

When 'yes' means 'no':

why the small details of clinical interactions matter

We welcome the inclusion in this month's *BJGP* of the article by Albury *et al*, which employs Conversation Analysis (CA) to understand how weight-loss interventions can be introduced effectively into the discourse of general practice consultations.¹ It shows how the initial spoken responses of patients who are offered weight-loss management services by their GP, demonstrate strikingly consistent patterns in relation to subsequent uptake of these services. Somewhat surprisingly, 'yes' or 'yeah' responses did not have a significant association with attendance. On the other hand, responses prefaced with 'oh' (for example, 'oh right, I'll try anything') did have an association with attendance at weight-management services.

The findings demonstrate how bringing together evidence from a large number of audiorecorded consultations (226 recordings in this study) in this kind of research can challenge some of the assumptions we might otherwise make about our talk. The study is unusual as it took place within the context of a trial, enabling the researchers to integrate their analysis with statistical data about actual attendance at the suggested service. They have demonstrated, in a nuanced way that these interactional patterns are relatively predictable. We make the case that the empirical study of interaction, though time-consuming, is crucial if we are to provide communication skills guidance to practitioners and students that is effective for real-life practice and takes full account of the consultation as a co-constructed accomplishment.

WHAT IS CONVERSATION ANALYSIS AND WHAT CAN WE LEARN FROM IT?

CA is the study of naturally-occurring interaction. It has a long tradition in medical settings but remains poorly understood by the majority of clinicians. Studies which employ CA rarely grace the pages of mainstream medical journals. This is surprising, given the central role of interaction in medical work.

Social interactions happen so frequently in day-to-day life, that it is easy to overlook their complexity. Social action is jointly accomplished in interaction; when we talk, we do work. Since its inception in the 1960s, CA has demonstrated that conversations — even apparently mundane conversations

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— are intricate, systematic achievements.² They involve a coordinated system of turn-taking, locally organised sequences of talk, and speaker transitions which operate quickly, below an immediate level of consciousness. Making these patterns explicit is a useful method for understanding and applying effective communication in the workplace, including the consultation room.

CA has made many contributions to our understanding of medical consultations. For example, West studied 'troubled' sequences of talk between doctor and patient,³ and Frankel⁴ conducted a 'microinteractional' analysis of sequencing in the medical consultation. CA has shown how diagnostic information is delivered at the level of the interactional turn,⁵ how parents and paediatricians negotiate decisions about antibiotic prescribing⁶ and how 'lifestyle' advice (for example, smoking) is problematised by the doctor.⁷

One of the best known contributions of CA is the work of Robinson and Heritage who showed that patients are more willing to volunteer additional unmet concerns during a consultation, if the doctor asks 'Is there something else you want to address in the visit today?' rather than 'Is there anything else you want to address in the visit today?'⁸ They also showed the importance of question design at the opening of a consultation. For example, making a general enquiry ('What can I do for you today?') is more effective in eliciting the patient's account than a closed request ('Sore-throat, huh?').⁹ Changing

interactional moves can therefore be shown to alter outcomes in the clinical encounter.

RELEVANCE OF CONVERSATION ANALYSIS IN CONTEMPORARY GENERAL PRACTICE

The focus of Albury's paper (regarding referral to a weight-management programme) is highly relevant to primary care clinicians who are increasingly expected to weave into their consultations a range of imperatives that may or may not align with the primary focus of the consultation — usually with no additional time available. Research that 'zooms in' on the interactional details can offer important insights into how to handle these imperatives and — as this paper suggests — may guide action regarding whether, how, and to what extent to invest valuable time in their pursuit.

There has been a seismic shift in general practice in recent years, making interactional understandings of the encounter increasingly important. The focus on risk management, combined with the redistribution of work between professionals and a context of externally imposed directives and performance metrics, means that inter-agency referrals regarding 'lifestyle' issues, and the 'negotiation work' that necessarily ensues, are commonplace.

Previous work has shown the role of computers in prompting such 'institutional' health promotion talk and how this

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presents challenges which are quite different to the incorporation of such advice as 'professional talk' when the moment seems appropriate.^{10,11}

Research such as that championed in this issue by Albury *et al* cautions us to gather evidence about the small details of practice 'on the ground' before uncritically adopting wholesale system changes. Asking clinicians to recommend weight-management programmes to patients – even those available for free – costs GPs' time and demands new 'work' of the clinician-patient interaction.

Albury *et al* also challenge clinicians to remain alert to how they hear patients' responses and to remember that language is inherently ambiguous, imbued with meaning and intentions which may not be immediately apparent. Even 'straightforward' utterances (such as an unqualified 'yes') can be inherently contradictory – an important warning not only to clinicians, but to the designers of information systems that assume a binary world stripped of its interactional nuance and local context.

IMPLICATIONS FOR FUTURE RESEARCH

Over two centuries ago, William Osler famously directed doctors:

'Listen to your patient; he is telling you the diagnosis.' (William Osler, 1849–1919)

However, practical guidance on how small-scale features of interaction play out in practice, and how clinicians can listen more effectively, is scarce. We might conclude from Albury *et al's* study that closely listening to the patient is valuable in indicating the patient's 'readiness to change'. The research offers clinicians some interactional clues to listen out for in the consultation. These are clues which can inform strategic decisions about how best to use valuable consultation time, and also act as a guide to likely patient action that goes beyond the talk.

Crucially, the study speaks to research funders of the importance of supporting

research which focuses on consultations; it speaks to clinicians of the importance of paying attention to the small details of consultations; and it speaks to policymakers, serving as an apt reminder that with every new service redesign comes a demand on GPs – often hidden from view – to learn new ways of negotiating their practice.

The paper sets out an important research agenda for primary care. Not only are the findings of direct relevance to everyday general practice, but the authors venture into relatively uncharted territory in embedding a CA study within a RCT, thus opening up potential for further explanatory and interpretive work. This is an exciting development and one which could enrich future primary care research.

The value of microinteractional analysis, as a counterpoint to more quantitative, statistical methods in healthcare, has been convincingly argued,¹² but in combination these methods can be seen here to provide a powerful understanding of the GP encounter. Bringing these different research worlds together inevitably brings epistemological challenges; it is likely that particular care is needed to avoid reducing the complexity of interactional work to reductionist modes of explanation. But we hope it may pave the way for more research that takes the microscope to the details of talk and reveals phenomena we would not otherwise see.

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