patient-initiated call in which the patient presents her symptoms of what she proposes may be a sinus infection. Prior to the following extract, the consultation has mainly consisted of a series of question-answer sequences during which the GP is continuously adding notes to the patient's digital records. Just before the extract begins, the patient has mentioned that she "keeps getting really hot and really cold".

Extract 2. P26GP06: 3.05-3.34

```
01    GP:   Myeah.
02               (1.3)
03    GP:   M:kay, (0.2) uh:m and that's- (.) °b-° (.) does that
04          begin aroun' the same time aroun' ↑Saturday,=or::
05               (0.7)
06    P:    Yeah. (.) >yeah yeah< (.) it did yeah ↓Saturday.
07               (2.7) ((keyboard typing))
08    GP:   An' your th::roat (.) is tha' (0.3) s:ore s:till, or:
09          (0.2) tha' [had- ]
10    P:               [No: I] feel l:ike it's okay today.
11               (4.8) ((keyboard typing))
12    GP:   *M:kay*.
13               (0.9)
14    GP:   ↑Uh:m:, (0.5) just a few more questions=you mentioned
15          obvi's'y (0.2) forehead (.) cheeks are all quite
16          a:chy:: (0.2) uh:m:
```

In line 01, the GP responds to the patient's prior informing regarding her temperature. In line 03, the GP again announces a readiness to move the consultation forward ("M:kay") and subsequently the GP continues on the patient's previous comments regarding her temperature fluctuations by asking

when these fluctuations started: “does that begin aroun’ the same time aroun’ ↑Saturday,=or::”. Here, “the same time” refers to the time the patient previously mentioned when her overall symptoms started. The patient produces a positive, type-conforming answer in line 06. Consequently, there is a 2.7-second gap (line 07), which is audibly occupied by the GP typing on his keyboard. The patient does not attempt to re-enter or expand on her response, suggesting recognition that the silence is functionally tied to the GP’s note taking rather than a lapse in talk.

After the 2.6-second gap, the GP takes the floor again by initiating another question-answer sequence, without overtly accounting for the preceding absence of speech. After the patient’s response in line 10, there is another relatively long gap (4.8 seconds), again accompanied by keyboard typing. In line 12 the GP takes the floor again without providing an account for the preceding gap. Both these silences are considerably longer than the ‘standard maximum’ of approximately 1.6 seconds in telephone interaction (Jefferson, 1989). Yet, these are not treated as problematic; the audible typing provides hearable evidence of the GP’s continued engagement. In Mondada’s (2012) hierarchical terms: the activities of talking and note-taking are treated as *exclusive.* The activity of entering notes into the patient’s medical record here is foregrounded (in lines 07 and 11) whilst the activity of talking/responding to the patient is backgrounded (postponed to lines 08 and 12 respectively).

Both participants orient to these gaps not as disruptions but as part of the ongoing organisational structure of the consultation, alternating between eliciting information (through the question-answer sequences) and documenting that information (through (audibly) typing it into the patient’s medical records). This resonates with Hoey’s (2015) notion of *silence where silence should be*: an expectable absence of talk linked to the institutional task at hand. In a face-to-face consultation, a patient could visually observe the GP typing and see them simultaneously looking at their computer screen, but here, audibility seems to substitute for visibility, displaying the gap interpretable as having a purpose.

Taken together, the two extracts in this section show how gaps in telephone consultations can be presented as interactionally meaningful when linked to the institutional tasks of the encounter. In both cases, the GPs

accompany such gaps with audible evidence of background work, thereby framing them as purposeful rather than problematic. This audibility seems to provide a substitute for the visual cues available in face-to-face settings, enabling patients to interpret extended periods of non-speech not as lapses in talk but as orderly pauses tied to consultation-relevant activities.

7.4 Silences accounted for by verbalising 'material activity'

This section examines how GPs manage silences by verbalising otherwise unobservable, mainly computer-based activities, as part of the ongoing consultation. Whereas the previous section focused on silences made hearable through *material sounds* (e.g., paper handling or keyboard typing), here the emphasis is on how GPs explicitly *announce* or *describe* what they are doing on their screens so that these activities become hearable and their corresponding silences accountable for patients. Through a close analysis of two extracts, this section shows how these verbalised accounts prevent silences from being potentially treated as lapses, enable patients to interpret otherwise opaque tasks as purposeful parts of the consultation, and facilitate progressing the consultation.

Extract 3 comes from a medication review. The patient is on one repeat medication, and the GP has decided to extend that prescription.

Extract 3. P13GP03: 1.51-2.37

```
01    GP:   So I'll just extend [your  ] prescription just no:w so:
02    P:                      [Righ:']
03                (.)
04    GP:   Your birthday's in Ma:rch: so (.) I'm gunna make i'
05          (0.5) for another s:::ix months:.
06                (0.7)
07    GP:   Uhm: (.) an'then [↑aroun'] n:ext March or A:pril if=
08    P:                   [Yeah.  ]
09    GP:   =you c'n book an appointment to review your medicine
10          again, (0.4) uhm let me [jus:t-]
11    P:                            [↑Yeah:] no problem.
12                (0.6)
13    GP:   I'll just (.) do a few clicks on my computer,
14                (2.5) ((two audible mouse clicks))
15    GP:   Uh::m: jus' checking if you:: (0.2) have any other long
16          term health conditions that we would review::.
17                (0.7)
18    GP:   °Re:call:s.°
19                (0.8)
20    GP:   S:o:: (1.9) yeah ↑so: (0.2) around March next year
21          is your birthday.=so: (.) if you book a review then,
```

```
22          (0.3) you are 'ligible for an en [aitch es] health=
23    P:                                     [Yeah.   ]
24    GP:   =check you c'n book tha' a' the same ti:me.
```

In lines 01-05 the GP announces that he will extend the patient's prescription for six months, which the patient responds to with a minimal response token in line 08 ("Yeah."). Subsequently, the GP instructs the patient to, around next March or April, "book an appointment to review your medicine again,". He continues by announcing some further activity "let me jus:t-" but the patient overlaps in line 11 by responding to the prior GP's instructions of when to book in another medication review ("Yeah: no problem.").

Following a 0.5 second gap, the GP explicitly announces some (otherwise unobservable) activity: "I'll just (.) do a few clicks on my computer," (line 13). This verbalisation treats the upcoming silence (of line 14) not as an interactional lapse (or a gap), but as an accountable pause tied to some action relevant to the consultation activity. More specifically, by foregrounding the activity of 'doing some work on the computer', it treats this activity and the activity of 'talking', similar as in the previous extract, as *exclusive*. The subsequent 2.5-seconds silence accompanied by multiple mouse clicks is therefore legitimised in advance. By explicitly announcing this action, the GP ensures that the patient can interpret the following silence as meaningful and therewith as non-problematic.

After having announced and legitimised the pause in line 13, the GP then uses the resumed talk in lines 15–16 ("Uh::m: jus' checking if you:: (0.2) have any other long term health conditions") to make explicit what the 'few clicks' and corresponding silence were for. The pause in line 14, while hearably filled with mouse clicks, is therefore not only pre-empted but subsequently also retrospectively presented as purposeful, tied to reviewing the patient's records. The brief utterance in line 18 ("°Re:call:s.°"), produced almost as a reading-aloud comment, further reinforces this orientation: the GP continues to provide verbal evidence of ongoing otherwise unobservable work.

When the GP returns to instructions for the patient in lines 20–24, explaining when to book a next medication review and potentially also an NHS health check, there is no indication from the patient that any of the preceding silences have disrupted the interactional trajectory. In short, this extract shows how the GP combines explicit announcements, audible evidence (mouse clicks),

and retrospective accounts ("jus' checking…") to present silences as accountable and relevant for the progressivity of the consultation.

Extract 4 comes from another telephone consultation. The patient needs to undergo a repeat bone density scan (a DEXA), which is common for patients who previously received certain breast cancer drug treatments. As part of ordering the DEXA – which will be carried out in a secondary care setting – the GP is required to complete a referral form, which is the main reason for the consultation. During the consultation, the GP is completing this form on her computer screen and frequently refers to the questions on that form.

Extract 4. P05GP04: 1.43-2.28

```
01    GP:   So (.) <I don't think> you've had any fra:ctures have
02          you Caroline (.) I can't s:ee any=[is tha-]
03    P:                                      [↑no    ]
04                (0.2)
05    GP:   ↑No that['s ]
06    P:              [has]n't happened (.) in spite of being ran
07          over when I was seven.
08                (0.8)
09    GP:   ↑O:h: bless=you (0.2) o:ka(h)y (.) so I c'n tick no:
10          <t:o tha:t:> (0.5) uh:m (0.5) there's no:ne of tha'
11          and the:n (0.2) ˚let's just tick that's a ↑no˚ (.)
12          >'nd=then< it's b'cause we're on <anastrozole isn't it¿>
13          .skhh
14                (1.0)
15    P:    .h uh letrozol=
16    GP:   =You're on letrozol↓ (.) #righ' no' a problem.#=
17    P:    =Yeah.
18                (0.5)
19    GP:   Tha:t's o:↑kay let me then tha' ↑one, (.) and then:
20          (0.5) ju::st gonna check: (0.2) we've not got any
21          other- (.) ↑no your weight's nice and healthy (.)
22          nothing to worry about the:re so I c'n click no, (0.5)
23          we've been- (0.5) recommended a r- (.) a repeat scan
24          (0.5) uhm (0.4) you're not: on anything for your bone
25          health <at the mo:ment> it's jus'[thē] (.) [t-]
26    P:                                    [.hh]     [I ] take
27          Adcal.
28    GP:   Tha:t's fi:ne #yeh.#
```

The extract starts with the GP producing a declarative regarding the patient's history with bone fractures ("<I don't think> you've had any fra:ctures"), followed by a confirmation-seeking tag ("have you Caroline?"). Before the patient is able to respond, the GP elaborates on her prior declarative by adding "I can't s:ee any", meaning she is currently looking at the patient's medical records but cannot see any documented bone fractures. Before the GP is able to complete her turn, the

patient interrupts with a response to the GP's prior request for confirmation, saying she indeed never had any fractures.

Following the patient's elaboration in lines 06-07 ("in spite of being ran over when I was seven."), the GP responds with an affiliative assessment ("O:h: bless you", line 09) before shifting back to the consultation task in line 09 ("o:ka(h)y (.) so I c'n tick no: to tha:t"). Here, the GP verbalises the action of recording information (in this case regarding the patient's history with bone fractures) on the referral form. Similar to Extract 3, this makes otherwise opaque computer-based activity observable and furthermore also accountable to the patient. In other words, it is turning invisible activities into hearable events rather than allowing them to remain unnoticed or not understood. Moreover, it also seems to legitimise the asking of questions that otherwise might seem unusual or out of place at the current moment (Greatbatch *et al.*, 2005; Jones, 2007); it demonstrates that the GP is simply asking those questions because the referral form requires her to do so. Furthermore, this practice also simply prevents a silence from falling between turns, risking the patient might treat this silence as an opportunity to self-select as next speaker.

The GP continues verbalising the action of completing the referral form in lines 10-11 ("there's no:ne of tha' and the:n (0.2) °let's just tick that's a ↑no°"), explicating she is ticking boxes as part of completing the form and also even which boxes. Whereas in the first verbalisation (lines 09-10), the answer to the question on the form is directly dependent on the patient's response (the patient does not have a history with bone fractures so therefore the answer to the question on the form is 'no'), it is not clear at this point in the consultation exactly what kind of questions the GP is answering now.

At line 12 the GP initiates a new line of inquiry, regarding the patient's medications intake ("'nd=then it's b'cause we're on anastrozole") followed by a confirmation-seeking tag ("isn't it¿"). After the patient states she is actually on a different, related, medication, the GP confirms that and states that this is not something problematic for the progressivity of the task at hand. After a minimal response token of the patient ("Yeah", line 17), the GP again underscores the 'unproblematic' nature of taking letrozole and continues by again verbalising completing (part of) the referral form, presumably related to the patient's

medication intake: “let me then tha’ ↑one”. By verbalising these actions rather than leaving them unmarked, the GP not only makes invisible work hearable but also manages the progression of the consultation, marking closure of one task (ticking the box to answer a question on the referral form) before moving on to the next.

The GP subsequently shifts the topic to the patient’s weight and announces she will check the available relevant information in the patient’s records. Before she finishes her turn in lines 20-21, the GP concludes the patient’s weight is “nice and healthy”, treats the topic of weight as unproblematic “nothing to worry about” and consequently states that, as a result of this, she can “click no”. Here too, the GP’s verbalisation prevents potentially long, unaccounted-for silences while signalling transitions between topics, while also ensuring the consultation keeps progressing smoothly. The GP continues by stating that the referral is for a repeat scan (as opposed to presumably an urgent scan) and asks the patient if she is taking any other medication related to ‘bone health’. After the patient responds by saying she is taking an over-the-counter calcium supplement (Adcal) – which is something that would not be retrievable from the patient’s record as this only includes prescribed medications – the GP in line 28 asserts that “tha:t’s fi:ne”.

Taken together, Extracts 3 and 4 show how GPs actively turn otherwise invisible, primarily computer-based, activities into hearable events through verbal announcements, retrospective accounts, and sometimes accompanied by the audible evidence of actions such as mouse clicks (similar to what happens in Extracts 1 and 2). By making these activities observable, GPs not only legitimise silences as purposeful rather than problematic, but also prevent opportunities for patients to self-select as speakers. At the same time, these practices seem to manage the progressivity of the consultation: they close down one course of action, provide evidence of ongoing ‘background’ work, and facilitate progressions to next topics. In this way, what might otherwise appear as moments of inactivity or disruption, or as apparently unusual or irrelevant questioning (as in Extract 4), instead become integrated, accountable parts of the consultation’s trajectory.

7.5 Silences accounted for by verbalising 'looking'

This section examines how GPs use verbalised descriptions of 'looking' (for example at patient records or prescribing systems) to account for silences during telephone consultations. The following extracts illustrate how, through this practice, GPs make these otherwise invisible but especially *silent* activities hearable, pre-empt forthcoming gaps, and provide retrospective evidence of ongoing background work. By doing so, this is another way in which GPs manage the interactional progressivity of the consultation, maintain control of the floor, and ensure that silences are treated as meaningful and relevant rather than as problematic interactional lapses.

Extract 5 comes from a telephone consultation that is formally documented as a medication review. The extract comes from the end of the consultation and starts with the GP asking the patient if there are other things she would like to discuss.

Extract 5. P02GP03: 11.16-11.31

```
01    GP:   Is there anything else you want t'discuss t'day:?
02               (0.6)
03    P:    No: that's it [(thank you)]
04    GP:                 [All right  ] just before you hang up I'm
05          just >having a look-< (0.5) uh: there's an aler' here
06          about your blood pressu:re,
07               (0.8)
08    P:    Yeah I've go' an appointment.
09               (1.7) ((mouse scrolling + mouse click))
10    GP:   Let's have a look (0.4) oh: yes:: so you've go' an
11          appointment >on th'eleventh of Ju::ne< with ↑Ma:rk?
12               (0.8)
13    P:    ↓Yeah:.
14               (0.2)
15    GP:   ↓All righ' then.
```

In line 01, the GP asks the patient whether there is "anything else" she wants to discuss, which is a common practice of projecting consultation-closure (see Chapter X). However, here, in line 04, it is the GP who initiates a new topic in a new turn, projecting that – despite the fact the patient has just indicated having nothing else to discuss – the consultation is not yet finished. His turn prefaces some upcoming business that is presented as a minimal time imposition ("just before you hang up") and the GP subsequently explicates his activity as ">having a look-<", again presenting it as something minimal ("just"). The GP makes this

otherwise invisible activity hearable through an explicit description and also accounts for a possible following silence, preparing the patient for an absence of talk while the GP is having a look on one of his screens. After the GP has also provided an account for him having a look ("there's an aler' here about your blood pressu:re,"), a (0.8 seconds) gap follows before the patient offers information in alignment with the GP's orientation to her blood pressure needing some attention. The "yeah" in line 08 is affiliative and by adding she already has booked a follow-up appointment, she treats the 'problem' prompted by the alert as already solved.

Line 09 involves the most analytically salient silence in this extract. The GP and the patient produce no talk for 1.7 seconds while the GP is looking at his screen (as announced in lines 04-05), accompanied by the relative soft sound of mouse scrolling and clicking. By announcing this silence, it is presented as part of the ongoing activity of looking at the (cause of the) alert. The GP takes the floor again in line 10 by again explicating a new otherwise unobservable activity ("let's have a look"), now focusing on the patient's prior informing of line 08. The GP's subsequent change-of-state token "oh: yes::" displays the receipt of new information and therewith accepts the prior talk as informative (Heritage, 1984b). It also implies that the 'having a look' has been successful, further legitimising the preceding gaps as meaningful. Another short silence follows, but unlike the previous silences in this extract, the patient is here invited to provide some uptake on the GP's previous informing turn. In line 13 the patient produces a minimal response token ("↓Yeah:."), marking the alert as not news to her (in contrast to the GP) and confirms she indeed already has a follow-up appointment regarding her blood pressure. Consequently, in line 15, the GP initiates topic-closure.

Extract 6 comes from another telephone consultation that was also formally documented as a medication review. The GP and the patient have already discussed a wide range of medicines the patient is currently taking and just prior to this extract the GP has added a new medicine (valaciclovir, which is used for treating cold sores) to the patient's prescription. The patient has already been using this medication for a while, said she is taking one a day and the GP is now trying to work out how many packs to prescribe.

Extract 6. P29GP01: 13.47-14.53

```
01    GP:   Okay so if you're having one: hh (0.5) daily:, (0.2)
02          uh::m (0.4) .pt (1.1) °see wha' the° (0.7) °pack size
03          is for tha'° (0.4) °uh::m:°
04                (10.2) ((tongue clicks + keyboard typing))
05    GP:   >So I'm just checking uh:m< (1.1) wha' size packs i'
06          comes in (1.0) uh::m: (0.8) pu=pu=pu=pu=pf:: (0.2)
07          .pt.hh (.) tha' comes in f:orty two::. (.) s-=which is
08          a strange (0.8) <amount:,>
09                (0.2)
10    P:    Jus' isn't i', huh huh=
```

In line 01, the GP refers to the amount of tablets the patient previously mentioned ("you're having one: hh (0.5) daily:,") and consequently in lines 01-03 pauses talk repeatedly. The relatively quiet delivery of lines 02-03 ("°see wha' the° (0.7) °pack size is for tha'° (0.4) °uh::m:°") displays an orientation towards concurrent (background) activity, such as looking at one of his computer screens. By explicating this activity as well ("see", line 02), the GP announces and legitimises the relatively long subsequent silence of line 04. The GP produces 'filling' tongue clicks within this silence, displaying a continued engagement and projecting that he is still actively pursuing the announced task of 'seeing what the pack size for valaciclovir is'. Together with the "uh::m:°" in line 03, these also function as floor-holding devices, retaining the floor and preventing the patient from treating the silence as a transition relevant place and with that as an opportunity for self-selection.

After the 10.2 seconds pause, the GP retrospectively (but also prospectively) accounts for the silence by again (re-)explicating his otherwise unobservable conduct ("So I'm just checking"), again also treating the previous (and any potential forthcoming) silence as meaningful, tied to an institutionally relevant task. The "uh:m" (line 05) and "uh::m:" (line 08) again function as floor-holding devices (Tübben & Landert, 2022), projecting that the following silence is not to be treated as a transition relevant place. In addition to that, the GP produces a series of pause-filling non-lexical sounds ("pu=pu=pu=pu=pf::"), an audible lip smack and inbreath (".pt.hh") to presumably avoid the patient self-selecting but again also to provide auditory evidence of an ongoing effort in looking something up. Speakers use such non-lexical sounds to display a variety of meanings (Ogden, 2013; 2020). Here, it signals progressivity, by conveying an ongoing effort; 'I am still working on this'. Subsequently the GP evaluates the

medication's pack size as "strange" (presumably because it differs from the usual one month (28 or 30 day) quantity in a medicine pack). Finally, in line 10, the patient aligns with the GP's evaluation.

Extract 7 comes from another telephone consultation which is about discussing average blood pressure readings taken by the patient at home. As a result the GP and the patient have established that the patient's blood pressure is too high. The patient is already taking a medication for treating high blood pressure (ramipril) but as a result of the readings, the GP has proposed to start taking an additional (and another kind of) blood pressure medication (bendroflumethiazide). The extract starts with the GP talking about the dose of the newly added medication.

Extract 7. P16GP03: 2.08-3.17

```
01    GP:   So (.) I'm going to start (.) a small dose: (0.2)
02          jus'to be cautious: (.) of two point five miligra:ms:,
03                (2.3)
04    GP:   I'm just having [a look.        ]
05    P:                  [Do I still have] to take- (0.5) >the
06           other one< as well?
07                (1.2)
08    GP:   Uh: ↑yes plea:se you must keep taking the other one,
09                (0.4)
10    P:    Yes (0.2) [yes] (.) [all right yes.]
11    GP:             [A- ]     [actually      ] I've got some
12          s:oftware that helps me with my prescribing
13          decisions:=so (0.2) I'm going to jus' try:: (1.8) °a
14          different tablet.°
15                (2.5) ((one mouse click))
16    GP:   I'm jus' looking through your other medicines you see:.
17                (1.3)
18    GP:   Let me [see:]
19    P:           [All ] right (.) yeah,
20                (.)
21    GP:   Maybe we'll put you on:- (0.3) I'll just check another
22          tablet (0.4) °one second.°
23                (10.7) ((couple mouse clicks + keyboard typing))
24    GP:   So I'm going t'try you on a different table' (0.2)
25          I'm jus' checking here: (1.9) when you firs:t start
26          this new table' you might feel a bit light headed,
27          (0.2) because (0.2) uh:m (0.4) blood pressure tablets
28          can do tha' (.) so the first time you take it take it
29          at bed time, (0.6) but from the next [day  ] you can=
30    P:                                         [Righ']
31    GP:   =take it first >thing in the morning< with your oth'r
32          tablets:.
33                (0.9)
34    P:    All righ' yeah,
```

After the GP talks about a future course of action "I'm going to start (.) a small dose:" and an account for it being a small dose ("jus'to be cautious:"), there is a

relatively long 2.3 seconds pause in line 03, which might indicate a shift of attention from the GP on his computer screen. Despite the fact this silence could be treated as a transition relevant place, the patient does not take the floor. In line 04 the GP takes the floor again with an account for the preceding (and presumably also any following) silence: "I'm just having a look.", explicitly displaying an otherwise unobservable engagement with the prescribing system on his computer. The patient self-selects in overlap (line 05), asking if he still has to keep taking the ramipril as well. The following 1.2 seconds gap before responding (line 07) might suggest the GP's attention is still predominantly on 'having a look'. Subsequently, in line 08, the GP provides a confirming ("↑yes plea:se") directive ("you must keep taking") response to the patient's prior request for confirmation. The patient then affiliates with and shows understanding of the GP's instruction in line 10.

The GP's turn-initial "actually" in line 11 appears to suggest that the subsequent talk constitutes a revision of a speaker's prior turn, and can therefore be understood as a 'change-of-mind token' (Clift, 2001). Subsequently the GP refers to "some s:oftware", accessible on his computer screen and explicitly announces he will revise what he has said previously by exploring the possibility of starting the patient on a different tablet. It is likely that the GP got an alert on his screen because there was a potential interaction or contraindication between the originally proposed medication and something else that the patient is taking or some other known health condition (for instance an issue with their kidney function). The GP's delivery in lines 13-14 is suspended (see the 1.8 seconds pause), presumably again signalling a dependency on a parallel activity (e.g., searching, reading, looking at his screen, etc.). After a further silence (2.5 seconds, line 15), the GP verbalises what he is doing: "I'm jus' looking through your other medicines you see:." (line 16). This accounts for both the preceding and the following gap, treating and presenting these gaps as interactionally legitimate. The patient acknowledges this, displaying understanding in line 19: "All right (.) yeah,"). The continuation of "let me see" (line 16) further explicates the act of searching and/or looking through the patient's medical records as well.

In line 21, the GP suggests starting the patient on a different tablet than previously mentioned. Again, he states some otherwise unobservable activity:

"I'll just check another tablet" and subsequently explicitly prepares the patient for an upcoming silence: "°one second.°", signalling there is not only a silence to come but also presenting it as meaningful. What follows in line 23 is the longest silence in this extract (and in my entire dataset). The GP produces no vocal fillers, but some background sounds (periodic keyboard sounds) might be audible to the patient. Most importantly, the GP's prior "I'll just check" and "°one second.°" function as a crucial legitimisation of this long silence, protecting it from being treated as an interactional lapse and/or a transition relevant place.

After the 10.7 seconds silence, the GP's "so" marks a return to talk and shows that the silence (or some activity conducted during this silence) has yielded a result, namely the GP has found another tablet which it will be preferable for the patient to try. In line 25 the GP again explicates he is checking something "here:" (on the screen). Another pause (1.9 seconds) follows. Again, the "jus' checking" marks the silence as having a purpose. The extract ends with the GP providing information and instructions regarding taking the new medication to the patient and the patient consequently accepting this treatment plan and confirming his understanding of it.

The last extract comes from the opening phase of a patient-initiated telephone consultation. The patient wants to talk about a letter she received from a secondary care specialist, which contains the results from a procedure and includes some further treatment recommendations. The patient is not able to remember the exact date of this particular letter and the GP starts the extract with referring to the most recent letter documented in the patient's records.

Extract 8. P02GP03: 1.09-1.43

```
01    GP:   The latest letter that we've go' on your ↓reco:rds (.)
02          is f:rom the Middleton e en tee Westfield Hospitals,
03          from the [ninth of May::,]
04    P:             [Yeah that's-   ] (.) that's the one.='ave you
05          read i'?
06                (.)
07    GP:   I'm just opening that now: >one moment plea:se,<
08                (2.3)
09    GP:   S:o:: (1.1) you said it was from:: let's just have a
10          ↑look,
11                (6.2)
12    GP:   .pt (0.3) ↓yeh.=so this is from Furkan Hami:d, (.)
13          uh:m: (0.3) professor, 'm jus' goin' to::: (0.2) have
14          a look a' the letter,
15                (2.2)
```

16 GP: S:o:: (0.3) in >↑twenty twenty one< you had a- 'n issue
17 with your: (0.2) left (0.2) ea::r (0.5) an' then you
18 had a procedure in >twenty twenty three< in your left
19 ea:r? (0.7) uh:: (.) they said (0.4) I ↑revie:wed (.)
20 missus Adams (0.5) t'find the surg'ry: (0.8)
21 has been effective, (.) it's reduced an' abolished the
22 active symptoms, (0.7) the:: (0.2) bee pee pee vee: has
23 reduced from an intens'ty of ten to three out o' ten
24 (0.8) the third window symptoms 'ave reduced from <ten
25 to-> (0.3) ten- (1.2) ten out of ten to ↓zero: (0.5)
26 bu' there's a block'd feeling in the ear with pain
27 behind i', (0.8) examination showed no >evidence:< of
28 active inflamation I wonder if >this is a< neuropathic
29 pain: (0.6) I'd like- (.) I'd be grateful if my
30 colleagues could arrange: a high resolution cee tee of
31 the ↑temporal bo:nes: (0.7) ↓lo:cally t'see if there's
32 any more deep seated pathology: (0.7) in addition:
33 (0.2) I:'d be grateful t'c'mmence the patient on
34 amitriptyline: ten milligrams: (0.7) increasing to
35 twenty milligrams: (.) stop the cinnarizi::ne (0.6) and
36 che:ck about the topirer- (.) ↓topiramate (0.9) an'
37 then stopping for vestibular migrai:ne (0.9) ↑o:kay
38 so: (.) did you want to talk these things through
39 so tha' we c'n ar[range them,]
40 P: [Yeah yeah] ↓yeah.
41 (0.8)
42 P: Yeah that's wha' I want t'ta::lk (.) t'you about:.

In lines 01-03, the GP introduces the most recent letter in the patient's record, explicates the source of the letter and its date. The patient displays recognition of the letter ("Yeah that's- (.) that's the one") and subsequently requests confirmation that the GP has read this letter. In line 07, the GP verbalises otherwise silent, screen-based, activity ("I'm just opening that now:") and therewith indicates he has not read this letter yet. Moreover, this also pre-empts and legitimises the forthcoming silence (">one moment plea:se,<"). The GP explicitly holds the conversational floor by presenting the following 2.3 seconds silence (line 08) not as an interactional lapse but as a purposeful pause related to ongoing relevant background work (i.e. in this case opening the letter the patient has requested to talk about).

In lines 09-10, the GP takes the floor again and again verbalises his otherwise unobservable activity ("let's just have a ↑look,"), projecting that he has gained access to the letter and now is in the process of collaboratively (see the use of "let's") determining whether it is from whom the patient said it is from. The following 6.2 seconds in line 11 is therefore treated as legitimate, tied to the GP's silent act of 'having a look'. The GP's line 12 displays that the 'having a look'

has been successful and makes the shift from 'looking for' to 'looking at' the letter hearable. Especially "this" (l. 12) explicates that the GP is now directly looking at the letter on one of his computer screens. The GP's subsequent announcement ("'m jus' goin' to::: (0.2) have a look a' the letter,") provides a prospective account: it ties the following silence (2.2 seconds in line 15) to the activity of reading (or at least having a look at) the letter.

From line 16 onwards, the GP launches into some history taking (lines 16-19) and eventually into reading out the letter (lines 19-37). By initiating such an extended discourse unit, the GP claims the floor as long as his project (i.e. reading (out) the letter) is not yet completed (Houtkoop & Mazeland, 1985). In lines 19-37 the GP is noticeably 'doing reading aloud' (cf. Drew, 2006b). This is done by presenting the results and advices as reported speech ("they said, l.19), including relatively long pauses, delays and turn-holding expressions (such as stretching "the::" in line 22). Indeed, the patient does not self-select during the GP's reading out. The GP ends his reading aloud discourse unit by re-situating the letter's content within the ongoing consultation in lines 37-39. The patient aligns in overlap ("Yeah yeah ↓yeah.") and subsequently makes explicit that the letter's content is indeed the matter the patient considers as the main business of the consultation.

Overall, this extract shows how the consultation's agenda (talking about a particular letter), requires the GP to manage a complex interplay of screen-based activities (e.g. locating and accessing the letter) and reading aloud in order to demonstrate what information has been shared with him. By verbalising otherwise silent computer activity and thereby presenting silences as purposeful, the GP legitimises silences as relevant for the overall progressivity of the consultations and also maintains control of the conversational floor. The GP uses verbalised descriptions of accessing and reading letters to manage silences and secure the floor. Whereas earlier extracts demonstrated GPs announcing "looking" in order to legitimise gaps and prevent patient self-selection, here the practice of reading aloud projects an extended, non-interruptible turn.

Taken together, the extracts in this section demonstrate how GPs actively verbalise acts of 'looking' at screens, medical records, letters, or prescribing systems to account for silences that might otherwise be treated as problematic

(e.g., as gaps or interactional lapses). By explicitly announcing what they are doing prospectively, GPs pre-empt and legitimise forthcoming silences, marking them as purposeful rather than problematic. Retrospective accounts provide evidence that work has been conducted during a pause, and manage the progressivity of the consultation by marking closure of one task before moving on to the next. Across the extracts, these practices also enable GPs to secure and hold the conversational floor during otherwise 'vulnerable' silences. In the case of Extract 8, this practice extends beyond accounting for silence and projects an extended, non-interruptible discourse unit. Thus, through the verbalisation of otherwise invisible screen-based activities, GPs manage not only the contingencies of silence but also, again, underscore that 'silence' is not merely the absence of talk and not the absence of action. Notably, these seem to be successful interactional practices in that patients do not initiate talk, interrupt or otherwise disrupt the GP's turn.

7.6 Discussion

The analysis presented in this chapter highlights how silences in GP telephone consultations are not merely absences of talk but are actively managed and are made meaningful through a range of interactional practices. Across the extracts, GPs structurally account for silences arising from conducting background work, demonstrating that these periods of non-speech are interactionally consequential and relevant accomplishments.

The analysis of GPs accounting for silences through hearable 'material activity' (Section 7.3), such as typing on a keyboard or handling papers on the desk, reveals how the audibility of such material activities provides a key interpretative resource in telephone interactions. These findings demonstrate that silences coinciding with these actions were treated by both GPs and patients as part of the ongoing work of the consultation rather than as problematic conversational breakdowns. This is in line with previous findings from research on face-to-face interaction (Hoey, 2015; Jefferson, 1989), where visible bodily conduct similarly contextualise silence. However, in a context where visual cues are absent, such sounds generated by the GP's actions become the primary resource for establishing accountability and continuity. These findings thus

underscore the adaptability of participants in compensating for the limitations of telephone-mediated interaction, where embodied conduct is (largely) unavailable.

When GPs verbally announce material activities (Section 7.4), for instance by stating "I'll just do a few clicks on my computer", these practices seem to serve multiple functions. They pre-empt patient self-selection, legitimise forthcoming silences, and project the continuation of their current activity. Such practices show that GPs orient to the risk that unannounced or non-accounted for silences may be (interactionally) problematic in telephone interaction, and thus deploy explicit accounts to facilitate the progressivity of the consultation. The frequent use of items like 'just' in these verbalisations further mitigates the potential disruption by downplaying the duration of the upcoming silence.

The analysis of references to 'looking' (Section 7.5) adds a further level of complexity. Here, the GPs use formulations such as 'let's just have a look at the letter' to account for silence arising during otherwise unobservable and most importantly *silent* activity. These announcements occur both prospectively and retrospectively: prospectively to prepare patients for an upcoming period of silence, and retrospectively to establish its meaning and relevance after a period of silence.

Taken together, these findings indicate that silences emerging in contexts of GPs' 'background work' in telephone consultations are interactional accomplishments, contingent on participants' orientations, the sequential organisation of talk (what happens before and after such periods of non-speech), and the availability of resources for making silences accountable. More broadly, these findings shows that telephone consultations might require additional interactional work around these silences. Therefore, the analysis suggests three practical recommendations for general practitioners, perhaps particularly for those relatively new to conducting telephone consultations:

1. Use brief phrases to announce silences before engaging with background tasks. For instance expressions like 'one moment please' or 'bear with me please'.

2. Verbally announce material activity, ideally prior to commencing that activity. For instance by saying 'I'll just do a few clicks on my computer' or 'I am going to add some notes to your records'.
3. Verbally announce the activity of looking, for instance when checking a patient's record or reading a letter. Consider phrases as 'let's have a look' or 'I am just having a look at the letter now', again ideally prior to commencing any such activity.

These recommendations are especially important for telephone consultations, because in cases where GPs do not provide such accounts or where material activities are inaudible, there is greater potential for confusion or misalignment, for example when patients interpret periods of silence as disengagement or as opportunities for self-selection.

These findings also raise questions about how 'silence' itself is conceptualised and represented in conversation analytic research. In the extracts examined in this chapter, so-called silences are not pure absences of activity. They often coincide with, or are filled with, other forms of action – either material or embodied (albeit unobservable). From a multimodal perspective then, what is transcribed as a pause in talk may actually constitute a continuation of the same turn-at-talk, including both speech and embodied/material action.

This has implications for how CA transcription conventions may reproduce normative assumptions about silence as 'inactivity'. When a transcript marks a gap between turns, or a pause within a turn (note that the notations itself already imply a distinction between talk and non-talk), it potentially overlooks the continuity of action that nevertheless exists in these moments. For example, in Extract 1 of this chapter, the silence that follows the GP's "uhm" in line 05 could be viewed not as a 'suspension' of interaction, but as part of the same ongoing turn, in which moving/folding the papers represents continued participation in the same activity of 'double checking these questions'. Therefore, what is conventionally labelled as 'silence' may need some reconceptualization – not as an absence, but as a separate modality within the broader multimodal organisation of social interaction.

To conclude, in this sense, telephone consultations offer a particularly revealing context for examining how participants *make understandable* the embodied features of their conduct. They highlight how interaction remains multimodal even in the absence of visual/sensory access, and thus how participants reconstitute multimodality through talk itself. The present chapter therefore contributes to wider debates in multimodal and multi-activity research (e.g., Haddington *et al.*, 2014; Mondada, 2014; Pasquandrea, 2011) by demonstrating that modality is not necessarily fixed or limited by medium but is rather collaboratively interactionally constructed by its participants.

Chapter 8. Discussion

8.1 Introduction

The aim of this PhD project was to address the pressing empirical and societal need for a deeper understanding of how telephone consultations between GPs and patients unfold in practice. To address this need, this project sought to produce new knowledge about the interactional practices associated with and used in telephone consultations between GPs and patients, and to closely describe how these consultations are sequentially organised. In order to produce this fine-grained and empirically grounded knowledge, I set out the following three objectives:

1) Identify (some of) the core interactional practices of telephone consultations in primary health care.
2) Discover how these core interactional practices are designed and delivered.
3) Identify (some of) the key interactional affordances and challenges arising for GPs and patients during remote consultations.

Whilst focusing on some of the core interactional practices, in this thesis I looked at a particular type of consultation which is commonly conducted over the phone (i.e., the 'medication review', Chapter 5), a particular phase in the consultation (i.e., the closing phase, Chapter 6) and a particular feature of telephone consultations (i.e., the absence of visual cues, Chapter 7). This discussion chapter situates the reported findings within the broader context of the thesis, examining how they extend, challenge, or refine the existing body of literature and what implications they hold for future research and practice. I will start with offering a summary of each thesis chapter (Section 8.2). Subsequently I will consider the study's original contribution to knowledge (8.3), its particular strengths (8.4) as well as limitations and possible directions for future research (8.5). I will end with some concluding remarks (8.6).

8.2 Summary of thesis chapters

The literature review in **Chapter 2** showed that the context in which health care is delivered has changed dramatically over the past couple of years. Because of the COVID-19 pandemic, various forms of remote consultations were rapidly introduced in primary care (Khan *et al.*, 2020; Krist *et al.*, 2020; Murphy *et al.*, 2021) and many general practices routinised remote services as a tool of delivering health care (Royal College of General Practitioners, 2020). Evidence now suggests that telephone consultations have become the dominant and most established form of remote consulting in UK NHS general practice. Reviews of qualitative studies, which predominantly utilise interview data, have highlighted a number of characteristics, benefits and disadvantages, reported by both clinicians and patients, usually after a remote consultation took place. For instance, previous studies found that phone consultations are regarded as beneficial for certain patient groups, such as diabetic patients (Krahmer *et al.*, 2021), patients with asthma (Pinnock *et al.* 2003) and patients with mental health problems (Liberati *et al.* 2021).

The key risks associated with telephone consultations are that the information exchange can potentially be inadequate in both content and tone, that important concerns can remain unsurfaced, and that the therapeutic relationship is not desirably established or becomes eroded (Rosen *et al.*, 2022). Without visual or sensory cues, clinicians must entirely rely on verbal reports and paralinguistic features such as tone, speech patterns, pauses and voice pitch in examining whether a patients is ill enough to require urgent care, but also to assess whether a patient is listening (well), is concerned, stressed or knows what they need to do (Payne *et al.*, 2023; Reisman & Brown, 2005). Not relying (or misjudging) these cues can lead to inappropriate triage, missed diagnoses, or unnecessary follow-up (in-person) visits. Several studies identified a mismatch in consultation mode (e.g., using a telephone consult when a face-to-face examination was more appropriate) as a recurrent cause of safety incidents. All these reported (communicative) challenges are exacerbated by contextual factors such as clinicians' high workload, limited time, and particularly the absence of formal training in remote communication skills.

Across the literature there is broad consensus that telephone consultations require a distinct set of communicative and interpretive competencies that have not yet been adequately examined, let alone have been properly embedded in medical communication training and education (Greenhalgh *et al.*, 2024; Patterson *et al.*, 2024). Much of the existing body of literature on remote (telephone) consulting addresses questions of its acceptability, feasibility, or suitability of different consultation formats. What these studies are not able to provide, however, is an account of how telephone consultations are interactionally organised turn-by-turn. Because these did not examine naturally occurring talk, they were not able to show what GPs and patients actually do to manage the (potentially distinctive) conditions of telephone consultations, nor how some of these key interactional practices unfold moment-by-moment. Only by closely examining real-time interactions we can understand the fine-grained practices through which telephone consultations are conducted, which is something that cannot be revealed from research generated by interviews, focus groups or surveys (Aguinaldo, 2022; Potter & Hepburn, 2005).

To address the knowledge gap presented in the literature review, **Chapter 3** introduced conversation analysis as a method for investigating how social interaction is organised and managed within its interactional context. Built on Garfinkel's (1967) ethnomethodological framework and taking on Goffman's (1983) call for interaction to be studied as a topic in its own right, CA studies (non-simulated) naturally occurring interaction and aims at uncovering and describing the fundamental principles interactants use in assigning, attributing and establishing meaning to what they say and do in episodes of social interaction. By recording interaction in health care encounters and taking a detailed approach of analysing stretches of social interaction, conversation analytic research, like this study, has the potential to put forward evidence-based rigorous recommendations regarding what communicative practices may or may not work best in a particular context. Yet, because CA aims at identifying recurrent interactional practices and their contingencies, their findings do not necessitate strictly causal or deterministic relationships between specific (interactional) actions and their outcomes. Rather, it offers a set of considerations

and approaches for a practitioner's interactional toolkit. I discussed some examples of such CA studies, showing that only by precisely looking at the actual interaction we can make concrete recommendations for medical professionals, policy makers and educational curricula developers. So, by audio-recording interactions between GPs and patients during telephone consultations and by thoroughly analysing them using the method of CA, this PhD study contributes specific, evidence-based and rigorous recommendations about some of the key interactional practices through which telephone consultations are conducted and can be managed effectively.

In **Chapter 4,** I presented the specific methods and practical challenges of carrying out this PhD project. I described the participant recruitment processes, how I recorded, stored and transcribed the data, I offered a descriptive overview of the data and I discussed all the associated ethical considerations I took into account. I also described how I analysed the data, emphasising that rather than approaching the data with preconceived ideas about the value (e.g., strengths and limitations) of telephone consultations, I focused on identifying what GPs and patients treated as relevant within their interactions themselves. Therefore, the analysis chapters presented in this thesis prioritised participants' orientations over my own interpretations.

The first analysis chapter, **Chapter 5**, involved a particular consultation type: the medication review. I closely examined how these medication reviews actually unfold in telephone consultations and focused specifically on how GPs and patients collaboratively manage the interactional delicacy over balancing medical necessity with patients' own experiences of their medication. I noticed that there are three key consideration that recurrently shape the discussions around medications: its (i) effectiveness, (ii) tolerability, and (iii) necessity. In the analysis, I therefore specifically focused on how and when GPs and patients make relevant these three considerations in their discussions about either continuing, reducing or stopping medications. Besides that, the analysis shows that one of the first challenges in medication reviews is that the nature of contemporary primary care makes it unlikely that the person doing the review (the GP) will be the person who initially prescribed the medication(s). Therefore, the reviews routinely start with the GP and the patient collaboratively establishing that the

patient is indeed taking the particular medicine, at the particular dose and frequency as is reflected in the patient's medical records.

When discussing medication (dis)continuation, a recurring feature across the data extracts is the use of polar yes/no-interrogatives, such as "are you happy to keep taking that?" or "have you had any side effect with pushing up the dosage?". These questions are systematically designed to prefer an interactionally preferred response (Schegloff, 2007), thereby reinforcing the presumption that patients will continue their prescribed treatments and maintain the status quo. Such questioning does not solely seek patient's input but also functions as an implicit expert endorsement of continuing on their current medication regimen. In responding to these questions, patients often downplay certainty and refrain from expressing a strong personal commitment towards their experiences with taking the medications. These responses do not necessarily indicate an 'actual' lack of understanding or uncertainty but display they may not have the right to possess certain kinds of (medical) knowledge (Drew, 1991; Pilnick, 2022).

The analysis shows that, whilst medication reviews are seemingly structured and routine, they actually involve delicate negotiations between medical authority and patient autonomy, particularly when it comes to decisions about continuing or discontinuing medication. Policy guides state that "the final decision to prescribe or de-prescribe must be based equally on the clinical evidence, the prescriber's experience and the patient's values, experiences and wishes" (NHS England, 2020, p. 8). However, the detailed analysis shows that the sequential position of involving the patient in the decision-making process (by for instance asking 'are you happy to keep taking that?'), after establishing the medicine's effectiveness (regardless of basing it on clinical evidence or not), implicitly reinforces the presumption that continuation of the medicine is indeed the most logical appropriate course of action.

Specifically, the analysis points to three considerations for practitioners conducting medication reviews:

1. Be attentive to how question designs, particularly polar yes/no-interrogatives, may implicitly direct patients towards medication continuation.

2. Reflect on how the timing of inviting patient's input may implicitly favour medication continuation.
3. Recognise that involving patients in medication decision-making does not necessarily result in patient autonomy.

A final point I consider in Chapter 5 is the suitability of conducting medication reviews over the telephone, as opposed to traditional face-to-face consultations. In my corpus of telephone consultations there is a relatively high amount of formal medication reviews (9 out of 29) and, moreover, virtually all consultations include some form of talk around medicine use. This seems to point to a perception, at least among the participating practices but presumably in general as well, that medication reviews are an activity that can be done effectively over the telephone. This is understandable as it seems to be redundant to physically see a patient in a context where presenting symptoms are not the main reason for the consultation. Whereas, in general, telephone consultations provide an acceptable (and sometimes beneficial) alternative to face-to-face, it may also cause some limitations. GPs are unable to observe non-verbal cues, such as body language or facial expressions, which could be instrumental in checking the patient's understanding (for instance about the purpose of a particular medication) and in evaluating their level of comfort (for instance in cases of discontinuing medications or reducing doses). Despite the fact the (participating) practitioners deem medication reviews can be done successfully over the telephone, the analysis in Chapter 5 shows that these discussions are perhaps more complex and interactionally delicate than might be assumed at first glance.

In the second analysis chapter, **Chapter 6**, I focused on how GPs and patients bring their telephone consultation to an end. Central to the analysis is the point that, generally, the closing phase of a consultation includes an opportunity for the patient to raise additional questions or concerns they could not fit into the natural flow of the conversation. In my analysis, I identified and discussed three ways in which GPs and patients interactionally organise the closing phase of their consultations. First, I examined extracts in which patients implicitly indicated having no further concerns to raise. I showed that patients use explicit (repeated) expressions of gratitude and high-grade assessments as

interactional resource to initiate closing sequences. This complements previous conversation analytic research on closing sequences in conversation (Antaki, 2002; Button, 1987). I argued that, within the context of a telephone consultation, displaying appreciation suggests that the patients' medical concerns have been sufficiently addressed such that no additional issues and/or questions remain. Additionally, whereas previous studies (West, 2006) state that doctors typically initiate closings, these findings offer a more nuanced perspective. However, although patients (by displaying gratitude) may take the first interactional step towards closing, the analysis also shows that GPs maintain an element of control over the trajectory of the consultation by inserting clinically relevant sequences (i.e., safety-netting or arrangement-setting) before eventually closing the consultation.

The second part of the analysis considered the use of turn-final confirmation-seeking tags (e.g., 'okay?' and 'all right?') by GPs in initiating the consultation. In this part I claimed that these tags serve a twofold purpose. Firstly, they invite the patient to confirm their agreement with or acceptance of a just mentioned particular action (e.g., arranging a referral or a treatment plan). Secondly, they invite the patient to confirm a 'readiness' to move towards the end of the consultation. Whereas at first glance these tags offer the patient the final opportunity to raise any additional concerns, a potential issue is that such requests for confirmation prefer a confirmation as their response (Schegloff, 2007). This implies that closing the consultation, or at least moving towards closing, would be the most appropriate further course of action.

In the third part of the analysis, I focused on the most frequent way of closing the consultation: the 'is there anything else'-question. These extracts show that the preference organisation (Schegloff, 2007) of this question design structurally elicits a negative 'no'-type response (Heritage *et al.*, 2007). I claimed that this question design does not only invite patients to confirm they have no further questions or concerns to raise but also, simultaneously, invites patients to confirm a 'readiness' to close the consultation. Even in seemingly straightforward 'no'-responses (i.e., 'no I don't have anything else to discuss'), patients still perform further interactional work (e.g., offering an account for why they don't have anything else to discuss), thereby emphasising their 'readiness'

in wrapping up the consultation. I also discussed instances in which patients follow a (preferred) 'no'-response by nevertheless presenting an additional concern or asking another question. I suggested that one possible reason for this could be that patients treat 'anything else' as something that has not been discussed in the consultation *at all*.

Taken together, the findings of this analysis chapter illustrate the limitations of current UK GP training models, such as the Calgary-Cambridge model (Kurtz *et al.*, 2003). This model provides only a broad-brushed approach to closing consultations, failing to address the interactionally complex matters involved and does not specify how and/or why some specific practices do or do not work. Specifically, my findings point to four considerations for practice:

1. Recognise that closing-related questions do not only solicit additional concerns but also indicate that the consultation is almost over.
2. Be mindful of the sensitive design of closing-related questions, particularly how negatively polarised questions interactionally prefer a 'no'-response.
3. Consider the sequential placement of closing-related questions, as their placing may implicitly encourage patients to accept both what has just been discussed (for instance a treatment plan) and that the consultation is reaching an appropriate end.
4. Attend to the multiple ways patients may understand 'anything else', as either related to what has been discussed during the consultation or as something not yet discussed at all. A possible solution to this is to separate out 'any questions about that?' in relation to the matter previously discussed and then ask about other concerns.

In sum, this chapter underscored the critical role of question design and sequential placement for the effective elicitation of additional concerns, especially in remote consultations where nonverbal cues are limited (Rothwell *et al.*, 2012) and where there already is a less favourable spatial environment to raise these concerns (Stivers & Timmermans, 2020).

The last analysis chapter, **Chapter 7**, included an examination of how periods of silence in telephone consultations are managed and made meaningful through a range of interactional practices, rather than being treated as mere absences of talk. Central to this analysis is the point that GPs' concurrent 'background' activity often coincides with periods of non-speech. Across my dataset, GPs and patients orient to these moments as accountable and GPs make use of both audible and verbalised resources in order to ensure that patients understand the GP is maintaining the progressivity of the consultation.

The first part of the chapter focused on silences that coincide with hearable material activities, such as keyboard typing or handling papers. In these instances, the sounds generated by the GPs' actions seem to provide an interpretive resource for the patient, allowing them to treat periods of non-speech as part of the ongoing work of the consultation. These findings align with prior research on face-to-face interaction (Jefferson, 1989; Hoey, 2015), where visible bodily conduct contextualises silences. In the case of telephone-mediated interaction, however, where visual access is limited (or even absent), the audibility of such actions becomes the primary means by which participants maintain accountability, continuity and progressivity.

In the second part of the chapter, I examined cases in which GPs verbally announce their engagement in otherwise unobservable activities, for example, by stating "I'll just do a few clicks on my computer." I claimed that these verbalisations appear to serve multiple functions. They pre-empt the patient self-selecting as next speaker, legitimise upcoming silences, and display a continuation of the current activity. These practices show that GPs are consistently aware that unmarked silences could be interpreted as interactionally problematic and that explicit announcements serve to, again, maintain the overall progressivity of the consultation.

The last part of the chapter addressed references to the silent act of 'looking' (at letters, test results, or notes). I demonstrated that utterances such as "let's just have a look [at the letter]" serve both a prospective and a retrospective function. They prepare patients for an upcoming period of non-speech and, after the silence, make its relevance and meaning hearable. In this way, GPs both

manage the interactional 'risks' associated with silence and structure the consultation to maintain a shared orientation to the unfolding tasks.

Taken together, the findings of this chapter indicate that silences in telephone consultations co-occurring with GPs' background activities are interactional accomplishments that depend on the participants' orientations, the sequential organisation of the talk, and the availability of resources for making periods of non-speech accountable. I also highlighted that telephone consultations require additional interactional work compared with face-to-face encounters. Without access to visual or other sensory cues, participants must explicitly make certain aspects of their interactions observable. Regarding how general practitioners could do this, the analysis identified three practical recommendations:

1. Use brief phrases to announce silence before performing background tasks. For example expressions like 'one moment please' or 'bear with me please'.
2. Verbally announce material activity, ideally prior to commencing that activity. For example by saying 'I'll just do a few clicks on my computer' or 'I am going to complete this referral form now'.
3. Verbally announce the activity of looking, for example when checking a patient's electronic record or reading a letter. Consider phrases as 'let's have a look' or 'I am just having a look at the letter now'.

I ended chapter 7 by raising a methodological consideration for conversation analytic research. In the extracts I examined, silences often coincide with ongoing material or embodied activity, meaning that what is conventionally transcribed as a pause may actually constitute a continuation of the same turn-at-talk. This suggests that established CA transcription practices may implicitly rely on normative assumptions about silence as mere inactivity, potentially overlooking the continuity of action that persists across these moments.

In sum, Chapter 7 demonstrated that telephone consultations offer a compelling context for understanding how participants make audible the embodied aspects of their behaviour. I claimed that social interaction within this

context remains multimodal even in the absence of visual cues, and that participants collaboratively construct modality through talk itself. These findings contribute to wider debates in multimodality and multi-activity research (e.g., Haddington et al., 2014; Mondada, 2014; Pasquandrea, 2011), by underscoring that modality is not fixed by medium but is collaboratively and interactionally achieved.

8.3 Contribution to knowledge

This thesis makes an original contribution to knowledge across three interrelated areas: (i) the study of remote (primary) health care, (ii) the methodological development of conversation analytic research, and (iii) the way in which communication skills training and health care education curricula are developed and delivered. I will address these three contributions separately in this section.

Firstly, this is one of the first extensive examinations of naturally occurring telephone consultations in routine UK NHS primary care. While previous studies have examined remote consultations largely through interviews, focus groups or surveys, only few have explored the interactional organisation of telephone consultations as they unfold in real time. By systematically analysing audio recordings of GP-patient consultations, this study provides empirically rigorous evidence of how telephone consultations are sequentially organised and how participants negotiate the anticipated interactional challenges associated with, for example, the absence of visual cues. In doing so, this thesis moves beyond descriptive or experiential/attitudinal accounts of remote care. It uncovers how talk itself constitutes the primordial manner through which health care is delivered in telephone encounters, whether through negotiating decisions regarding (dis)continuing medications (Chapter 5), navigating the closing phase of the consultation (Chapter 6) or managing silences whilst engaging in background activities (Chapter 7). These findings contribute to a more refined understanding of what telephone consultation exactly look like and how remote care is actually delivered in practice, thereby going beyond the empirical and theoretical boundaries of current research on the delivery of remote primary health care.

Secondly, and building on the previous paragraph, this thesis also offers an original methodological contribution. As I concluded previously, there is an increasing reliance on telephone consultation in NHS general practice but there is a substantial shortage of research examining the moment-by-moment talk-in-interaction in these encounters. Building on foundational sociological traditions - particularly Garfinkel's (1967) *ethnomethodological framework*, Goffman's (1983) *interaction order*, Parson's (1937) *structural functionalism* and Schutz' (1953) *intersubjectivity* – this thesis demonstrates how CA can be applied to explore the interactional organisation of telephone consultations in a primary health care context. By situating detailed CA analyses within these classical sociological frameworks, the thesis contributes to the ongoing development of sociology as a discipline. It shows how the fine-grained study of institutional communication continues to provide theoretical insights into how (social) order is produced and sustained through talk. Furthermore, this study also makes a methodological contribution by showing how established CA principles, such as turn design, sequence and preference organisation, are realised within the distinctive environment of telephone-mediated health communication. By examining settings where visual and embodied cues are unavailable, the analyses (but particularly the analysis offered in Chapter 7) contribute to the literature on multimodal and multi-activity (e.g., Haddington *et al.*, 2014; Mondada, 2014). It demonstrates that interaction remains fundamentally multimodal even in an audio-only context, and that participants actively construct and display modality through talk itself.

Thirdly, this study provides an evidence-based foundation for improving communication skills training and medical education curricula for remote (primary) care. There is a substantial lack of structured, targeted and evidence-based education and assessments in telephone consulting. As the NHS (2019, 2025) continues to prioritise remote and hybrid models of care, there is an urgent need to include the teaching of telephone consultations skills explicitly into both undergraduate and postgraduate medical training curricula. Current communication training models, such as the Calgary-Cambridge model (Kurtz *et al.*, 2003) do not adequately address the distinctive dynamics of telephone consultations, leaving clinicians uncertain (or even unqualified) about how to

adapt their communication techniques to compensate, for instance, for the absence of visual and non-verbal cues in telephone consultations. This thesis therefore not only contributes to theoretical and methodological debates but also offers practically relevant insights for developing more targeted, empirically grounded training materials and policy recommendations.

However, it is important to note that the nature of this study and its offered findings remain primarily descriptive. Within conversation analytic research, such description of health care interaction is nevertheless essential for building an evidence base, enabling the identification of recurrent practices and showing what may constitute effective communication in a health care setting. As Barnes (2019) noted, research of this kind is able to identify features of 'good practice' and thereby inform future developments in training and educational intervention. At the same time, Barnes highlights that much CA research in medical contexts (including this study) remains at a 'preintervention' stage. There is, however, a small body of before-and-after studies (see, for instance, O'Brien *et al.*, 2018) evaluating communication-based interventions, thereby providing a higher level of evidence, moving closer towards causal explanations. In this respect, while the present study provides a necessary foundation for the development of communication-based training and education in telephone consultations, further work would be required to move from 'preintervention' towards an 'intervention' stage (Robinson & Heritage, 2014). In doing so, an intervention could establish whether the practices identified here can be successfully translated into educational interventions, and whether their uptake leads to demonstrable improvements in consultation practices or actual health outcomes.

8.4 Strengths

A key strength of this thesis lies in its use of audio recordings of *naturally occurring* telephone consultations between GPs and patients. Unlike previous research that relies primarily on retrospective interviews, focus groups, surveys, or simulated encounters, the data I collected for this thesis captures the interactional organisation of real-world telephone consultations as it unfolds in real time. This enables a level of analytic precision and empirical grounding that

other qualitative approaches cannot provide. By analysing actual talk, the study reveals how telephone consultations are produced, managed, and constituted moment-by-moment, rather than how participants retrospectively (and mostly inaccurately) report or reflect on them.

Besides the context and quantity of the data collected for this study, it is also important to consider the characteristics of the sample from which these data were drawn. As summarised in Table 3 (page 87), the collected recordings varied in main reason for the consultation. These consultations took place within three different GP surgeries, included six general practitioners and the number of patients who did and did not have a previous face-to-face consultation with their GP was relatively equally distributed. It remains, however, plausible (albeit uncertain) that differences in reasons for consultation influenced the interactional practices observed in the analysis chapters. Nevertheless, the main focus of this study was not to compare interactional practices across a range of different consultation types, but to unpack how telephone consultations, in general, were structured and organised by their participants. Following ten Have's (2007) principle that any extract of naturally occurring interaction can be a 'good' example for analysis, the inclusion of multiple consultations spanning different contexts strengthens the argument that the interactional and institutional practices observed are relevant and likely to arise across a variety of distinct health care environments.

A further strength of this study is the inclusion of ethnographic observations alongside the audio-recordings. Although the field notes I took whilst co-present in the room with the GP at the time of the recording were not systematically analysed in detail, they provided valuable contextual information about the physical and organisational conditions in which the recorded telephone consultations took place. In particular, my observations regarding the GPs' non-verbal behaviour (e.g., where were they predominantly looking at?, what kind of resources were displayed on their computer screen?, did they write things down on paper?) turned out to be particularly valuable. In fact, my notes on these topics led me to investigate cases when GPs were engaging in such 'background' activities, which eventually formed the foundation for Chapter 7. So, the

combined use of ('informal') ethnographic observations and the audio-recordings enriched the analyses presented in this thesis.

8.5 Limitations

This study focused exclusively on GP-patient conversations. Although GP-patient consultations constitute a central site of care delivery in NHS (primary) health care, primary care involves a broader range of health care professions who engage in telephone consultations (nurse practitioners, pharmacists, paramedics, etc.). Interactions with each of these groups and their patients may involve different (core) interactional practices and distinctive associated interactional features. Future research could therefore extend the analysis presented in this thesis by incorporating data from consultations between patients and a broader range of health care practitioners. Comparative analyses across professional categories would allow for a more comprehensive understanding of how real-world telephone consultations (in general) are actually organised.

Virtually all patients that participated in this study had at least some prior experience with telephone consultation. This reflects the contemporary nature of NHS general practice, where remote consultations have become increasingly routine, especially since the COVID-19 pandemic. However, prior experience and familiarity with telephone consultations may have influenced both patients' and clinicians' conduct, for instance by shaping their expectations of turn-taking or opportunities for raising additional questions or concerns. Future studies might seek to include a more varied patient sample, including patients with limited or no prior exposure to remote consultations. In addition, this study excluded patients requiring a translator and anyone speaking on behalf of someone else lacking the capacity to give informed consent (e.g., children, people living with dementia, individuals with a learning disability). Nevertheless, there is an equally pressing need to improve access to primary care for these individuals. Therefore, there is an opportunity for future research to look into the interactional practices (and potential challenges and affordances) associated with these types of consultations when conducted over the telephone.

Another limitation concerns the type of consultations recorded. All appointments in this study were pre-booked, mostly even weeks in advance. This was beneficial in terms of patient recruitment as it allowed sufficient time to obtain informed consent. However, it also resulted in a dataset containing relatively few consultations dealing with urgent or acute problems. Only four consultations in my dataset included such discussions, as these were collected at a surgery that incorporated a telephone appointments clinic specifically for my study only a couple of days in advance. As a result, the analysis offers a limited insight into triage decision-making or the management of highly time-sensitive cases over the telephone. Future research could address this gap by focusing on same-day or urgent out-of-hours calls, which are likely to present a range of distinct communicative practices and potential difficulties. The recruitment process in this study has shown that, by using text messages for obtaining informed consent, participants could be recruited relatively quickly, enabling including patients with a same-day appointment. Such research could further highlight how GPs manage risk when visual and other sensory resources are limited.

A final key limitation of this study concerns the variety of the dataset and some practical constraints that shaped it. Whilst the corpus includes a range of primary care telephone consultations, it is notably weighted towards a particular kind of consultation (the 'Medication Review'), which may have influenced the interactional practices and patterns identified in the analysis chapters of this thesis. As Clayman (2024) noted, relatively narrow or uneven datasets risk producing findings that are unduly context-bound or shaped by the recurrent characteristics of particular consultation types (such as medication reviews), rather than reflecting broader interactional practices. Medication reviews, for instance, are GP-initiated appointments which may systematically influence how closings (see Chapter 6) are initiated and accomplished. In addition, the dataset was also shaped by practical constraints, including challenges regarding access and recruitment, which limited the potential extent of diversity in participants and consultation types. As mentioned previously (in Chapter 5), medication reviews are routinely performed over the phone and typically scheduled in advance, making them more accessible for inclusion in the dataset of this study.

As a result, some of the interactional practices identified in the analysis chapters may be (at least partly) contingent on the particular co-occurring interactional conditions of medication reviews. Therefore, whilst the analyses attend closely to participant orientations and the turn-by-turn sequential organisation of telephone consultations, the findings should nevertheless be understood as grounded in, and potentially constrained by, the particularities of the dataset used for this particular study.

8.6 Future directions

While this thesis examined three aspects of telephone consultations (medication reviews, closing sequences, and the management of silences), there are still numerous other communicative activities and interactional practices warranting closer analysis. For example, the opening phase of the consultation, the delivery of test results, requests for clarification and other types of interactional repair. Since this thesis illustrates how conversation analysis can effectively uncover the organisation of real-time telephone consultations, there is ample scope for future studies.

8.7 Conclusion

To conclude, this thesis has addressed the pressing empirical and societal need for a deeper understanding of how telephone consultations between GPs and their patients unfold in practice. It has identified and described some of the core interactional practices of NHS primary care telephone consultations. The analyses showed that some of these practices are (successfully) adapting to the distinctive limitations and affordances of telephone-mediated care. They also explain why certain interactional practices do or do not work best. This study underscored the value of using conversation analysis to examine actual telephone consultations. It provided evidence-based recommendations and considerations to inform general practitioners, clinical policy makers and educational curricula developers. Overall, this PhD thesis contributes to a more refined and empirically grounded understanding of how telephone consultations are actually conducted. It highlighted that a telephone consultation is not simply a substitute version of a face-to-face encounter, but constitutes a distinct interactional environment requiring particular and additional interactional work.

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Appendices

Appendix 1. Transcription Conventions

Adapted from Jefferson (2004) and Hepburn (2004).

P:	Patient
GP:	General practitioner
[ ]	Brackets represent overlapping talk
=	An equal sign represents no gap (latching) between turns
(0.5)	Pause of 0.5 seconds
(.)	Micropause; pause or gap shorter than 0.2 seconds
?	Sharp rising intonation
¿	Medium rising intonation
,	Slight rising intonation
.	Falling intonation
_	Flat intonation
!	Exclamation-like prosody
↑	Sharp (noticeable) rise in pitch on syllable level
↓	Sharp (noticeable) fall in pitch on syllable level
word	Vocal emphasis
:	Lengthening of preceding syllable
#word#	Creaky voice
word	Crackling voice
£word£	Smiley voice
~word~	Wobbly voice
Huh heh	Laughter
WORD	Talk that is louder than surrounding talk
°word°	Talk that is softer than surrounding talk
<word>	Talk that is slowed down in comparison to surrounding talk
>word<	Talk that is speedup up in comparison to surrounding talk
wo-	Talk that is cut off
.hhh	Hearable inbreaths
hhh	Hearable outbreaths
wo(h)rd	Within-speech aspiration
(word)	Transcriber uncertainty
( )	Unclear talk
((keyboard typing))	Characterization of non-verbal activity

Appendix 2. Health Research Authority Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor Alison Pilnick
Rm. B28, Law and Social Sciences Building
University of Nottingham
Nottingham
NG7 2RD

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

08 January 2024

Dear Professor Pilnick

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Improving the remote delivery of primary health care post COVID-19**
IRAS project ID:	**315822**
Protocol number:	**23024**
REC reference:	**23/YH/0249**
Sponsor	**University of Nottingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **315822**. Please quote this on all correspondence.

Yours sincerely,
Anna Bannister

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms. Angela Shone*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Waiting room poster]	Final 1.0	21 November 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Liability insurance cover]		
GP/consultant information sheets or letters [PIS for GPs]	Final 1.1	16 November 2023
IRAS Application Form [IRAS_Form_11102023]		11 October 2023
IRAS Application Form XML file [IRAS_Form_11102023]		11 October 2023
IRAS Checklist XML [Checklist_24112023]		24 November 2023
IRAS Checklist XML [Checklist_20122023]		20 December 2023
IRAS Checklist XML [Checklist_11102023]		11 October 2023
Letters of invitation to participant [Cover letters patient participants]	Final 1.0	29 August 2023
Letters of invitation to participant [Cover texts patient participants]	Final 1.0	29 August 2023
Organisation Information Document [Organisation Information Document]		
Other [Response to provision opinion]	Final 1.0	22 November 2023
Other [Delegation Log]	Final 1.0	29 August 2023
Participant consent form [Participant Consent Form]	Final 1.1	21 November 2023
Participant consent form [Optional authorisations consent form patient participants]	Final 1.1	15 December 2023
Participant consent form [GP participant consent form]	Final 1.0	29 August 2023
Participant information sheet (PIS) [PIS for Patients]	Final 1.1	16 November 2023
Research protocol or project proposal [Research Protocol]	Final 1.1	16 November 2023
Schedule of Events or SoECAT [Schedule of Events]	Final 1.0	29 August 2023
Summary CV for Chief Investigator (CI) [CV Chief Investigator]	Final 1.0	29 August 2023
Summary CV for student [CV Student]	Final 1.0	29 August 2023
Summary CV for supervisor (student research) [Summary CV Alison Pilnick (supervisor)]	Final 1.0	29 August 2023
Summary CV for supervisor (student research) [Summary CV Elizabeth Stokoe (supervisor)]	Final 1.0	29 August 2023
Summary CV for supervisor (student research) [Summary CV Tony Avery (supervisor)]	Final 1.0	29 August 2023

IRAS project ID	315822

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations.	NHS Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met. HRA and HCRW Approval has been issued The NHS organisation has not provided a reason as to why they cannot participateThe sponsor may start the research prior to the above	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	Study funding arrangements are detailed in the Organisation Information Document.	A Principal Investigator should be appointed at participating NHS organisations.	Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm Occupational Health Clearance. These should confirm enhanced DBS checks and appropriate barred list checks.

	deadline if the participating NHS organisation positively confirms that the research may proceed. The sponsor should now provide the local information pack to participating NHS organisations in England and/or Wales. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 3. Health Research Authority Approval Letter for Amendment

NHS
Health Research Authority

Yorkshire & The Humber - South Yorkshire Research Ethics Committee

NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

16 April 2024

Mr. Gilian Noord
Rm. B20, Law and Social Sciences Building
University of Nottingham
Nottingham
NG7 2RD

Dear Mr. Noord

Study title:	**Improving the remote delivery of primary health care post COVID-19**
REC reference:	**23/YH/0249**
Protocol number:	**23024**
Amendment number:	**23024 SA01**
Amendment date:	**20 March 2024**
IRAS project ID:	**315822**

The above amendment was by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Completed Amendment Tool [Completed Amendment Tool 315822 - 23024 SA01]	Final 1.0	20 March 2024
Letters of invitation to participant [Texts for Patient Participants]	Final 1.1	18 March 2024

Participant consent form [CONSENT FORM Improving Delivery Remote Care Final v1.3 12.04.2024 Clean]	1.3	12 April 2024
Participant consent form [CONSENT FORM Improving Delivery Remote Care Final v1.3 12.04.2024 TC]	1.3	12 April 2024
Research protocol or project proposal [PROTOCOL Improving Delivery Remote Care]	Final 1.2	12 March 2024

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

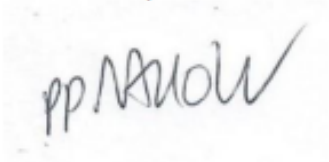
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS Project ID - 315822:	**Please quote this number on all correspondence**

Yours sincerely



Dr Simon Baudouin
Chair

E-mail: southyorks.rec@hra.nhs.uk

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Mr. Gilian Noord*

Yorkshire & The Humber - South Yorkshire Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 02 April 2024

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Simon Baudouin (Chair)	Retired Medical Doctor	Yes	
Miss Priscillia Fidelis	Senior HCA	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Mrs Nicki Allott	Approvals Administrator

Appendix 4. GP Practice Invitation Letter





Dear [insert name],

We are letting you know about a research study called *Improving the remote delivery of primary health care post COVID-19*. Telephone consultations have become increasingly important in the delivery of primary care since the start of the pandemic. For this study, we want to audio-record telephone consultations to get a better understanding of how GPs and patients communicate during these consultations. We plan to do the study in practices using TPP SystmOne.

At this stage we are looking for initial expressions of interest and will follow this up with more detailed information. The study will involve practices recruiting patients to have **one** of their consultations audio recorded, and for any GPs participating we would like to audio record around six of their consultations. A member of the research team would be present in the practice during all research activities to help things run smoothly.

There is **an allowance of £150** per practice for overall participation in the study (including the GP practice staff reading all the study documentation, working with a researcher on exactly how the study will run in practice, sending texts/letters out to patients to recruit research participants, printing the consent forms, etc) and an additional allowance of **£12.50 for every successfully recruited patient participant**.

The research will be carried out by researchers from the University of Nottingham and the London School of Economics and Political Science. It is funded by the Economic and Social Research Council.

Please let me know if you think this study might be of interest to your practice and we will send you more information in due course. If you would like to have an informal chat about the study, you can contact the research team by phone or text on 07564844909 or e-mail on gilian.noord@nottingham.ac.uk.

Yours sincerely,

Appendix 5. Consent Form

University of Nottingham
UK | CHINA | MALAYSIA

UKRI Economic and Social Research Council

Consent Form for Participants
(Final Version 1.3 date: 12.04.2024)

Title of Study: Improving the remote delivery of primary health care post COVID-19

IRAS Project ID: 315822

Name of Researcher: Prof. Alison Pilnick (Chief Investigator)
Gilian Noord

Name of Participant: **Please initial box**

Please read this information sheet before completing the consent form: [insert url]

1.	I confirm that I have read and understand the information sheet version number final 1.1 dated 16/11/2023 for the above study and have had the opportunity to ask questions.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw within 14 days of the consultation, the recording will not be transcribed nor analysed but will not be erased. I understand that should I withdraw after 14 days of the consultation, it is possible that the data may have been used in the project analysis, then the information collected so far cannot be erased but it can be excluded from any subsequent analyses and will then not be shared with others.	
3.	I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	
4.	I understand that my phone consultation will be audio-recorded, that the recording may be heard by the research team, that my voice will be disguised when played to others and that direct quotes from the anonymized transcript may be used in the study reports, in training or educational materials or at research presentations.	
5.	I understand that a researcher is co-present in the consultation room during the phone consultation to make notes about the GP's non-verbal behaviour, information regarding the purpose of the consultation and anything else which may impact on the consultation.	
6.	I agree to take part in the above study.	

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes (if patient participant)

Appendix 6. Participant Information Sheet for Patient Participants

Participant Information Sheet for Patients
(Final Version 1.1: 16.11.2023)

IRAS Project ID: 315822

Title of Study: **Improving the remote delivery of primary health care post COVID-19**

Name of Chief Investigator: Prof. Alison Pilnick
Local Researcher(s): Gilian Noord

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. This information sheet explains our study and answers particular questions you may have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Economic and Social Research Council (ESRC) as part of a PhD studentship.

Who has reviewed the study?

All research in healthcare is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the Yorkshire & The Humber - South Yorkshire Research Ethics Committee.

What is the purpose of the study?

The purpose of the study is to examine communication between General Practitioners and patients when they are doing a medical consultation over the phone. We are especially interested in finding out if there are particular difficulties in these kinds of consultations, and if so whether they are more likely to occur in specific contexts and if there are successful ways in overcoming these difficulties. In addressing these questions we are planning to audio-record phone consultations and then analyse the recordings.

Why have I been invited?

You are being invited to take part because you are a patient at [*insert appropriate name of surgery*] and you have a planned phone appointment with a General Practitioner. We are inviting up to 80 participants like you to take part and we hope to record up to 80 remote consultations in total.

Do I have to take part?

You are not obliged to participate in this study: it is up to you to decide whether or not to take part. We will only record a consultation if everybody participating, including the General Practitioner, has agreed to take part in our study. If you do decide to take part you will be given this information sheet to keep and be asked to complete and sign a consent form. If you decide to take part you are still free to withdraw at any time during the consultation and up to 14 days after the consultation, without giving a reason. This would not affect your medical care or legal rights.

What will happen to me if I take part?

If you agree to take part, the consultation with the General Practitioner will be audio-recorded. Additionally, a researcher will be co-present in the consultation room at the time of the phone consultation to make ethnographic fieldnotes involving the GPs non-verbal behaviour during the consultation, information regarding the purpose of the consultation and anything else which may impact on the consultation. What happens during your conversation with the general practitioner should be no different to what would have happened if you were not taking part in our study.

When you are on the phone with the General Practitioner, they will check again that you are comfortable with being recorded and will ask you whether you are comfortable with the researcher being co-present with the General Practitioner in the consultation room during your consultation. At this stage, or at any stage during the consultation you may ask for the recording to be stopped or ask for the researcher to leave the consultation room. Likewise, the General Practitioner may also stop the recording or ask the research to leave the room at any time during the consultation.

If you agree to take part, we will ask you after your consultation with a GP to allow us to use the audio-recording for further research and training purposes. You will then be asked to sign an optional authorisation form. This authorisation form allows you to tell us who, in addition to members of the research team, may listen to your recording. The form allows you to decide how we can use the audio-recording for future research and training purposes. No-one outside the research team will use or hear the recording unless you provide written authorisation at this point. We will only use your recording in the ways that you authorise us to.

Why are we recording your consultation with the GP?

We need to make audio-recordings in order to capture what really happens in communication between General Practitioners and patients, so that our study findings are based on real-life observations rather than assumptions. The recordings make it possible to listen to the communication and transcribe and analyse the consultation in a very detailed way.

Who will hear the recordings and why?

The research team will hear the recording in order to do the research. We would also like to play clips from some of the recordings to other people at closed sessions with other experienced researchers (both within and outside the University of Nottingham) and with health care staff. After the recording, we will seek separate optional authorisation to use clips from some recordings in the following ways:

- Provided everyone recorded has given permission, we will play audio clips from the recording in closed sessions with other communication researchers, within and outside the University of Nottingham, to strengthen the research results.
- Provided everyone recorded has given permission, we will play audio clips from the recording in talks about this study for professional audiences of researchers, health and social care staff and trainees or to patient and public involvement groups.
- Provided everyone recorded has given permission, we will use audio clips from this recording in communication skills training materials for courses with appropriate registration. The clips will be stored on copy-protected disks or drives, kept in the trainers' possession, and/or in a copy protected digital repository – with passwords known only by the trainers and the researchers.
- Finally, if everyone permits it, we would like to use the recording in the future for new research studies by the current team and other researchers who may wish to look at aspects other than those we are focusing on in this study.

In the clips we present to other people outside the research team, we will disguise your voice and we will blank out any information that could be used to identify you (for example person names, dates of birth and place names).

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

While it is unlikely, it is still possible that the recording process may affect how you and the General Practitioner talk. We will do all that we can to make sure that recording does not disrupt your time with the General Practitioner. It is however difficult to know whether or not recording will have an effect. If you feel that the recording or the presence of the researcher in the room is having an unwanted effect, please ask for the recording to be stopped or for the researcher to leave the room. Likewise, if the General Practitioner feels the recording or the researcher's presence has an unwanted effect, they will do the same.

Although the recording of your consultation is anonymized (person names, dates of birth and place names will be replaced by a silence matching the length of the word in the recording and will be pseudonymized in the transcript) and your voice will be disguised when the recording is presented to researchers outside the research team, it is still potentially possible that someone you know will be there, and that they will recognise you. We will make it clear to all participants that they must not use your name or discuss your personal details during or after the meeting.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help to better understand the communication skills needed for good remotely delivered primary care. In the longer term, this will help GPs to use these communication skills for the care of patients in primary care, like you.

What happens when the research study stops?

The research data will be stored and archived at the University of Nottingham.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting [please provide the contact details of PALS for the hospital/Prison Complaints]

[include separate contact details for every participating GP surgery]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a

password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (Professor Alison Pilnick) is the Data Custodian (manages access to the data). This means that we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally–identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Where possible, information about you which leaves the GP practice will have your name, date of birth and any other information that could identify you removed and a unique code will be used so that you cannot be recognised from it.

If you participate in the study, your consultation will be transcribed by a member of the research team. All names (and any other information that could identify you) will be removed in the written transcriptions so that you cannot be identified from it. These anonymised transcriptions may be used in training materials or published for scientific purposes. If you later wish to see a copy of the transcript of your involvement in this study, you should ask to speak to the researchers. The researchers' contact details are given at the end of this information sheet.

All research data will be kept securely for 7 years after we have completed all work on the study. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to the data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised, so that you could not be identified. We do not expect to share our data in countries whose data protection laws differ to those of the UK.

Although what you say in your conversation with the general practitioner is confidential, should you disclose anything which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time (up to 14 days after the consultation), without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records. However, we will not begin any analyses for at least 14 days after the consultation. This means that if you wish to

withdraw within 14 days, we will not transcribe and use your consultation in any analyses, but we will not erase the audio-recording. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Involvement of the General Practitioner (GP)

Just like you, the General Practitioner is also informed about this study and needs to give informed consent for the audio-recording as well. Also, the General Practitioner may as well withdraw within 14 days of the consultation.

What will happen to the results of the research study?

The results of this study will be written up as part of an educational qualification (PhD) at the University of Nottingham which is due to finish in September 2025. The results will also be discussed at research meetings and potentially written about in research journals. Your personal details will not be given in any presentation or publication.

Further information and contact details

For further information, please contact:

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Appendix 7. Participant Information Sheet for GP Participants

Participant Information Sheet for General Practitioners
(Final Version 1.1: 16.11.2023)

IRAS Project ID: 315822

Title of Study: **Improving the remote delivery of primary health care post COVID-19**

Name of Chief Investigator: Prof. Alison Pilnick
Local Researcher(s): Gilian Noord

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Economic and Social Research Council (ESRC) as part of a PhD studentship.

Who has reviewed the study?

All research in healthcare is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the Yorkshire & The Humber - South Yorkshire Research Ethics Committee.

What is the purpose of the study?

The purpose of the study is to examine communication between General Practitioners and patients when they are doing a medical consultation over the phone. We are especially interested in finding out if there are particular difficulties in these kinds of consultations, and if so whether they are more likely to occur in specific contexts and if there are successful ways in overcoming these difficulties. In addressing these questions we are planning to audio-record phone consultations and then analyse the recordings.

Why have I been invited?

You are being invited to take part because you are a General Practitioner at [*insert appropriate name of surgery*]. In total, we are inviting up to 14 participants like you to take part and we hope to record up to 80 remote consultations in total.

Do I have to take part?

You are not obliged to participate in this study: it is up to you to decide whether or not to take part. We will only record any consultations if everybody participating, including the patients, have agreed to take part in our study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time during each consultation and up to 14 days after each consultation, without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you agree to take part, up to 8 of your phone consultations with patients will be audio-recorded. Additionally, a researcher will be co-present in the consultation room at the time of the phone consultation to make ethnographic fieldnotes involving your non-verbal behaviour during the consultation, information regarding the purpose of the consultation and anything else which may impact on the consultation. What happens during your conversation with a patient should be no different to what would have happened if you were not taking part in our study.

Shortly before each separate phone consultation, the researcher will check again that you are comfortable with being audio-recorded and whether the researcher can be co-present in the consultation room during the phone consultation. The researcher will also ask you whether there are any concerns about the patient's suitability to participate and their capacity to give informed consent, before phoning the patient. At this stage, or at any stage during the consultation you may ask for the recording to be stopped or for the researcher to leave the consultation room. The researcher, who is co-present with you in the consultation room at the time of the recording, can assist you with stopping the recording equipment. Likewise, patients may also request to stop the recording or ask the researcher to leave the room at any time during the consultation.

If you agree to take part, we will ask you after each separate consultation with a patient to allow us to use the audio-recording for further research and training purposes. You will then be asked to sign an optional authorisation form. This authorisation form allows you to tell us who, in addition to members of the research team, may listen to the recording. The form allows you to decide how we can use the audio-recording for future research and training purposes. No-one outside the research team will use or hear the recording unless you provide written authorisation at this point. We will only use your recording in the ways that you authorise us to.

Why are we recording your consultation with a patient?

We need to make audio-recordings in order to capture what really happens in communication between General Practitioners and patients, so that our study findings are based on real-life observations rather than assumptions. The recordings make it possible to transcribe the consultation and analyse the communication in a very detailed way.

Who will hear the recording and why?

The research team will hear each recording in order to do the research. We would also like to play clips from some of the recordings to other people at closed sessions with other experienced researchers (both within and outside the University of Nottingham) and with health care staff. After each recording, we will seek separate optional authorisation to use clips from some recordings in the following ways:

- Provided everyone recorded has given permission, we will play audio clips from the recording in closed sessions with other communication researchers, within and outside the University of Nottingham, to strengthen the research results.
- Provided everyone recorded has given permission, we will play audio clips from the recording in talks about this study for professional audiences of researchers, health and social care staff and trainees or to patient and public involvement groups.
- Provided everyone recorded has given permission, we will use audio clips from this recording in communication skills training materials for courses with appropriate registration. The clips will be stored on copy-protected disks or drives, kept in the trainers' possession, and/or in a copy protected digital repository – with passwords known only by the trainers and the researchers.

- Finally, if everyone permits it, we would like to use the recording in the future for new research studies by the current team and other researchers who may wish to look at aspects other than those we are focusing on in this study.

In the clips we present to other people outside the research team, we will disguise your voice and we will blank out any information that could be used to identify you (for example person names, dates of birth and place names).

Expenses and payments

Your practice will be paid an allowance of £150 for overall participation and an additional allowance of £12,50 for every recorded phone consultation.

What are the possible disadvantages and risks of taking part?

While it is unlikely, it is still possible that the recording process may affect how you and a patient talk. We will do all that we can to make sure that recording does not disrupt your time with a patient. It is however difficult to know whether or not recording or the researcher's co-presence will have an effect. If you feel that the recording or the presence of the researcher is having a disturbing effect, please ask for it to be stopped or stop it yourself, or ask the researcher to leave the room. Likewise, if a patient feels the recording or the researcher's presence has a disturbing effect, they may ask for the recording to be stopped or request for the researcher to leave the room.

Although the recording of your consultation is anonymized (person names, dates of birth and place names will be replaced by a silence matching the length of the word in the recording and will be pseudonymized in the transcript) and your voice will be disguised when the recording is presented to researchers outside the research team, it is still potentially possible that someone you know will be there, and that they will recognise you. We will make it clear to all participants that they must not use your name or discuss your personal details during or after the meeting.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help to better understand the communication skills needed for high-quality remotely delivered primary care and how to use these communication skills for the care of patients in primary care.

What happens when the research study stops?

The research data will be stored and archived at the University of Nottingham.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting: [please provide the contact details of PALS for the hospital/Prison Complaints]

[include separate contact details for every participating GP surgery]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (Professor Alison Pilnick) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Where possible, information about you which leaves the GP practice will have your name and the practice name removed and a unique code will be used so that you cannot be recognised from it.

If you participate in the study, your consultations will be transcribed by a member of the research team. All names (and any other information that could identify you) will be removed in the written transcripts so that you cannot be identified from it. These anonymised transcriptions may be used in training materials or published for scientific purposes. If you later wish to see a copy of the transcript of your involvement in this study, you should ask to speak to the researchers. The researchers' contact details are given at the end of this information sheet.

All research data will be kept securely for 7 years after we have completed all work on the study. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to the data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised, so that you could not be identified. We do not expect to share our data in countries whose data protection laws differ to those of the UK.

Although what you say in your conversations with patients is confidential, should you disclose anything which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time (up to 14 days after the consultation), without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about

you that we have already obtained as we are not allowed to tamper with study records. However, we will not start with any analyses for at least 14 days after the consultation. This means that if you wish to withdraw within 14 days, we will not transcribe and use your consultation in any analyses, but we will not erase the audio-recording. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Involvement of the patient

Just like you, each patient will also be informed about this study and needs to give informed consent for the audio-recording as well.

What will happen to the results of the research study?

The results of this study will be written up as part of an educational qualification (PhD) at the University of Nottingham which is due to finish in June 2025. The results will also be discussed at research meetings and potentially written about in research journals. Your personal details will not be given in any presentation or publication.

Further information and contact details

For further information, please contact:

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Appendix 8. Optional Authorisation Form

University of Nottingham
UK | CHINA | MALAYSIA

UKRI Economic and Social Research Council

Optional Authorisation Form for Participants
(Final Version 1.1 date: 15.12.2023)

Title of Study: Improving the remote delivery of primary health care post COVID-19

IRAS Project ID: 315822

Name of Researcher: Prof. Alison Pilnick (Chief Investigator)
Gilian Noord

Name of Participant:

Date of Recording:

Recording anonymised label:

I am aware that standard procedures will be followed to protect confidentially. Person and place names will be removed from audio clips and voice will be altered. Audio clips will only be shown in presentations, training materials or online or in future research studies where I specifically agree to these uses.

I understand that giving consent to the additional use(s) of the recording is optional and I understand that I am free to withdraw my consent for how the audio clips can be used at any time, without giving any reason, and without my medical care or legal rights being affected.

Where I have initialled, I agree to the following use(s) of the recording.

A.	**Audio clips may be played to other researchers** I agree that audio clips from this recording may be used in closed sessions with other communication researchers, within and outside the University of Nottingham, to help strengthen the research results.	
B.	**Audio clips may be played at presentations about the research** I agree audio clips from this recording may be used in talks about this research for professional audiences of researchers, health and social care staff and trainees or to patient and public involvement groups	
C.	**Audio clips may be used in communication skills training materials** I agree that audio clips from this recording may be used in communication skills training materials for courses with appropriate registration. I understand that names will not be revealed during training sessions and my voice will disguised when the clips are played.	
D.	**Clips may be used for future research** I agree to use the audio recording for future research aiming to better understand other areas of communication needed for good care. I understand that some of these studies may be carried out by researchers other than the current team who ran the first study.	

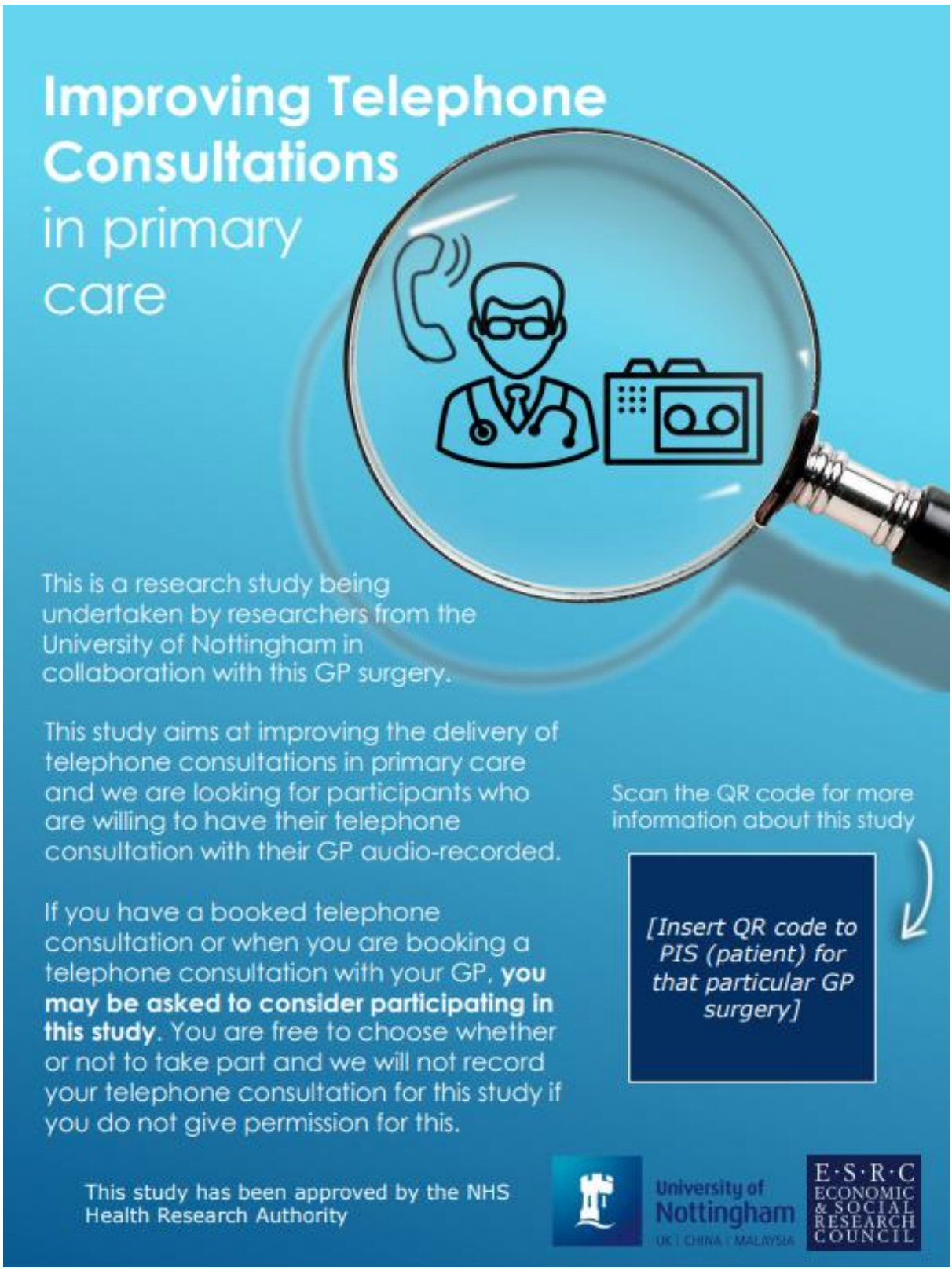
_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes (if patient participant)

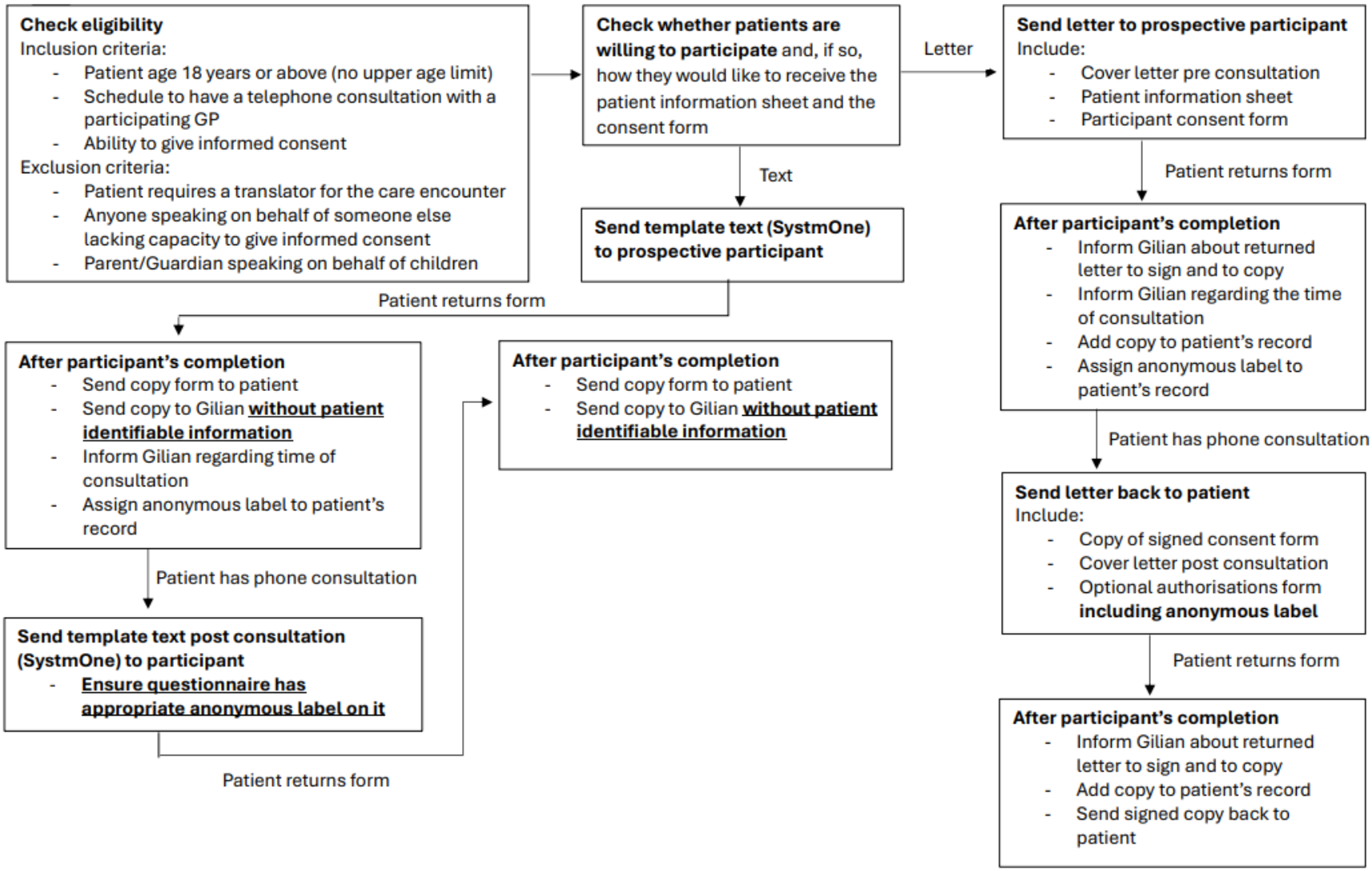
Appendix 9. Consultation Room Cue Cards



Appendix 10. Waiting Room Poster



Appendix 11. Flowchart Patient Recruitment



Appendix 12. Texts for Patient Participants





Text pre consultation
(Final version 1.1: 18.03.2024)

Dear [insert name]

Thanks for considering taking part in our study.

Please read the information sheet before completing the form.

If you decide to take part, please complete this form below where you will also find a link to the information sheet:[insert link to SystmOne questionnaire].

Text post consultation
(Final version 1.0: 29.08.2023)

Dear [insert name]

Thanks for taking part in our study.

Please complete the optional authorisation form: [insert link to SystmOne questionnaire].

Appendix 13. Cover Letters for Patient Participants





Cover letter pre consultation
(Final version 1.0: 29.08.2023)

Dear [insert name],

We are writing to invite you to take part in a research study being undertaken by the University of Nottingham in collaboration with our GP practice. This research aims at improving the delivery of telephone consultations in primary care and we are looking for participants who are willing to have their telephone consultation with their GP audio-recorded.

Our records show that you could be eligible to take part, because you have a booked telephone appointment with a GP at our practice. If this is not the case, please accept our apologies and ignore this letter. If you are interested in finding out more about the study **please read through the enclosed Participant Information Sheet**, which provides you with all the details of the study and answers particular questions you may have. We have not given your personal details to the researchers and you are not obligated to take part in the study.

If you read the enclosed information sheet and decided to take part in the study, **please carefully read and sign the enclosed Consent Form**. Please enter your name on the top, initial the boxes and sign the form at the bottom, **and return it in the stamped envelope enclosed**. The Participant Information Sheet must not be returned and is yours to keep.

If you would like to have an informal chat about the study, you can contact the research team by phone or text on 07564844909 or e-mail on gilian.noord@nottingham.ac.uk.

Thank you for reading this letter and considering taking part in this study.

Your sincerely,

[insert name]

Cover letter post consultation
(Final version 1.0: 29.08.2023)

Dear [insert name],

We are writing you because you took part in a research study being undertaken by the University of Nottingham in collaboration with our GP practice. For this research you agreed to have your telephone consultation with a GP audio-recorded. If this is not the case, please accept our apologies and ignore this letter. A copy of the signed Consent Form you sent to us before your consultation is enclosed and is yours to keep.

As is described in the Participant Information Sheet, we would like to ask you to **carefully read and complete the enclosed Optional Authorisation Form.** This form allows you to tell us who, in addition to members of the research team, may listen to your recording. No-one outside the research team will use or hear the recording unless you provide written authorisation at this point. We will only use your recording in the ways that you authorise us to.

Please enter your name on the top, initial the boxes and sign at the bottom/the back of the paper, **and return the form in the stamped envelope enclosed**.

If you would like to have an informal chat about this, you can contact the research team by phone or text on 07564844909 or e-mail on gilian.noord@nottingham.ac.uk.

Thank you for reading this letter and taking part in this study.

Your sincerely,

[insert name]

Appendix 14. Observation Form





Observation Form

Date:

Recording anonymised label:

Has the patient previously had an in-person appointment with the GP?

Yes No

Does the patient have any previous experience with telephone consultations?

Yes No

First time consultation about concern or follow-up?

New concern Follow-up

Reason/context for consultation


University of
Nottingham
UK | CHINA | MALAYSIA


UKRI
Economic
and Social
Research Council

Notes