What happens when patients say "no" to offers of referral for weight loss? - Results and recommendations from a conversation analysis of primary care interactions

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Abstract

Objective

Guidelines recommend that clinicians should offer patients with obesity referrals to weight management services. However, clinicians and patients worry that such conversations will generate friction, and the risk of this is greatest when patients say no. We examined how doctors actually respond to patient refusals, and how patients reacted to clinicians in turn.

Methods

Conversation analysis of 226 GP-patient interactions recorded during a clinical trial of weight management referrals in UK primary care.

Results

Some clinicians responded to refusals by delivering further information or offering referral again. These actions treated patient refusals as unwelcome, and acted to pursue acceptance instead. However, pursuit did not lead to acceptance. Rather, pursuing acceptance lengthened consultations and led to frustration, offence, or anger. Clinicians who accepted refusals and closed the consultation avoided friction and negative emotional displays.

Conclusion

Patient refusals have the potential to create negative consequences in the consultation and clinician responses were key in avoiding these. When clinicians acknowledged the legitimacy of patient refusals, negative consequences were avoided, and the conversation was briefer and smoother.

Practice Implications

When patients refuse the offer of a free weight management referral, GPs should accept this refusal, rather than trying to persuade patients to accept.

Highlights

- We identify how clinicians respond when patients refuse an offer of a free weight management referral in UK primary care.
- When patients refused an offer, some clinicians tried but failed to persuade them to accept, leading to displays of frustration and anger.
- Other clinicians accepted patients' refusals and closed the consultation swiftly and smoothly.
- When patients refuse an offer of referral to weight management services, clinicians should accept this. Interactional trouble is likely if not.

1. Introduction

General practitioners (GPs) are advised to offer patients with obesity support to lose weight[1-5]. Multiple national guidelines recommend that GPs opportunistically engage in brief weight loss interventions with adult patients who have a BMI>30[6-9]. These interventions comprise of discussing weight and offering referral to effective behavioural weight management programmes. Commercial weight management services are more effective than primary care services[10] and, from 2021, every GP in England will be able to offer these referrals. Whilst offering referral opportunistically can increase patient access to effective weight loss services, discussing weight can be a delicate issue[11], and many clinicians report concerns about discussing weight[12]. These include lack of confidence that the discussions will be well received[13]; concerns that patients will react negatively, including being offended[13]; and beliefs that they will damage ongoing relationships[13, 14], discouraging future care seeking[14]. Reviews suggest that patients may welcome discussions about weight loss, particularly from their GP, and talking about the different options available can be helpful[15]. Patient reports also emphasise that how GPs communicate during these discussions is important, as certain ways of communicating could evoke feelings of blame[16], stigma[17], or discrimination[15]. Existing research shows that discussions about weight loss are indeed interactionally delicate, and indicate that clinicians need more support navigating this delicacy with their patients[18].

Studies of weight management referrals have focussed on how clinicians raise the topic, and offer referrals in a helpful and supportive way[19]. Of course, not all patients accept these offers. In terms of how refusals actually happen, research has consistently shown that they are complex interactional actions[20], with great potential for negative consequences. If refusals occur in an interactional environment that is already sensitive, consequences can be particularly negative, producing misalignment between the parties. In conversations about weight loss, which both clinicians and patients claim to be interactionally delicate with strong potential to cause offence, it is important to know how clinicians might best respond to refusals, and the implications of this response for the rest of the interaction. Learning how best to respond to refusals in this context is also likely transferrable to managing refusals of other offers in clinical settings.

Conversation analysts have paid considerable attention to how refusals are actualised[20]. Refusals are dispreferred interactional actions, and are typically indirect and delayed when they are produced. They are usually followed by justifications, or accounts, displaying the underlying reasoning. In healthcare interactions where clinicians hold greater authority[21] and access to medical knowledge, explicit displays of refusal are rare[22], and little is known about the best way to respond.

In this paper we focus on how GPs responded when patients refused an offer of referral, and what happens next. We use conversation analysis, a well-established method for studying clinical interactions[23, 24] and highlighting recommendations for practice[25] to analyse real consultations recorded as part of a clinical trial examining the effectiveness of free referrals to weight management[26]. Our objectives were to:

- Illuminate how GPs responded when a patient refused an offer of referral
- Identify which ways of responding mitigate the potential for negative consequences
- Recommend ways that clinicians can best navigate conversations when patients refuse a referral

2. Methods

2.1 Context – the BWeL trial

The BWeL trial was a parallel two-arm, randomised controlled trial assessing the effects of GP-delivered very brief opportunistic weight loss interventions in primary care. At the end of a typical 10-minute consultation, GPs either offered patients very brief weight loss advice (advice arm), or endorsed, offered, and facilitated a free 12-week referral to a community weight management service (CWMS) (support arm). GPs were trained in what to do but were encouraged to use their usual style, and aim to deliver the entire intervention within about 30 seconds. Patients were followed-up to assess their responses to the intervention, and what actions they had taken afterwards. Interventions were generally well accepted and led to uptake of the behavioural support programme, and weight loss[26].

2.2 Audio recording processes

Half the participants in each arm were randomly selected for audio recording. Patients could decline audio recording, or request deletion afterwards. Audio recordings were collected on hand-held recorders, turned on by GPs at the start of the intervention discussion. The recorder was visible to both parties. Some GPs did not record, although prompted; some participants did not consent to be recorded; some recordings were rendered unusable for technical reasons; some GPs delivered advice rather than offering referral; and many of these recordings were not uploaded by the research team as they did not prioritise it. This meant that, of 470 potential recordings, a total of 226 (49%) were available for analysis. Recordings were 8-458 seconds long (average, 95 seconds). Ethical approval was granted by the NHS Research Ethics Service (reference: 13/SC/0028).

2.3 Analysis

We used conversation analysis (CA) and transcribed data using Jeffersonian conventions[27] which capture how talk is delivered, including speed, pitch, and turn construction. We

mapped referral sequences systematically and located where and how refusals were produced. Refusal was defined as hearable explicit rejection, such as “No”[28]. Analysis focussed on how GPs responded to patient refusals, and the implications for the interactional sequence. We conducted a detailed analysis of word choice, action format (e.g., refusal, and response to refusal), sequential positioning, deviant cases, and prosody. We used what conversation analysts term the ‘next turn proof procedure’[29] to identify how clinicians responded and the interactional consequences. Excerpts are presented to illustrate and exemplify findings. Identifying information has been removed.

3. Results

From 226 audio recorded consultations we identified 26 cases where the patient’s initial response to being offered a free CWMS referral was a hearable explicit refusal[28], such as “No” or “No, Not interested”.

```
1  Doc:    It’s going to <Slimming World> which
2          is to do with u:m (.) advice on u::m
3          (0.6) your diet.
4          (.)
5  Doc:    Um a:nd what to eat, And they (.)
6          they sort of see you, And they-
7          (0.4) they weigh you every week.
8          (0.4)
9  Doc:    Would you be °interested° in going
10         along to a group like that?
11 Pat:→   U:m no,
12         (.)
13 Pat:    Not really.
14         (.)
15 Pat:    I wou- probably wouldn’t have the
16         time with all the ex- (.) things
17         I do anyw(h)ay. Huh.
```

Excerpt 1

Excerpt 1 illustrates an explicit refusal within a typical intervention. GPs usually started by announcing that a referral was available and providing some information about it (lines 1-7). Patients typically did not respond verbally to this information. GPs next would ask a ‘referral question’ (lines 8-10) enquiring if a patient would like to take up this offer. Refusals were typically the first response produced after these referral questions (lines 11-13). Refusals could be hedged or mitigated, (e.g. “U:m no, (.) Not really”, lines 11-13) or could be delivered immediately, without mitigation. Refusal was often accounted for by patients in their subsequent turns. Although refusal is a delicate interactional move, accounting, hedges, and hesitations act to mitigate some potential awkwardness. This patient accounts for rejection from lines 14-17, by stating that they do not have time to attend.

Clinicians commonly responded to these refusals either by (a)expanding the sequence to provide further information about the benefits of weight loss (12/26 consultations), or

(b)acknowledging patient responses but abandoning the sequence and moving to close the consultation (11/26 consultations). A third type of response was used in 3/26 consultations by a single clinician, and extended consultation time beyond what is typically available. Therefore, we focus here on the two most common responses. We noticed marked differences in the consequences of each approach. We now examine these two typical clinician responses to displays of explicit refusal, and what happened next.

(a) Responding to refusal by providing further information about the benefits of weight loss

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

Excerpt 2

In Excerpt 2 the clinician has informed the patient that a free referral is available, and explicitly asks if they would be interested (line 1). Following the patient's response "Not really" (line 3), the GP repeats this, and the patient upgrades their response to a clear refusal, "No". In response the GP asks the patient a negatively framed question 'not thought about losing weight?' and then associates weight loss with the patient's health. The patient then engages in moral justification to account for the refusal, stating he has had operations and his "knees are shot" which prevents him from exercising. This moral work shows that the patient is orienting to their responsibility to 'be a good patient' by 'emphasising the role of unavoidable or external factors'[30]. He then extends his moral work, justifying his lifestyle as healthy, stating he does not smoke, or drink "that much", hearably resisting the

perceived need for referral. The patient's non-lexical "pfff"(line 19) conveys exasperation with the conversation[31]. This is followed by a rhetorical question "Do I really want to then start going on a diet?"(line 21).

```
24            (.)
25 Doc:       .tch ↑There is evidence that shows that it i-
26            is >a good way< to help people lose
27            we[ight,
28 Pat:         [I thin[k so.
29 Doc:               [(exactly)if exercise is ↓difficult.=
30            =[Uh.
31 Pat:        [You also- >you also< categorise people into
32            .hh (0.3) e::r a category that maybe: (0.4) m:y
33            size and frame isn't necessarily the same as your
34            size and frame a::nd,
35 Doc:       >I appreciate that<,
36            (.)
37 Doc:       =[Uh.
38 Pat:       [#(°U::h°)# I just get angry about it >°to be
39            quite honest°<.
40 Doc:       Yea- #e:- i:- e:-# .hh which is where sometimes
41            it- this (.) conversation can- [can be delicate.=
42 Pat:                                      [Yeah that's fine,
43 Doc:       =And [that- th- and that that's why the,
44 Pat:            [#I- I- I- I'm# not against it.=
45 Doc:       = Ye[a:h,
46 Pat:           [I'm not against it, I know people that have
47            been on diets for forty odd years °and (0.5)
48            you know°.
49            (1.3)
50 Doc:       The choice is there [if you,
51 Pat:                           [Oka:y. No that's fi:ne.
52 Doc:       It's your choice e::r whether you u::h #ar#
53            want to take up the offe::r- >offer or not
54            really.<
55 Pat:       No. I think- [I think-,
56 Doc:                    [We would- we [would encourage you,
57 Pat:                                  [I- I- I could do that
58            off my own back (I think).=
59 Doc:       =We would encourage you to- to do so.
60 Pat:       Okay.
61 Doc:       That's all I'll tell you about °(that)°.
```

Excerpt 3

This discussion continues in Excerpt 3, where the GP responds to this extended resistance display by providing information about the evidence base for CWMS (lines 25-29), emphasising the benefits for people, like this patient, who have barriers to exercising. In providing further information this GP is orienting to the refusal as inapposite. The GP seems to be indicating that being given more information may mean the patient can produce a different (positive) response.

The patient though, moves from a resistance display asserting a healthy lifestyle, to an upgraded display explicitly resisting the "category", possibly of being obese or overweight.

He asserts that his “size and frame” are different from the GP’s size and frame, potentially implying that he looks larger because of his body shape, rather than due to carrying unhealthy fat (lines 31-34). Following the GP’s acknowledgement, the patient upgrades his initial display of frustration to anger, saying “I just get angry about it to be quite honest” (lines 38-39). The GP orients to this upgraded response by acknowledging that these conversations can be “delicate” whereupon the patient mitigates his previous display to saying he is “not against” it (lines 44-46). The GP states “the choice is yours” (line 50), which the patient acknowledges. However, the GP *again* states it is the patient’s choice and the patient responds with another “no” (line 52). He begins what is projectable as an account following this “I think-”, but the GP overlaps this turn, explicitly encouraging the patient to take up the referral (line 56), again displaying pursuit of acceptance, although the patient has now rejected the referral twice. The patient restarts his abandoned turn saying, “I can do it off my own back” (lines 57-58), and the GP again states he would encourage the patient “to do so”. This turn is hearable as a restart of the GP abandoned turn at line 56, which was encouraging CWMS attendance, and is not preceded by any acknowledgement of the patient’s turn suggesting self-directed weight loss. Therefore, the placement of this turn, makes “do so” hearable as still referring to CWMS attendance, rather than the self-directed weight loss the patient mentions.

To summarise, in this excerpt we see the patient refuses the referral offer. Response is then pursued by the GP through delivery of additional information, acting to persuade the patient to attend, which receives a strongly upgraded resistance display. The interaction becomes increasingly difficult, as the GP then offers referral a second time, which is again rejected. The GP tries again to pursue a response, explicitly encouraging the patient to accept, despite escalating refusal responses. The GP does not acknowledge the patient’s response as legitimate, and the interaction ends in this negative interactional environment.

In some cases, interactional troubles were even more visible. The next excerpt shows a similar pattern of pursuit from the clinician, and a significant display of frustration from the patient.

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

Excerpt 4

In this excerpt, the GP is offering a referral to the patient whose partner (Par) is also present. The patient's first response following completion of the announcement is a display of refusal, hedged with an "U::m" preface delaying the production of the (dispreferred) response "no"(line 13). At line 14, the GP says, "is that- you wouldn't be interested at all". This may act as the GP confirming she has heard correctly, or as a challenge to the patient's response. The patient initiates a response which is cut off, "I've not-" and his partner starts to speak inaudibly. The patient forcefully "sh"s her, acting to cut off her turn and to display some frustration, or annoyance. He then produces an extended account which acts to assert his ability to lose weight without support. His use of hardened consonant sounds and short turns, act as a further display of frustration, or annoyance. Despite this rejection the GP provides more information about the medical benefits of

weight loss (lines 33-37). This potentially indicates that these displays of refusal were taken as displaying "trouble with or inadequacy of the invitation or offer"[28], which further information might rectify. However, the patient's responses become short, unmarked, acknowledgements, potentially conveying frustration.

```
38 Pat:    Okay.
39 Pat:    So how about if you come back and see me: in
40 Doc:    about a month's time and I can weigh y[ou.=
41 Pat:                                          [Yeah.
42 Doc:    =Again.Th[en. And we can see if you've managed=
43 Pat:             [Okay.
44 Doc:    = to (.) lose any.
45 Pat:    °Okay, (.) Yeah°.
46 Doc:    Okay and then we can have another chat about what
47          >sort of< (.) further plans that you might have
48         (.) to help you lose weight, Or whether we need
49         to >sort of< rethink things then.
50 Pat:    That's fine.
51 Doc:    >And then I can check your blood pressure again
52         [then as well<.
53 Pat:    [Okay.         That's fine.
54 Doc:    Is that all right?=
55 Pat:    =That's fine.
56 Doc:    So if you'd like to make an appointment for a
57         month's ti:me,
58 Pat:    Okay.=
59 Doc:    =Okay.
60 Pat:    Yep. Fine.
61 Doc:    And now I'm going to switch this thing off.
62 Pat     Good.
63 Par:    hh hhh [hh h hhh hh
64 Doc:           [hh hh h h
```

Excerpt 5

The discussion continues in Excerpt 5 and, even though the patient rejected the offer of referral at line 13, the GP invites him to come back so she can weigh him "to see if you've managed to lose any". This implies that she expects him to lose weight, despite his refusal of the offer of support to lose weight. She then says that, at this appointment, they can also review what plans "you might have" to lose weight, and says that they can "rethink" things then, seemingly ignoring his extended account (lines 17-31)where he strongly asserted that he did not want help. This turn is responded to by the patient with a sharp, clipped "That's fine." which he repeats with the same prosody over his two subsequent turns, acting to display frustration, moving the sequence forwards without displaying agreement to the proposal. He responds to the GP's subsequent confirmation checks with "Yep. Fine." which act as a display of passive resistance, specifically to the GP's offer to make an appointment in a month. Resistance has strengthened throughout this sequence, from an initial account to clear displays of annoyance. On line 61 the GP says, "I'm going to switch this thing off" (the audio recorder), and the patient responds immediately with a clipped "Good", displaying that terminating the recording, and thus the consultation, is a very welcome

action. The patient's partner starts to tentatively laugh (line 63), which the GP joins, collaborating to attend to the awkwardness of the interaction. The patient does not join this laughter sequence, further evidencing his display of frustration.

The most common GP responses following displays of refusal were those shown in these five excerpts. GPs would follow a display of refusal (or a subsequent account for refusal) with turns which acted to provide more information about acceptability of the offer, or of weight loss in general. In resisting rather than accepting refusal, the provision of additional information in these turns can be seen as attempts to convince or persuade patients to accept. Despite the frequency of these attempts there were no examples where patients moved from refusal to acceptance following 'convincing' or 'persuading' turns from the GP. Instead, this approach was usually followed by extended resistance displays from the patient.

(b) Responding to refusal by acknowledging the patient's response and moving to close the consultation

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

Excerpt 6

In Excerpt 6 the GP has announced that a referral is available, at line 1 he asks "Would you be interested in doing something like that or not?". The patient produces a refusal "No" (line 3). This is followed by a mitigator "Not really". The patient then initiates another turn, pause, and restarts her turn with a second refusal "No". The patient potentially initiates an account at line 3 following her refusals "it's" overlapping with the GP's information receipt:

"You don't feel as though you want to do that at the moment.". Rather than restarting her abandoned turn, the patient responds with a third "No" response, and the GP acknowledges this saying "Okay" (line 8). In the GPs next turn, he assesses this response with a sequence closing "that's fair enough", and then initiates closings by arranging another appointment. The patient produces minimal responses throughout the closing sequence, however these have affiliative characteristics in their placement in overlap with the GP's talk, and they act collaboratively to move the sequence to close[32].

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

Excerpt 7

Excerpt 7 illustrated a similar pattern. The GP topicalises weight at line 1, asking "Have you ever thought about doing anythink about the weight?". The patient responds at line 4, after a pause, with a preferred response "Yes". The GP then asks if the patient would "be interested in using one of the slimming clubs" acting to "test the water"[33], for the upcoming referral through eliciting the patient's perspective[34]. The patient produces a dispreferred response "no". The GP then does an information receipt ("No. Not at all."), and then states that the slimming club would be free, acting as an implicit offer. The patient produces a second "no" response (line 9), here refusing the offer. This is followed by a confirmation check from the GP "Nope, Not interested?" which received a second "no" response. The GP acknowledges this with an "Okay. "That's fine".

These excepts illustrate that GPs who did an information receipt following a display of refusal, and acknowledged the patient's rejection as a legitimate response did not generate the escalating resistance displays shown when GPs pursued responses. As their responses were oriented to as legitimate, patients also did not engage in lengthy moral work accounting for their rejection or, indeed, provide any account for their decision. As a result, these discussions were both very brief, but also ended in a positive interactional environment.

4. Discussion and Conclusion

4.1 Discussion

We identified two common patterns in how GPs responded when patients explicitly rejected the offer of a free referral to a community weight management service. In some consultations, GPs followed displays of rejection with subsequent versions of the offer, or delivery of additional information, acting to convince or persuade patients to accept. These GPs often followed this further information by offering a referral again, which was consistently rejected. Often this second rejection was followed by upgraded and lengthy resistance displays from patients, which conveyed frustration or annoyance, and the GP would then move to close the consultation in this negative interactional environment. The evidence from our conversation analysis indicates that this approach was time consuming, potentially harmful, and did not result in any change in the patient's initial response.

Conversely, in other consultations, GPs acknowledged rejection, gave an information receipt, and assessment of the patient's response (e.g., "Okay, you don't want to go. That's fine."), then moved to close the consultation. This did not generate resistance displays and, in many cases, patients showed positive, affiliative responses in the closing turns. These conversations were also briefer than when GPs delivered further information. By responding in this way GPs demonstrated how they can respond to rejection and expedite collaborative closing without generating resistance displays.

Previous conversation analytic studies have focused on how patients achieve the refusal of a clinician's offer[35, 36]. We contribute analysis of how doctors responded to refusals. We observed that clinicians frequently (and unsuccessfully) pursued a positive response from patients following rejection displays. Opel et al's study of vaccine hesitant parents found that, if rejections were pursued by clinicians, around half of parents who initially resisted would agree[37, 38]. In contrast to Opel's work, we found that pursuing acceptance was not successful when offering referral to weight management.

Delivering more information was the most common pattern observed in this collection following displays of rejection. As in ordinary talk, rejection was taken as displaying "trouble with or inadequacy of the invitation or offer" and, as such was often followed by attempts to remedy the source of the trouble, and then by a subsequent offer[28]. However, rather than remediating the trouble, these attempts to pursue agreement through providing more information often escalated rejection displays. These findings align with a systematic review of health behaviour change talk in clinical settings which indicated that pursuing responses after resistance displays often resulted in further displays of resistance[39].

Our existing research has shown that clear communication when offering referrals can avoid refusals in many cases, as these may be grounded in misunderstandings of what is being offered (such as misunderstandings that the referral is free)[19]. However, even when misunderstandings are avoided, refusal is a valid choice for patients who do not wish to uptake. Here we build on this previous work and show how best to respond to refusals.

Our results illuminate reports from interview studies with doctors and patients, showing that there is potential for patients to be offended or upset[16, 40]. However, our data showed it was not necessarily the discussion of weight-loss itself that engendered these responses, but how doctors responded to rejection. Patients became upset or angry as GPs did not acknowledge their responses as legitimate and, in some cases, continued to discuss weight-loss even when the patient had indicated they did not want to talk further.

Although patients do *resist* treatment recommendations[41, 42] overt *refusals* are rare in healthcare settings. One recent study, however, showed that overt refusals may occur if the preceding offer or request is formulated with 'low entitlement' (e.g. clinicians display they have limited authority to make a request) and 'high contingency' (e.g. clinicians indicate the patient may not be able to comply with that request)[22], which serve to open up the option of refusal. In our data many offers were also low entitlement/high contingency in their formulation (e.g., 'it's completely up to you'). As with O'Brien et al's study, we found that, although offers were designed to make refusal a relevant option, clinicians nevertheless treated the choice to refuse as inapposite. These actions contrast with English guidelines, which advise that, when discussing weight loss, GPs should "recognise that this may have been raised on numerous occasions and respect someone's choice not to discuss it further on this occasion."[3].

Three reasons potentially underpin clinicians' attempts to persuade a patient to accept. Given that clinicians report concern that offering advice alone to patients with obesity is not effective, the ability to recommend weight management services, free of charge, may have led to GPs trying to convince or persuade a patient to attend something with good evidence of proving effective support. Secondly, as clinicians were taking part in a trial, they may have been pursuing a 'yes' more than they might normally. Another underlying reason, however, may relate to weight stigma in clinical settings. People from stigmatised groups are less likely to receive person-centred clinical communication, and research has shown that men living with obesity are less likely to experience person-centred care[43]. Shared decision making is an important aspect of person-centred communication and, by not acknowledging a patient's choice to reject referral as a relevant response, clinicians omit this key aspect[44]. Doing so may be a manifestation of weight bias which is commonly reported among healthcare providers[45].

A strength of this study was our conversation analysis of recorded data. This meant that analysis was not led by the analysts' a-priori assumptions nor limited by recall or social desirability biases. Data were collected across several surgeries and from diverse patient groups. A limitation was that data were audio only, and we could not analyse embodied conduct. Another limitation is that other approaches may also be appropriate to use following rejection, but these were not present in our data.

4.2 Conclusion

When patients declined a referral to a weight management service, GPs commonly attempted to convince or persuade them to accept, whilst others moved the consultation to a close. No patient changed their response after attempts to convince or persuade but this strategy did lead patients to express frustration. Alternatively, when doctors acknowledged the legitimacy of the patient's refusal, and moved the consultation to close the consultations appeared to end positively. Consequently, we recommend clinicians accept this initial refusal.

4.3 Practice Implications

GPs worry that talking about weight could cause offence or upset. Our findings highlight that when patients refuse an offer of referral for weight loss some GPs attempted to convince or persuade them to accept. This approach did not produce acceptance, and could produce negative interactional consequences, as patients became frustrated or upset. Instead of trying to convince or persuade patients to accept, doctors should acknowledge a patient's choice as legitimate, and move to close the consultation. This approach follows a patient-centred model[44], and is likely to avoid causing offence, thereby addressing many concerns about having these conversations.

CRediT author statement

Charlotte Albury: Conceptualisation, Methodology, Investigation, Funding acquisition, Writing - Original Draft, Writing - Review & Editing. **Helena Webb:** Methodology, Investigation, Formal analysis, Writing - Review & Editing. **Sue Ziebland:** Conceptualisation, Investigation, Writing - Review & Editing. **Paul Aveyard:** Conceptualisation, Investigation, Supervision, Funding acquisition, Writing - Review & Editing. **Elizabeth Stokoe:** Methodology, Investigation, Formal analysis, Writing - Review & Editing

Conflict of Interest

Slimming World and Rosemary Conley donated free weight-management courses for NHS patients enrolled in this trial. PA was an investigator on a trial part-funded by Cambridge Weight Plan. PA spoke at a symposium at the Royal College of General Practitioners Conference that was funded by Novo Nordisk. CA co-developed guidelines for general practitioners on discussing weight. The guidelines were published by Obesity UK and the development of it was supported by Novo Nordisk. None of these activities led to payments to the investigators. The other authors declare no conflicts

Acknowledgements

We are grateful to the NHS doctors and patients that took part in this study and the other investigators who made it possible.

Funding

Charlotte Albury is funded by a Mildred Blaxter postdoctoral fellowship from the Foundation for the Sociology of Health and Illness and by the National Institute for Health Research School for Primary Care Research. The consultation data was from the BWeL trial which was funded by National Prevention Research Initiative. The funding partners are Alzheimer's Research UK, Alzheimer's Society, Biotechnology and Biological Sciences Research Council, British Heart Foundation, Cancer Research UK, Chief Scientist Office, Scottish Government Health Directorate, Department of Health, Diabetes UK, Economic and Social Research Council, Engineering and Physical Sciences Research Council, Health and Social Care Research Division, Public Health Agency, Northern Ireland, MRC, Stroke Association, Wellcome Trust, Welsh Government, and World Cancer Research Fund (Grant ref number: MR/J000515/1). Helena Webb is a Senior Researcher at the University of Oxford, funded by EPSRC. Paul Aveyard is part funded by the Oxford NIHR Biomedical Research Centre and NIHR Oxford and Thames Valley Applied Research Collaboration. Sue Ziebland is an NIHR senior investigator. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care.

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