Navigating epistemic challenges: Self-initiated self-repair in weight loss discussions within clinical settings

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ARTICLE INFO

ABSTRACT

This paper focuses on the phenomenon of self-initiated self-repair in weight loss discussions within clinical settings. It shows that one of the primary functions of self-repair is to manage epistemics in talk. The study explores repair operations and techniques, shedding light on the linguistic resources employed by doctors and patients to modify knowledge claims in relation to their interactional objectives, the speaker's epistemic status, and the epistemic stance expressed by the interlocutor. Throughout the paper, we demonstrate how self-initiated self-repairs contribute to achieving epistemic balance and congruence in talk between healthcare providers and seekers, supporting the smooth delivery of unsolicited weight loss advice. Data are in British English.

1. Introduction

Competent and effective communication in clinical settings is essential for the delivery of recommendations and treatment, as well as for building interpersonal relationships between healthcare providers and seekers. However, discussing weight management can be challenging for both parties. General practitioners (GPs) are encouraged to talk about weight loss with people living with obesity (NICE, 2014), but they are often uncertain about how to initiate the conversation, what advice to offer, and how to deliver it (Albury et al., 2019, 2021a, Warr et al., 2021, Tremblett et al., 2022a, Tremblett et al., 2022b, Albury et al., 2023, Ayre et al., 2023). Patients report negative experiences of weight loss discussions (Ananthakumar et al., 2020). Inefficient communication hinders the provision of weight management guidance (Critchlow et al., 2020; Hajizadeh et al., 2023).

The delivery of weight loss advice is problematic for several reasons. Firstly, advice-giving is inherently troublesome action both in ordinary informal (Buttny, 2004; Goldsmith, 2000; Jefferson and Lee, 1981; Riccioni et al., 2014; Zhang, 2021) and in institutional communication (Buttny, 2004; Ekberg and LeCouteur, 2015; Hepburn and Potter, 2011; Heritage and Sefi, 1992; Hudson, 1990; Wu et al., 2024; Yip, 2020). This is largely due to epistemic asymmetries between the advice-giver who has the role of a competent party and the advice-receiver who appears as a less knowledgeable participant in the interaction. The

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resulting "epistemic imbalance" (Heritage, 2012) poses a threat to the receiver's negative face (Brown and Levinson, 1987) which can hinder compliance with recommendations.

Secondly, in clinical settings, advice-giving is further complicated by the institutional roles of the participants, creating a potential clash between the doctor's professional expertise and the patient's lived experiences (refer to section 2 of the paper). This challenge intensifies when advice is offered opportunistically, without any enquiries from patients. Unsolicited advice is even more face-threatening, and it is often met with resistance (Heritage and Sefi, 1992). However, a strategic allocation of epistemic rights can save the recipient's face, effectively mitigating resistance displays, fostering alignment and social affiliation (Stivers et al., 2011). Hence, promptly addressing problematic stances has the potential to enhance the delivery of weight loss advice, ensuring a smoother interaction between healthcare providers and patients.

This paper explores how epistemics is managed in clinical interactions on weight loss through conversational repair. Focusing on self-initiated self-repairs, we analyse how linguistic resources are adjusted by speakers in the process of talking to sound more or less knowledgeable depending on their interactional goals. We show that repair is an important interactional tool that can reduce epistemic imbalances, supporting the delivery of weight loss advice.

The paper is organised as follows. Firstly, we introduce the concept of epistemics and its role in clinical interaction. Secondly, we briefly outline the notion of repair as a conversational practice, its structural elements, types and interactional import. This is followed by the description of the data and methods of the study. Then, we provide a detailed analysis of self-initiated self-repairs performed by doctors and patients. The last section concludes the paper and summarises the results.

2. Experience vs expertise: epistemics in clinical interactions

Communication in clinical settings displays asymmetries "between professional and lay person's capacities to direct the interaction in desired and organizationally relevant ways" (Drew and Heritage, 1992, p. 49). These asymmetries, first of all, arise from imbalances in epistemics, which involve "knowledge claims that interlocutors assert, contest and defend in and through turns-at-talk and sequences of interactions" (Heritage, 2012, p. 370). In the process of any interaction, participants take up certain epistemic stances, by which we mean "the moment-by-moment expressions of the speakers' relationship, as managed through the design of turns-at-talk" (Heritage, 2012, p. 377). These stances can be relatively strong (more knowledgeable) or weak (less knowledgeable). Speakers routinely orient towards the relevance of who knows what, what they are expected and responsible to know, as well as towards possible discrepancies between their own and their interlocutor's knowledge.

In linguistics, the study of epistemics primarily focuses on modality and evidentiality (Aikhenvald, 2004; Boye, 2012; Coates, 2015; Palmer, 1986), exploring how speakers use various linguistic resources to express their level of commitment to the propositional content of their assertions. Heritage (2012) offers a compelling example of this, demonstrating how different linguistic resources can be deployed to convey varying degrees of certainty about the possibility that it is raining:

> *It's raining.*
>
> *Perhaps it's raining.*
>
> *It might be raining.*
>
> *I think it's raining.*
>
> *I heard it's raining.*
>
> *I wonder if it's raining.*
>
> *Don't you think it's raining.*
>
> *Do you think it's raining?*

(Heritage, 2012, p. 371)

The resources in the example include lexical stance markers and grammatical indices of certainty and uncertainty. Besides, the speaker's (un)certainty can be expressed through certain prosodic features, such as intonation, stress, pitch, loudness, pauses, hesitations, extenders etc.

Epistemic stances expressed by interactants are dynamic, and they can be revised and negotiated as the interaction unfolds (Mondada, 2011). What we "know" is widely-recognised to be context-sensitive (Jackman, 2006). Managing epistemics in talk, speakers can either upgrade (raise/boost) their stances or downgrade (lower/limit) them (Heritage, 2012), which is again achieved by deploying various linguistic resources. For example, speakers may use certain lexical marker (like intensifiers or evidentials) to upgrade their stance, or different lexical markers (like hedges) to downgrade it.

A case of epistemic upgrading through lexical epistemic markers is exemplified in Excerpt 1 which comes from our data. Here, the GP is delivering risk and benefit information to the patient living with obesity. In line 2, the speaker performs self-repair via lexical "inserting" (Schegloff et al., 2012): they make a stop after *other* and insert the quantifier *many* before *other conditions*. The repair boosts the initial claim about the number of health conditions associated with excessive weight:

Excerpt 1

```
1   DOC:    u::m (0.4) it's gonna (.) re↑duce your risk °er° in the future
2     →     as well (0.4) o:f (.) ↑other (.) many other (0.4) conditions so
3           ↑heart disea:se stro:kes, (0.4) dia↑betes a lot of forms of ↑cancer
```

In Excerpt 2, we can observe the opposite process, i.e. epistemic downgrading achieved through hedging. The doctor compares the patient's current weight with the weight taken six months ago and informs them about weight gain. The patient responds by reporting weight loss. Initially, the speaker takes up a more assertive stance, delivering a statement (line 8): *Yeah I had lost a fair bit actually*. However, this statement is repaired at line 12 with an epistemic hedge: *I thought I had.*[1] The repair changes the statement from a factual assertion to a subjective opinion in the past, making the initial claim more tentative.

Excerpt 2

```
1   DOC:    So you go:t yourself wei:ghed an:d you:: we:::re
2           .h a hu::ndred (3.1) and [si:x.
3   PAT:                             [Six (pound)/(oh) something.
4   DOC:    Yeah.<A hundred and six. .h ↑So, it has crept
5           up a little bit ha:sn't it.=Since w- cos we la:st
6           weighed you about six nine mo:nths ago,
7           (0.4)
8   PAT: →  .sh Yeah I had lo:st a fair bi:t [a:ctually;
9   DOC:                                     [Yeah_
10  DOC:    Yeah.
11          (0.5)
12  PAT: →  Well I: thou:ght I ha:d.
```

Epistemics in clinical communication, as in many other institutional contexts, is firmly bound to membership categories, social roles and activities expected from each party. Doctors, due to their professional competence and expertise, hold higher *epistemic status* than patients. Epistemic status embraces "the parties' joint recognition of their comparative access, knowledgeability, and rights relative to some domain of knowledge" (Heritage, 2012, p. 376). Clinicians, being service providers, have "more direct, immediate, and current access to institutional information" (Lee, 2016, p. 175), as well as "superior medical knowledge to diagnose and the authority to prescribe" (Stivers et al., 2011, p. 8). Thus, healthcare professionals reasonably position themselves as more knowledgeable participants in clinical interactions.

However, patients may assert their epistemic priority as owners of first-hand knowledge. Knowledge of experiences belongs to the individuals who have lived through them (Pomerantz, 1980), so people have the right to speak about their feelings, interests, lifestyles, goals, achievements, expectations etc. Therefore, patients are considered "owners of experience" in the weight loss-related domain, while doctors are "owners of expertise" (Bolden, 2013; Heritage, 2012). As a result, constant negotiation is required to balance the epistemic rights of the interactants.

A number of studies have addressed the problem of distribution of epistemics rights between healthcare providers and seekers (Angell and Bolden, 2015; Heath, 1992; Heritage, 2011, 2013; Heritage and Sefi, 1992; Landmark et al., 2015; Lindström and Weatherall, 2015; Peräkylä, 1998, 2006; Pino and Jenkins, 2023; Stivers, 2005). Peräkylä (2006) showed that in the delivery of a diagnosis, both parties simultaneously orient to the doctor's authority and the patient's knowledgeability. Lindström and Weatherall (2015) also demonstrated that doctors privilege their epistemic expertise in

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[1] A reviewer suggests that the repair in Excerpt 2, occurring in the third turn, might be initiated by the doctor's *yeah* in lines 9 and 10. However, the doctor's intonation indicates that *yeah* in both lines functions as a continuer, providing a minimal response to the patient's claim rather than initiating a repair. Given the lack of clear evidence for repair initiation by the doctor, we interpret the repair in line 12 as a patient's self-initiated self-repair.

treatment decisions but consider patients' experiences. Pino and Jenkins (2023) identified "epistemic discrepancies" in understanding end-of-life prognosis between doctors and patients, and they described communicative actions used to address these discrepancies.

Epistemic relationships in advice-giving initiated by healthcare workers are even more intricate. Opportunistic weight loss advice belongs to this type of talk, as GPs need to raise the issue of weight with patients who have attended appointments with other health concerns. In their study of interactions between health visitors and first-time mothers, Heritage and Sefi (1992) demonstrated that unsolicited advice often carries problematic implications about the competence of the recipient. This can make the advice-receiver adopt a defensive stance concerning the advice-giver's claim.

The efficient distribution of epistemic rights between interactants is key for achieving conversational alignment, i.e. "cooperative responses that facilitate the proposed activity or sequence; accepting presupposition in terms of the proposed action or activity and matching the formal design preference of the turn" (Steensig, 2013, p. 248). In weight loss advice interactions, alignment requires participants to embrace their roles as the advice-giver (a GP) and the advice-receiver (a patient) (Tremblett et al., 2022). Alignment enhances patients' compliance with recommendations and supports shared decision-making (Landmark et al., 2015). Failure to acknowledge the other interlocutor's independent "epistemic access" (Stivers et al., 2011) to information impedes conversational alignment and hinders the effective delivery of guidance.

For successful communication, interlocutors need to achieve and maintain both epistemic congruence and epistemic balance in talk. "Epistemic congruence" (Heritage, 2012, p. 379) is expressed when "a speaker's epistemic stance is compatible with their epistemic status relative to some domain of knowledge and some particular other(s)". In other words, doctors are expected to display their institutional expertise, while patients should acknowledge it. Epistemic balance, on the other hand, requires that the speaker's epistemic stance aligns with the knowledge claims made by the other interlocutor. To sustain epistemic congruence and balance in a conversation, participants may need to adjust their turns as the interaction unfolds. One of the means to achieve this is conversational repair, which is discussed in the next section of this paper.

While conversational repair fundamentally addresses issues in speaking, hearing and understanding, there is substantial evidence in conversation analysis and interactional linguistics that links repair with epistemic stance (Bolden, 2013; Drew et al., 2013; Romaniuk and Ehrlich, 2013). Romaniuk and Ehrlich (2013), for instance, demonstrated in their study on courtroom interactions how repairs are used by witnesses to restrict their testimony to their epistemic domain. Our research builds on this understanding by showing how GPs and patients adjust their knowledge claims during weight loss discussions through self-initiated self-repair to achieve their interactional goals.

3. Conversational repair: structural organisation and interactional role

Conversational repair is defined as a range of practices aimed at fixing troubles with speaking, hearing, understanding or agreement (Schegloff et al., 1977). This practice encompasses such elements as *repair initiation*, which launches a repair process, and *repair completion*. The target of repair is known as a *trouble source* or *repairable*, and the outcome is referred to as a *repair solution* (Kitzinger, 2012). Based on which party initiates the repair, researchers distinguish self-initiated and other-initiated repairs, and depending on who completes the repair, they distinguish self-repairs and other-repairs (Schegloff et al., 1977).

In the course of repair, a speaker may also repeat some elements of speech that precede or follow the trouble source. This is known as "framing" (Schegloff et al., 2012), and it serves as a means for locating what is being treated as a trouble source. The repeated elements that come before the repairable are referred to as pre-frames, and the ones that follow it are post-frames. For example, in Excerpt 3 from our data, the doctor initiates a repair in line 1 after producing *there's a few reasons*. In the course of repair, they replace *a few* with *lots of* and post-frame it by repeating *reasons* after the repair solution:

Excerpt 3

```
1   DOC: →   u:m and there's a few reasons- ↑lots of reasons why we would

2            recommend that, but u:m .pt (0.6) #really it would help reduce

3            yo:ur risk of ↑heart attacks↑ in the ↑future and ↑strokes but

4            also help .h um: .pt (0.2) reduce the chance of dia↑betes,

5            (.2) u:m .pt and help your ↑knees and ↑joints and all sorts of

6            things. ↑ok↑↑ay? al↑↑[right↑?

7   PAT:                         °[yeah.°
```

Having a pre- or post-frame is a significant aspect of repair. According to Stokoe (2011), the more framing items present in the repair segment, the more exposed it becomes.

Repairs may contain other structural elements that also make them more noticeable − *prefaces* and *adjuncts*. *Preface* is defined as a "distinct and distinctly positioned constituent of the repair segment" (Lerner and Kitzinger, 2015, p. 59), e.g. *well, or, oh*. Prefaces are important for establishing the relationship between a repair solution and its trouble source. For example, Lerner and Kitzinger (2015) have shown that the preface *or* indicates that the trouble source is not being fully discarded, and thereby it mitigates "the reparative character of the repair operation" (Lerner and Kitzinger, 2015, p. 77), while the preface *well,* on the contrary, overtly casts a repair solution as "a noteworthy revision" (Lerner and Kitzinger, 2019, p. 1) of the trouble source (see preface *well* in Excerpt 2, line 12).

Unlike prefaces, which precede repair solution, adjuncts are structural elements of a repair segment that appear in various positions (in repair initiation, resolution and next transition space) performing a specific function in each of these positions, e.g. *you know* (Clayman and Raymond, 2021). As we can see in Excerpt 4, the doctor uses *you know* twice in the turn: adjacent to an initial production hitch in line 1 and adjacent to the repair solution in line 2:

Excerpt 4

```
1   DOC: .hh o:kay: so: (.) um: ((1.6 paper sounds)) >yu know-< (0.2) >y:ur
2            already said you would < (.) you know
3                your keen to lose weight are:n:'t you.
4   PAT: ye[h. ]
```

Some repairs are "technical" by nature and correct mistakes in speech such as mispronouncing or grammatical errors. This kind of repair is also known as *repair simpliciter* (Bolden et al., 2022). For example, in Excerpt 5, the clinician replaces the erroneously chosen word *presenting* with *preventing* (line 4):

Excerpt 5

```
1   DOC:    Yea:h I mean certainly w' >in terms of- [preventing=
2   PAT:                                           [Yeah
3   DOC:    =the diabete- ↑and the other thing in terms of
4      →    presenting osteo-< preventing osteoarthri:tis
5           in your hi:ps and knee:s and be a[ble to carry
```

However, repairs are also performed when there is no observable "technical" problem, but rather some "functional in- adequacy" (Stokoe, 2011, p. 110) in the turn being amended. As Drew et al. (2013) highlight, "frequently speakers are in some way changing what they are in the course of saying, or have said, not in order to correct a mistake, but for some other interactional 'purpose'" (Drew et al., 2013, p. 73). The authors clarify that they use the term 'purpose' in scare quotes, as analysts cannot definitively determine a speaker's intent. Instead, analysts can examine the interactional effects of repairs. Repairs that address not technical issues in speech, but are performed for an interactional effect, are referred to as *interactionally significant repairs* (Romaniuk and Ehrlich, 2013).

Interactionally significant repairs are particularly interesting from an analytical standpoint as they extend beyond cor- recting factual error in talk and often involve introducing "alternatives to some current formulations of self and other(s), situations and relationships, and thereby serve as a resource for negotiating and perhaps reformulating a current set of identities" (Jefferson, 1974, p. 181). By comparing the trouble source and the repair solution of these repairs, we gain insights into the specific interactional work the repair performs.

In their analysis of other-initiated repairs, Hayashi et al. (2013) showed that instances of repair can be oriented towards the acceptability of action, matters of agreement, intersubjectivity of actions and occasions. This suggests that speakers may initiate repairs not only when information is inadequately received or understood but also as a way to challenge the in- terlocutor's stance—its obviousness, accuracy, or relevance.

Self-initiated self-repairs are especially intriguing. As Drew et al. (2013) note,

"[s]elf-repairs give us direct access to the alternative turn-designs considered by speakers, the initially selected design being rejected by the speaker in favour of the subsequent version selected, the repair. Hence in self-repair we can discern speakers' orientations to how best to construct turns for their sequential environment, to do the interactional work they are designed to perform" (Drew et al., 2013, pp. 74–75).

Romaniuk and Ehrlich (2013) demonstrated in their study of self-initiated self-repairs in courtrooms that defendants and their lawyers use repairs not only to correct mistakes or resolve understanding issues but also to present "a preferable version" of events or to limit their epistemic claims. Similarly, Stokoe's (2011) research on self-repairs involving gender

categories found that these repairs perform specific functions, such as positioning the speaker as "gender-aware" (e.g., repairing the term *girl* with *woman* when referring to females in an institutional context), or as downplaying the significance of a relationship (e.g., repairing the term *woman* with *girl* when referring to a female with whom the speaker had an affair).

In this paper, we demonstrate how self-initiated self-repairs (henceforth − *repairs*) are used to manage the epistemic stances initially expressed by interactants during the delivery of weight loss advice. By comparing the trouble sources with their repair solutions, we aim to capture the ways in which speakers manage and negotiate interactional challenges beyond merely addressing factual mistakes. Through a detailed analysis of the repair strategies and techniques employed by different parties, we explore the interactional work repairs perform and the specific linguistic adjustments speakers make to address emerging issues in conversation and better achieve their interactional goals. Additionally, we highlight the similarities and differences in the repair styles of doctors and patients, considering their respective institutional roles.

4. Materials and methods

The data for the study consist of audio recordings from 224 consultations between general practitioners (GPs) and patients living with obesity. During these consultations, GPs provided brief opportunistic weight loss advice in their own words at the end of the session, after addressing the patient's main concern.[2] The recordings were transcribed by the third author and professional transcribers, using Jeffersonian conventions (Hepburn and Bolden, 2017).

The first author studied the recordings and transcriptions to identify and collect the instances of self-initiated self-repairs. For the aims of our study, we collected only interactionally significant repairs, i.e. repairs which occur in the TCUs with no observable "technical" problems and serve to achieve some interactional effect. The collection in total is represented by 90 instances of repair. It is worth noting that in some cases of repair, the content of the trouble source is non-identifiable as the turn-constructional unit (TCU) (Sacks et al., 1974) was cut off by the speaker before the trouble source could be recognised. Such instances were not included in the dataset since they do not yield enough evidence to compare the trouble source and the repair solution and to establish the interactional input of the repair.

The collected instances of repair were examined by the three authors using conversation analysis (Clift, 2016; Goodwin and Heritage, 1990; Sacks et al., 1974; Schegloff, 2007; Sidnell, 2011). Conversation analysis as a methodological approach is primarily interested in the structure of social interaction. It aims to identify practices, actions and activities that underlie social interaction through a reliance of case-by-case analysis (Stivers and Sidnell, 2012). Conversation analysis as an analytic tool is based on recording and detailed transcription of naturally occurring data, and takes into account both linguistic (lexical items and grammatical structures) and paralinguistic (pitch, intonation, timing, speed, volume and vocal tone) aspects of interaction. This method is widely used to study communication in healthcare settings (Barnes and Woods, 2024; Parry and Barnes, 2024), including the delivery of weight loss advice (Albury et al., 2019). We identified the repair operations performed, the tasks that repairs carry out and the linguistic resources deployed to solve these tasks. In the following section, we present the results and discussions of the analysis.

5. Results and discussions

In this section, we present our results which focus on how participants of weight loss advice interactions use repairs to manage epistemics in talk. A typical opportunistic weight loss advice interaction consists of several "phases" (Tremblett et al., 2022): an appraisal of the patient's weight, communication of risk/benefit information, advice on weight loss and soliciting the patient's thoughts. These phases were consistently observed across the recordings, although not all GPs utilised every phase or followed the same sequence. Patients often had opportunities to respond to or ask questions about the GP's statements during these phases. These typical phases of weight loss advice interactions are relevant to our analysis because repairs are strategically employed within each phase to address specific communicative challenges and achieve distinct interactional effects. An example of a brief weight-loss advice interaction in full can be found in Fig. 1 in Supplement.

Our analysis shows that both doctors and patient use repairs to adjust their epistemic stances shifting them in two possible directions, either upgrading or downgrading their knowledge claims. We analysed doctors' and patients' self-repairs separately to establish which communicative tasks repairs solve for each party of the intervention, as well as to trace similarities and distinctions in the use of repair operations and linguistic resources. We firstly demonstrate epistemic upgrading performed by doctors (5.1) and by patients (5.2) through repairs. Then, we show epistemic downgrading repairs in doctors' (5.3) and patients' (5.4) turns.

5.1. Epistemic upgrading performed by doctors: claiming authority through expertise

Doctors upgrade their epistemic stances by means of repair mainly during weight appraisal and communicating risk/benefit information. By using self-repairs, clinicians present the issue of living with obesity as more urgent or important than

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it was initially projected. This is evident in Excerpt 6, where the GP initiates the topic of weight by assessing the patient's body mass index. In their first turn, the doctor performs two repairs in lines 3–4 and lines 5–7.

Excerpt 6

```
 1    DOC:        =↑randomisation number <↑two: three: ↑oh fou:r ni:ne ni:ne> oh
 2                one (0.4) .hhh so:, (0.6) tck with re↑gar:rds to your weight
 3          →     (0.4) ↑you:r (.) bee em ai your >body mass index< is ↑just
 4                slightly: it is (0.4) too high at the
 5          →     mo[ment and it would be really (.) would be in your best=
 6    PAT:           [o↑kay
 7    DOC:        =interests to: (.) consider (0.4) losing >a little bit of<
 8                weight
 9    PAT:        okay
10    DOC:   →    a::nd (.) u:m (0.6) and ↑it (0.4) you know there's >really good<
11                evide:nce that it will (0.6) definitely help your ↑back ↑pai:n,
12    PAT:        'kay
13    DOC:        and help with your joint pain >if you're< getting any
14                osteoarthritis of your ↑knee::s and you fee:t and things like
15                that [and your ↑hips it will help ↑tha:t, .hhhh=
16    PAT:             [yep
17    DOC:        =and obviously it ↑majorly reduces your risk of developing heart
18                disease and dia↑bete:s
19    PAT:        [↑okay
20    DOC:        [so it would definitely definitely be in your best intere:st to
21                consider losing a bit of weight
22    PAT:        ↑okay
```

In lines 3–4, where the first repair occurs, the GP produces the modifiers *just* and *slightly* which together with the projected attribute *high* refer to the patient's BMI. These modifiers are conversational features known as hedges or "minimisation", and they serve to enhance delicacy (Tremblett et al., 2022). The extension of the final vowel in *slightly:* initiates a repair which is pre-framed by *it is* and performed after a 0.4-s pause via "replacing" (Schegloff et al., 2012) *just slightly* with the antonymic modifier *too [high]*. The repair solution significantly upgrades the doctor's epistemic stance and presents the issue as more serious than it was projected.

Although the delicacy features of the turn are replaced in the course of repair, they are not "cancelled out" (Jefferson, 1974), as they are fully verbalised and not rejected by the speaker. These features remain hearable and "on the record" (Stokoe, 2011) for the patient. In this way, the repair completes multiple interactional goals (Romaniuk and Ehrlich, 2013). It strengthens the doctor's claim while also preserving delicacy in talk.

Later in the same turn, when speaking about the importance of losing weight, the GP performs one more repair (lines 5–7). The doctor starts with *and it would be really*, but halts the completion of this TCU and launches a repair that is preframed with *would be* followed by an adverbial phrase, *in your best interest.* The superlative form *best* in the repair solution further boosts the doctor's claim about the importance of weight loss. At the same time, the possessive pronoun *your* makes the statement more personalised for the patient.

In lines 6 and 9 of Excerpt 6, the patient gives a positive receipt of the doctor's turns. However, the GP continues to further upgrade their epistemic stance. This time, the repair is performed via "parenthesizing" (Schegloff et al., 2012), which involves interpolation of a clausal TCU into a turn-in-progress and then repetition of the pre-parenthetical talk. In line 10, the GP starts with *and it* which is produced with signs of hesitation: prosodic lengthening, an extender (*u:m*), several pauses and a restart. The speaker cuts off the TCU-in-progress and repairs it with a parenthetical clause (*you know there's really good evidence*). The repair strengthens the GP's grounds, as it adds information about the evidence of the benefits of weight loss. At the same time, the adjunct to the repair *you know* serves as an alignment token (Clayman and Raymond, 2021). Claiming the knowledgeability of expertise, the GP still appeals to the patient's epistemic perspectives. Thus, the speaker demonstrates an orientation towards sustaining epistemic balance in talk.

It is worth noting that the tendency towards epistemic upgrading is maintained by the GP throughout this sequence. When speaking about reasons to lose weight, the GP uses numerous intensifiers, such as *really* (line 10), *definitely* (line 11), *obviously* and *majorly* (line 17), and they repeat *definitely* twice before *be in your best interest* (line 20).

The cases of doctor-initiated self-repair described above happen early in the sequences and sometimes occur before the patient utters anything. Doctors initially adopt a less assertive stance but immediately upgrade it in the same or (less often) the following turn. However, upgrading repairs can be launched by GPs in response to some turbulence in communication, such as patients' uptake of the information delivered or disalignment expressed by patients.

In Excerpt 7, the repair in line 20 is closely related to how the patient receives the news about their BMI, which turns out to be much lower than the patient assumed.

Excerpt 7

```
 1   DOC:        Uh and the advice that I °give you people° is: #tha:t#
 2               (0.5) ↑anybody: (.) who: has a certain body mass
 3               ↑index (.) <abo:ve thi:rty?>,

 4   DOC:        #And you[:r-#

 5   PAT:              [Yeah, mine's fifty.

 6               (0.5)

 7   PAT:        Ge:e:/(tee)?

 8   DOC:        #Yours# >thirty-one pint fi:ve<.

 9   PAT:        Oh >thirty o-<, oh s[o-

10   DOC:                          [So you're only just over the

11               limit.=.hh but-

13                (.)

14   DOC:          N(h)o(h).N-=

15   PAT:          =↑I was (sayin')fifty percent ↑fat I am?

16               [>↑Hh h hhh.h h .h

17   DOC:        [N::o: >you're not<.

18   PAT:                          [h .h<

19   DOC:                          [Er but anyone with a body mass

20        →     index over thi:rty has a g- (0.3) e:r a ↑#much greater
21               chance of developing diabetes during [their life#.

22   PAT:                                            [Mhm.
```

When delivering risk information (lines 1–3), the GP starts with the generic *you people* and *anybody* and moves towards a more direct statement about the patient's BMI (line 4). However, the patient cuts the GP off with an overlapping turn (line 5), asserting an epistemic stance of confident knowledge: *Yeah, mine's fifty*. This is followed by a 0.5-s pause, which potentially indicates trouble with some aspect of the patient's turn. Indeed, in line 8, the GP delivers the correct BMI as a statement, demonstrating a high level of commitment to the proposition. The patient responds to this other-repair with an *oh*-back-channel and partially repeats the doctor's words (line 9). *Oh*-preface is a strong indication of a change of state in current knowledge due to the prior turn (Heritage, 1984). In this way, the patient accepts the information delivered by the GP as news.

At line 10, the GP performs a pre-emptive completion (Lerner, 2004) of the *so*-clause started by the patient in line 9. The doctor's turn contains *but* which is aimed at introducing a piece of information that contrasts with what has previously been established in the talk. However, in line 12, the patient overtakes the GP's turn with *That's (fine), I thought it was fifty,*

accompanied by laughter. The affiliative response indicates that the patient receipts the doctor's other-repair as "good news" (Maynard, 1997). This falls apart with the doctor's agenda: despite the fact the patient's BMI is much lower than the patient believed, it is still necessary for them to lose weight.

In line 19, the doctor manages to bring the conversation back on track. They recycle *but*, which was cut off earlier at line 11, and return to what they were saying at the beginning of the sequence using very similar language (an indefinite pronoun with *any-*, *BMI over thirty*). In line 20, the speaker halts the production of the attribute *greater* and repairs the TCU-in-progress by inserting the intensifier *much* before *greater chance of developing diabetes*. We believe that this upgrading repair is produced in response to the patient's uptake of the earlier doctor's informing as "good news": because their BMI is lower than they assumed, the patient might view weight loss as a less important issue, so the GP strengthens their epistemic stance.

Doctors also undertake epistemic upgrading when faced with a patient's disaligning response. This takes place in Excerpt 8, where the GP introduces the topic of weight by relating it to the patient's existing health conditions. In lines 10—11, the GP mentions that losing weight could help take the patient off some medication. The patient responds by expressing doubts and claims that they were taking painkillers even when they were *slim* (lines 12—14).

Excerpt 8

```
 1    DOC:     t.H (.) ri::ght um:: tch we've u:m had a little

 2             cha:t about you:r blood pre:ssu:re an::d abou::t

 3             um ↑pai:ns ↓and so forth, .hh (0.4) ↑Did you

 4             ↓kno::w that if you did lose a little bit of weight,

 5             (0.5) then a:ctually: your ↑joint pai:ns and your

 6             bloo:d pressure, (0.8) would a:ll be within ra:nge

 7             an:d um: you'd have less issues.

 8             (0.6)

 9    PAT:     Y[eah;

10    DOC:      [With tho:se and we could maybe take you off quite

11             a few of your ↑↑me::ds ↓an::[d (.) and so forth.        ]

12    PAT:                                 [tk.HH >I don't know if you]

13             (ought to) take me off my pai:n ones cos I ha:d them

14             when I was:- (0.5) [slim. ]

15    DOC: →                      [Would-] Ri:g[ht o:kay.

16    PAT:                                     [.sh [M:m.

17    PAT:     So- but the >blood pressure and that yeah I

18             kno[w that.

19    DOC: →      [Yea::h. <And it would probably reduce your risk

20             of- (0.9) well i-it would definitely regu-reduce

21             your risk of developing diabete:s an:[d (.) °heart=

22    PAT:                                          [Mm:.

23    DOC:     =attacks° and strokes in the future. .hhh Um:::
```

The discrepancy between the parties' views potentially undermines the doctor's authority (Peräkylä, 2006). The GP reacts to such an "epistemic push-back" (Heritage, 2012) from the patient with two subsequent self-repairs. The first is launched at line 15 when the GP produces *would* in overlap with the patient's turn, tailoring it as a suggestion/request, but abandons this TCU in favour of agreement: *Ri:g[ht o:kay*. The repair changes the interactional purpose of the turn: responding with agreement instead of a suggestion/request, the GP downgrades their authority of expertise and acknowledges the patient's authority of experience. This helps establish epistemic balance in talk.

However, in the following turn (lines 17—18), the patient partly aligns with the GP, namely that losing weight would positively affect their blood pressure. Doing this, they still claim their prior and independent "epistemic access" to this

information: *yeah I know that*. The doctor produces an agreement token (*yea::h.*) and develops on risk and benefit information at lines 19–21, where the second repair takes place. The GP starts saying that weight loss would reduce the risks of diabetes, heart attacks and strokes. They initially use the modifier *probably* with the verb *reduce* and perform a cut-off on *risks of* and, after a 0.9-s pause, repair the TCU-in-progress by replacing *probably* with its antonym *definitely*. The preface *well* marks the repair solution as "a noteworthy revision of the inadequate (but not wholly wrong) formulation" (Lerner and Kitzinger, 2019, p. 1). This repair serves to upgrade the doctor's epistemic stance that was challenged by the patient's disaligning response and to re-establish the congruence between the doctor's epistemic status and their epistemic stance.

In sum, epistemic upgrading performed by doctors through repair in weight loss advice interactions predominantly occurs when appraising the patient's weight and communicating risk or benefit information. It is achieved mainly by replacing trouble source items with more intense synonyms or with antonyms, and by inserting intensifiers or parenthetical clauses. Repairs performed in weight appraisal increase the directness of the approach to topic initiation, which can hinder patients' compliance with recommendations. Delicacy features in doctors' turns help emphasise the gravity of the problem and at the same time mitigate resistance displays from patients.

There have been observed two different cases of doctor-initiated upgrading self-repairs. In the first case, repairs happen in the first turn and are minimally related to the patient's verbal uptake of the delivered information. GPs initially adopt a less "knowledgeable" stance as their "departure point" but later boost their claims to sound more persuasive. In the second case, the epistemic upgrading is related to what previously happened in the talk, e.g. the patient's disaligning response to the doctor's turn, or the discrepancy between the patient's uptake and the doctor's agenda. In reaction to the stance adopted by the patient, the GP can launch several repairs, which initially balance the epistemic discrepancy between the two parties, and subsequently re-establish the GP's authority through expertise. In this way, doctors maintain epistemic congruence between their status and stance, and at the same time, interactionally pursue conversational alignment.

5.2. Epistemic upgrading performed by patients: claiming knowledgeability through experience

Due to the specifics of weight loss interventions and patients' institutional role, healthcare seekers engage in conversations predominantly after the topic has been initiated by GPs. This dynamic results in patients performing epistemic upgrading mostly in response to doctors' turns. Patients often raise their claims while accounting for their health behaviours related to weight loss. Repairs allow patients to assert their knowledge regarding various methods of losing weight, the efforts they have invested in and the outcomes they have already accomplished.

In Excerpt 9, the process of upgrading the patient's stance while asserting knowledge about the issue is evident. Earlier in this sequence, the GP inquires about the patient's motivation for weight loss. The patient responds by sharing their attempt to join a weight loss program but eventually abandoning it. The GP suggests that the issue may stem from a lack of internal motivation. The patient acknowledges this perspective, confessing that they are fully aware of what is required for weight loss, but they grapple with maintaining consistency:

Excerpt 9

```
1    DOC:      So it's something from withi:n that needs tuh (.)

2    PAT:      Yeah I- it's sort of um: h (0.4) yeah (0.2) mp.hh I

3              haven't got sort of the: (0.8) dri:ve if you know what

4       →      I mean. .hh I kn- I ↑know what I shou:ld be doing, I kn-

5              I know exactly what I °should be doing b't° (1.2) mp.h

6              I don't do: it.
```

In this sequence, the patient initially expresses a less knowledgeable stance. The speaker's statement is marked with hesitancy through several pauses, prosodic lengthening, the use of extenders (*um*), hedges (*sort of*) and restarts (lines 2–4). However, in lines 4–5, the patient significantly upgrades their epistemic stance when they repair *I know what I should be doing* inserting the intensifier *exactly* after the verb *know*. The repair solution is pronounced with an emphatic stress, which makes the repair more exposed.

A similar case of upgrading by means of inserting an intensifier takes place in Excerpt 10. The GP asks the patient if they are aware of the benefits of weight loss. The patient responds affirmatively (line 4) and, in their subsequent turn, reinforces their knowledge claim by asserting that they have been repeatedly informed about these benefits (lines 8–9).

Excerpt 10

```
 1   DOC:       According to this. .hh- (0.2) Did ↑↑you kno:w
 2              [(0.5) that ↑if you were to lo:se wei::ght, .h
 3   PAT:       [ihih ,
 4   PAT:       Ye:s=
 5   DOC:       =tha:t it would he:lp you with um your ri:sk factors
 6              as far as ↑heart attacks ↓strokes .hh <blood pressu:re
 7              contr[o::l .h  and ↓diabetes development.>          ]
 8   PAT:  →        [(There's)(.)  I've been to:ld (0.7) probably a]
 9              hundred times I've been told [or mo:re.]
10   DOC:                                    [Didj- (.)] tch ↑Oh well
11              [there you go: then.=.h And do you think [that's helped you.
12   PAT:       [Yes:.                                   [But it's taking
13              notice.
```

In this case, the repair is performed in several stages. At line 8, the patient starts speaking in overlap with the doctor. They produce *There's* and, after a pause, reformat their turn to *I've been told*. This is followed by a 0.7-s pause which launches another repair: the speaker inserts into the TCU-in-progress *probably a hundred times*. The repair is post-framed by recycling *I've been told* with the addition of the intensifier *or more*. The insertion of the hyperbolic modifier *a hundred times*, even though partially downgraded by the adverb *probably*, shifts the patient's epistemic stance to a much higher position. The intensifying increment *or more* further strengthens the claim. The doctor responds with a change-of-state token (*Oh*) and continues to orient to the patient's knowledge and experience at line 11.

When talking about the efforts they make to lose weight and their accomplishments, patients also perform upgrading repairs through parenthesizing (Schegloff et al., 2012). This repair operation introduces into a TCU-in-progress some grounds which support the initial claim. In Excerpt 11, the patient reports the effects of their work on their weight:

Excerpt 11

```
 1   PAT:       Um: (0.6) So (onl(h)y) no(h)w I just wo:rk khih
 2        →     .h and that seems 'cos I'm (.) constantly sort
 3              of moving abou[:t or I'm ] constantly lifting=
 4   DOC:                     [Yeah yeah;]
 5   PAT:       =and stuff and that seems to be bringing my weight
 6              [↓down so:=
```

In line 2, the patient halts the TCU-in-progress after *that seems* and inserts into their turn-in-progress a clausal TCU. After that, the speaker goes back to their pre-parenthetical talk and post-frames the repair by recycling *and that seems*. The parenthetical clause adds information about the reason for the patient's success and, in this way, strengthens their claim. The upgrading is also supported by the intensifier *constantly*, which is used twice in the clause, and by the choice of progressive tense constructions as the predicates of the clause.

In sum, patients engage in epistemic upgrading to establish their authority of experience, aiming to assert their under-standing of the significance of weight loss and methods for achieving it, as well as to communicate changes in their health behaviours and notable results. To secure this, patients deploy mainly such linguistic resources as intensifiers, quantifiers and parenthetical clauses. Patients' upgrading repairs are predominantly exposed — they are pre- and post-framed, and the repair solutions are often delivered with emphatic stress.

In the upcoming subsection, we analyse instances of epistemic downgrading accomplished through repairs. We elucidate the distinct tasks that these repairs address for each party in the interaction, detailing the repair mechanisms and linguistic tools employed. Additionally, we illustrate how doctors and patients exhibit different repair styles, reflective of their respective epistemic statuses and institutional roles.

5.3. Epistemic downgrading performed by doctors: acknowledging limitations

Our analysis reveals that doctors perform repairs to downgrade their epistemic stance mainly when speaking about the impact of weight loss on different health conditions and commenting on the efficacy of some methods of weight management. Downgrading is achieved through lexical insertion and grammar reformatting.

Lexical insertions mainly include the verb *help*, which restricts initial claims about the impact of weight loss on general health. This can be seen in Excerpt 12, where the clinician is telling the patient that losing weight can prevent the development of some medical conditions:

Excerpt 12

```
1    DOC:      .hhh ↑Basically um (0.2) we know that losing wei:ght
2         →    can: (.) prevent things like (0.6) or he:lp prevent
3              things like diabetes and heart dise[ase,
4    PAT:                                          [nYeah;
```

In line 2, the GP initiates a repair with a 0.6-s pause after *things like* and inserts the verb *help* before *prevent*. This repair slightly restricts the GP's initial claim about the preventive character of weight loss. The preface *or* also plays a specific role: it introduces the repair solution as an option but does not fully discard the trouble source (Lerner and Kitzinger, 2015; Stokoe, 2011). Rather, it offers an alternative to it.

Inserting repairs with *help* as a solution are used by clinicians also to limit their claims about the effectiveness of some ways and methods to lose weight, e.g. in Excerpt 13, where the GP presents the patient with a booklet containing advice on weight management.

Excerpt 13

```
1    DOC:      u::::m, (0.4) and then (0.8) ↑possibly give you some
2              infor↑mation that we're gonna give you now a little ↑booklet
3              >that you're gonna< fo↑llow, (0.4) ↑of (.) ways in which you
4         →    can actually im↑prove your w- (.) ↑help to improve your
5              ↑weight management as well
6    PAT:      °o↑kay°
```

At lines 4−5, the GP halts the production of *weight* and performs a repair inserting *help to* before *improve your weight*. In this context, the insertion is marked with a noticeable rising pitch and emphatic stress, making the repair more exposed. The chosen repair solution serves to downgrade the doctor's epistemic stance. With the addition of *help*, the statement suggests that while the tips provided in the leaflet may offer assistance in addressing the issue, they are not deemed sufficient to fully resolve it. This strategic linguistic choice emphasises a more cautious stance on the part of the doctor.

In order to downgrade their epistemic stance, doctors can distance themselves from the propositional content. They do this through agency shifts changing the subject of the TCU-in-progress from the 1st person (*I/we*) to the 2nd (*you*) or the 3rd person (*it/they*). Agency shifts are not simply subject replacing. They often involve reformatting of the whole TCU-in-progress, e.g. change of tense and voice of the predicate. A case of grammar reformatting can be observed in Excerpt 14, where the patient asks the doctor about weight loss tablets, and the clinician comments on their effectiveness.

Excerpt 14

```
1    PAT:                                              [How about
2           wei:ght loss tablets. (Would) you: have them.
3             (0.2)
4    DOC: →  N:o: they're th-I- I don't- they've really not been
5            shown to be particularly effective. They do potentially have
6            side effects (.) .h which I'd be very conce:rned about. And
7            its much better off to do it yourself through a healthy
8            eating (0.3) wa:y in the longer run
```

The repair takes place in line 4, and it is performed in several stages. The GP starts their turn with *No they're*, referring to the tablets, but halts the completion of the turn and makes an attempt of repair restructuring it to another set of subject and predicate: *I don't*. This repair candidate shifts the agency from the 3rd person (the tablets) to the 1st person (the speaker). The newly-projected turn with *I don't* is obviously intended to introduce the clinician's personal opinion about the effectiveness of the tablets and, in this way, to take up a more assertive epistemic stance. However, the GP drops this repair candidate and restarts the turn with *they* (the tablets) as the subject, as it initially was in the trouble-source, but with a different predicate *('ve not been shown)*. The use of the 3rd person plural as the subject and the passive construction as the predicate helps the GP to distance themselves from the propositional content and deliver the information as an objective fact. However, the previous attempt of repair (*I don't (?) believe/recommend*/etc.) is not completely cancelled, as the doctor's opinion is made explicit later in the same turn (*I'd be very concerned about,* line 6). In this way, the repair foregrounds the facts and backshifts the GP's personal opinion, saving it to be expressed later.

Thus, epistemic downgrading helps GPs to limit their initial claims about the impact of weight on general health as well as the efficacy of certain methods of weight management. To accomplish this, they deploy both lexical insertions and grammar reformatting. When performing downgrading repairs, doctors tend not to cancel the previous version of their statement. Instead, they present the repair solution as an alternative to the trouble source. This is achieved through the use of the preface *or*, or through partial recycling of the trouble source later in the turn.

5.4. Epistemic downgrading performed by patients: questioning the level of expertise and re-evaluating health behaviours

Patients perform downgrading repairs when discussing weight loss achievements, providing updates on their diets and commenting on how their lifestyles impact their weight. The downgrading repairs help patients to re-evaluate their health behaviours and question the level of their expertise in weight loss-related matters.

When discussing their diets, patients often categorise their eating habits under a specific label. However, they frequently perform repairs to express a degree of uncertainty about whether their dietary choices qualify as a "proper" diet. This occurs in Excerpt 15, where the patient and the doctor are discussing how the patient managed to lose some weight:

Excerpt 15

```
1    PAT:      .hh and I said to her I've gone [o:n
2    DOC:                                      [↑o↑↑kay?
3    PAT:  →   virtually a d- like a dairy ↑free diet, (0.4) [so it's
4    DOC:                                                    [we'll do that
5              ↑now for you (0.4) all ↑ri:ght?
```

The patient's shares that they have gone on a diet. In line 3, they cut-off their TCU-in-progress after producing the initial *d*-sound, presumably *a dairy-free diet* or simply *a diet*. The TCU is repaired with the hedge *like*, which serves to downgrade the patient's claim about the character of their diet.

A similar questioning of expertise happens in Excerpt 16, where the patient is explaining the influence of their family history on their eating habits. They mention that their father was diagnosed with diabetes and that this affected the patient's attitude to food:

Excerpt 16

```
1    PAT:     So (0.5) ((cough)) um:: my fa::ther (1.3) quite

2             late o:n in life only about five years ago he got

3             (0.3) diagnosed with um: (0.2) diabe:tes.

4             (0.7)

5    PAT:     U:m:: a:nd so that kind of made me think oh I

6        →    need to be meal- more sort've h.h wei:ght down

7             healthy eating.
```

The repair is launched in line 6, where the patient produces *I need to be meal-*, presumably heading for *meal-conscious*. However, they halt the production of the lexical item that would project a membership in a particular category of people. The speaker repairs the TCU with a descriptive phrase: *more sort've h.h wei:ght down healthy eating*. This repair solution comprises signs of hesitation, such as prosodic lengthening in *wei:ght* and a hedge (*sort've*), which also serve to downgrade the patient's epistemic stance.

Later in the same sequence (Excerpt 17), when elaborating on their eating habits, the patient performs two more repairs. Initially, the speaker claims that apart from chocolate and alcohol their diet is *quite healthy* (lines 2−5). However, they adjust their claim at lines 8−9:

Excerpt 17

```
1    DOC:     It's [di̲et:].

2    PAT:          [Di:et] in terms of f:ood, is probably quite

3             hea:lthy, [.hh (but)] (.) alcohol and chocolate=

4    DOC:                    [ Ye:a:h  ]

5    PAT:     =kinda (0.7)

6    DOC:     O:kay; ↑So the mea:l bit you think is- is pretty

7             rea:sonable it's [the- it's- ]

8    PAT: →                    [Pretty much] well we don't ha::ve

9             (0.7) we don't regularly eat (0.2) junk (0.4) [foo:d.

10   DOC:                                                   [Yeh

11   PAT: →   .hh Um: we: (0.2) prepa::re (1.5) if you count taking

12            a salad out of a bag as preparing foo:d, .hhh

13            [um:: you know we- we [sort've of (1.2) y'know (0.4)=

14   DOC:     [Ye(HH)ah hih        [Yeh

15   PAT:     =prepare food from- from scra:tch we don't- we don't

16            eat re̲ady mea:ls anymo:re,

17   DOC:     Yeh.
```

When asserting that they do not consume junk food (line 8), the patient uses the preface *well*, which marks the repair solution as a noteworthy revision of the previous formulation (Lerner and Kitzinger, 2019). The patient produces *we don't ha::ve*, which is delivered with prosodic lengthening, and after a 0.7-s pause, they repair this TCU replacing *have* with *eat* modified by *regularly*. The choice of a different verb and the use of the adverb of frequency to modify it make the patient's statement less categorical than their initial claim: it can be inferred that they might have some junk food at home, but they do not *regularly* consume it.

In line 11 of Excerpt 17, when claiming that they cook for themselves, the patient uses parenthesizing to question their expertise in diet-related issues. The in-breath and the extender in the beginning of the turn, the prosodic lengthening in *we: prepa::re*, and several pauses indicate the speaker's hesitancy. The patient halts the TCU-in-progress, and after a 1.5-pause, they insert into it a conditional clause: *if you count taking a salad out of a bag as preparing foo:d*. The repair is post-framed with a recycling of the pre-parenthetical *we prepare*, accompanied by numerous linguistic resources that indicate the patient's uncertainty − an extender (*um*), several hedges (*you know, sort've of*) and restarts (in lines 13 and 15). All these features serve to mark the patient's statement as tentative. At the same time, the parenthetical clause "invites" the GP to correct the patient's statement if needed, acknowledging in this way the doctor's authority of expertise.

Patient-initiated self-repairs are often marked with epistemic hedging: the speakers use phrases *I think, I thought, I am not sure*, which highlight the subjectivity of the statements. This happens in Excerpt 18, where the patient shares their experience of weight loss:

Excerpt 18

```
1   PAT:   →   mp.h ↑I have lost- (0.9) I think I've lost a sto:ne

2               in the last five yea:rs.

3               (.)

4   DOC:        Okay¿
```

The patient produces *I have lost* and initiates a repair by a cut-off and a 0.9-s pause. The repair is performed via inserting *I think* before *I've lost*, which increases the subjectivity and, hence, reduces the strength of the patient's initial claim.

The analysis has shown that patients' self-repairs, in contrast to doctors' ones, are predominantly exposed. The repair initiation in the case of patients' repairs is more distinct: it is marked with numerous signs of hesitation, restarts and long pauses (up to 3 s) before the solution is delivered. In addition to that, many patient-initiated self-repairs are launched by overt rejection of the trouble source: speakers first negate the repairable and then provide a repair solution. This occurs in Excerpt 19, where the patient reports some weight loss and comments on the reasons for that:

Excerpt 19

```
1   PAT:       Uh:: (2.9) I've lost a cou:ple of pounds in the last mo:nth;

2          →   (0.7) because I've been (3.0), I wouldn't say I've been

3              try:ing hard I've been (1.0) paying attention.

4   DOC:       °Yea:
```

The patient starts the turn with an extender and a 2.9-s delay. The first TCU is delivered with prosodic lengthening in *cou:ple* and *mo:nth*, followed by a 0.7-s pause. Then, the speaker starts introducing the reason for weight loss. They produce *because I've been* but halt the production of the main verb. The significant delay in speech (3 s) signals trouble with the projected TCU. The repair is initiated by negating what the speaker was about to say: *I wouldn't say I've been trying hard*. Following that, they recycle *I've been*, and after a 1-s pause, finally come up with a repair solution: *paying attention.* The repair considerably downgrades the projected claim about the patient's efforts, and the rejection of the trouble source makes the repair exposed. The GP's soft and drawn-out *yea:* ratifies the repair and renders the repair the accepted knowledge state for continuing the interaction.

It should be noted that similar repair initiation through rejection is also typical in cases when patients downgrade their deontic stance, which refers to the speaker's position regarding obligations and necessities (Landmark et al., 2015). For example, in Excerpt 20, where the patient recounts the influence of their "social job" on health behaviours, specifically concerning weight loss.

Excerpt 20

```
1    PAT:      =so we're quite-< .hhh b't- (0.4) and we can do that

2              fo:r (1.1) a month (.) and then (0.5) something will

3              happen=I got a quite a social: (0.7) jo:b.

4    DOC:      Yeh=

5    PAT:  →   = And I have to [<I don't have to go out and drink=

6    DOC:                      [°(which makes it) (difficult)°

7    PAT:      =b't- .hhh I'm expected to go out an:d socialise

8              quite a l[ot with my work and tha- that- (0.4)=

9    DOC:               [Yea::h.

10   PAT:      =can be problematic.

11   PAT:      .hh[hh Um:: b't- (0.5) not (0.3) no:t too bad.

12   DOC:         [Yea::h
```

In line 5, the speaker starts with *And I have to*, but promptly backtracks, negating the initial statement (*I don't have to go out and drink*) and launching a repair prefaced with *but* and an in-breath. The repair involves substituting the modal *have to*, implying obligation, with the passive construction *I'm expected to.* This alteration diminishes the asserted necessity of the reported behaviour and shifts the agency away from the patient. Additionally, the replacement of the verb *drink* with *socialise* broadens the activity's scope, no longer confined to alcohol consumption. The speaker's evaluation in line 11 (*not too bad*) further reinforces the transition from a stronger to a milder assertion.

In sum, patients perform downgrading repairs to limit the claims about their expertise on weight loss and to reconsider their behaviour connected to weight management. Patients' repairs tend to be exposed, often involving explicit rejection of the trouble source. This distinctive repair style appears to be intricately linked to the speakers' epistemic status and institutional role. As seekers of healthcare services, patients admit the confines of their knowledge regarding health-related issues, demonstrating a clear orientation towards prioritising the doctor's epistemic authority in the domain of weight loss advice.

6. Conclusions

This paper aimed to analyse how doctors and patients use self-initiated self-repairs to manage epistemics in conversations on weight loss. Our findings add to what has previously been established about the relationship between the medical expertise of clinicians and the personal experience of patients (Heath, 1992; Landmark et al., 2015; Lindström and Weatherall, 2015; Peräkylä, 2006; Stivers, 2005): self-initiated self-repair reflects a dynamic interplay between doctors' and patients' epistemic stances.

The analysis has shown that repairs are actively used by both healthcare providers and seekers to manage their epistemic stances shifting them in both possible directions — either upgrading or downgrading their initial knowledge claims. In order to perform repairs, both doctors and patients use similar repair operations (replacing, inserting, parenthesizing, grammar reformatting) and linguistic resources (quantifiers, intensifiers, hedges, shifts in agency, tense and voice). However, there are still essential differences in how repairs are employed by different parties of weight loss discussions.

Doctors perform epistemic upgrading when referring to the patient's weight to present the issue as more serious and urgent than it was initially projected, and when listing the benefits of weight loss. At the same time, healthcare practitioners downgrade their epistemic stances to acknowledge some limitations in relation between weight and other medical conditions or restrict their claims about the effectiveness of certain ways to lose weight.

Patients tend to upgrade their epistemic stances when speaking about their knowledgeability on how to lose weight, their previous or current attempts and efforts to handle the problem, and the progress they have achieved. However, healthcare seekers are inclined to question the level of their expertise in some weight loss-related issues such as the adequacy of their diets and the implications of their lifestyles for weight loss.

Doctors can initiate self-repairs in their first turn. In this case, repairs are induced by the speaker's own epistemic considerations and reflect the tendency of healthcare providers to begin with a less assertive stance and then progressively assert their knowledge claims to enhance evidentiality and increase the force of the impact on the interlocutor. Another case is when doctors adjust their knowledge claims in response to patients' uptake of delivered information. The patient's disaligning response to the doctor's knowledge claim may result in initial epistemic downgrading from the GP to align with the patient's stance and subsequent upgrading repair to re-establish the doctor's epistemic authority through expertise. In this way, doctors, on the one hand, display attempts to reach and maintain epistemic balance between their epistemic stance and the stance expressed by the patient. On the other hand, they interactionally pursue epistemic congruence between their own epistemic status and the epistemic stance they express.

Performing downgrading repairs, doctors tend not to cancel the previous version of their turn but rather present the trouble source as a viable option. This is achieved either by using the preface **or** to introduce the repair solution, or partially recycling the trouble source later in the turn. Patients, by contrast, tend to perform exposed repairs when downgrading their claims by cancelling the trouble source via negative constructions and actively deploying hedges. This difference in repair styles corresponds to the epistemic statuses and the institutional roles of the interactants. Clinicians maintain congruence between their high epistemic status and the stance they express, so they avoid overtly challenging their epistemic grounds. Healthcare seekers, on the contrary, are disposed to orient themselves to the doctor's authority and expertise. Hence, patients overtly question their own knowledgeability in domains beyond their direct epistemic access, recognising and deferring to the doctor's epistemic primacy.

6.1. Limitations

This study has several limitations. Firstly, the non-verbal dimension of interactions was not explored, as our data consist solely of audio recordings. Secondly, the recordings are limited to weight loss discussions and do not cover the entire conversations that took place during the medical appointments. Therefore, there is a possibility that the epistemic negotiations we observed were influenced by the issues raised earlier in the talk. Thirdly, epistemic relationships in weight loss advice interactions are also managed by other conversational practices which need further investigation. Lastly, future studies should explore other interactional functions of repairs in the delivery of weight loss advice.

Data statement

The data used in this study are sensitive and cannot be shared due to ethical considerations.

Funding sources

CRediT authorship contribution statement

Liliia Bespala: Writing − original draft, Validation, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Miriam Meyerhoff:** Writing − review & editing, Validation, Supervision, Methodology, Investigation, Formal analysis, Conceptualization. **Charlotte Albury:** Writing − review & editing, Validation, Supervision, Resources, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors have no conflict of interest to declare.

Data availability

The data that has been used is confidential.

Acknowledgements

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.pragma.2024.09.003.

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