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Patient cues about end-of-life matters: An observational study of palliative care consultations using conversation analysis

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ABSTRACT

Objective: This article examines instances of patients making allusive or ambiguous potential reference to death and dying (cues) and analyses how they are built and received in consultations.
Methods: Conversation analysis of video and audio recorded interactions in a large UK hospice. These consultations occurred between patients and companions and a variety of healthcare professionals (HCPs), comprising six palliative medicine consultants, five occupational therapists, and three physiotherapists.
Results: Patients may foreground the end-of-life (EoL) aspect of a cue by, for example, producing it while launching a topic or making a pronouncement/report. This exerts sequential pressure for HCPs to address the EoL implication (unmarked case), but HCPs may avoid engaging with it (marked case). Sometimes, patients allusively or ambiguously refer to death and dying in the course of another interactional activity, thereby backgrounding the EoL implication. The unmarked case involves the HCP attending to the ongoing activity, which maintains the backgrounding. However, HCPs can target the EoL implications in cues produced in the service of other activities or in cases in which the patient has unpacked with a non-EoL concern.
Conclusion: Although not determinative, the sequential environment in which the cue is deployed shapes how HCPs respond to it. This is important because it permits HCPs avenues for engaging in EoL discussion.
Practice implications: HCPs can better understand the interactional work done with cue like utterances if there are contextualised in the ongoing sequence of interaction. For patients reticent to talk about EoL issues, stepwise engagement with the topic, even when EoL has been backgrounded may provide an opportunity for discussing difficult but essential topics.

1. Introduction

Patients with life-limiting conditions benefit from opportunities to discuss worries, fears, and concerns, which may relate to end-of-life (EoL) issues. However, raising these topics is difficult for patients and healthcare professionals (HCPs) alike and inherently risky [1]. Part of ensuring good communication involves assessing patient readiness to discuss EoL issues [2]. In much of the existing literature patients' cues are treated as indicative of this readiness [3]. Widely, the literature posits that patients use cues to hint at concerns rather than articulating them overtly. Cues can be defined, "as a verbal or non-verbal hint which suggests an underlying unpleasant emotion and that lacks clarity" (p.141) [4]. They may include "vague words, metaphors, repetitions and unusual descriptions of symptoms" (p.220) [5]. Cues are treated as providing a means for patients to introduce delicate topics and opportunities for HCPs to encourage patients to elaborate and explore potential concerns. These studies suggest that for successful reassurance of patients it is crucial to recognise and attend to patient cues [5]. The literature discusses cues about any emotional issue but in this report, we more specifically investigate utterances that in context can be heard as possibly alluding to EoL concerns (we refer to these as 'cues' henceforth). More significantly, we also diverge by taking an interactional view of cues. We distance ourselves from the assumption that the cue suggests an underlying unpleasant emotion (or any internal state), positivistically understood. That is, we suspend assumptions about putative internal states (which is not to say that they do not exist or motivate action, as you say; we simply do not know). Rather, we consider them as social actions. We observe that elements of patients' talk can be heard in context as possible allusions to EoL matters, regardless of why they are produced, and HCPs can respond to them in ways that treat them as resources for focused and sustained EoL talk [6].

We explore the intersection of cues with their sequential location.

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Sequences are "ordered series of turns through which participants accomplish and coordinate an interactional activity" (p.157) [7]. If the design of the talk foregrounds the content of the cue as the primary focus of the sequence, the interactional expectation to respond to that content is likely to be high because of the structural features and preference for progressivity [8]. In other cases, the cues are done in service of another sequential activity and thus backgrounded, meaning there is little or no sequential pressure to respond to the possible EoL element. The role of the cue within a sequence thus shapes the interactional expectation for recipient response. Being able to make this differentiation and respond accordingly is an important practical task for HCPs and this has not been explored in previous research.

In this article, we examine cues as interactional objects that allusively and/or ambiguously refer to EoL matters. We isolate cases where the content of the cue is the main focus of a sequence (foregrounded) and cases in which the cue occurs in service of another interactional activity (backgrounded). From this, we differentiate the variation of interactional import depending on the way in which EoL is invoked. We identify constraints and affordances of these sequential features of cues for how HCPs can respond and for the possibility of engaging in focused and sustained discussion about EoL matters.

2. Methods

The dataset comprises recordings of 85 inpatient and outpatient consultations in a large UK hospice, involving 85 patients with life-limiting conditions (including motor neurone disease, cancer, heart failure), their companions when accompanied (38 companions) and 14 HCPs (six palliative medicine consultants, five occupational therapists, and three physiotherapists).

Most consultations (85 %) were video-recorded with the remainder being audio only. A thorough description of the methodological approach of the video-based research is described elsewhere [9]. All data were transcribed verbatim and the entire dataset was examined for cues. Extracts identified for detailed analysis were transcribed using Jeffersonian transcription [10], see Appendix A. Identifying information was pseudonymised. Ethical approval was provided by UK NRES Committees Coventry & Warwickshire (Ref: 14/WM/0128) in 2014, and Nottingham 2 (Ref: 17/EM/0037) in 2017 (see [9] for more details).

All utterances that, in context, can be heard as allusive, ambiguous, or oblique references to EoL matters were identified. The data extracts containing candidate phenomena (100 instances taken from 57 consultations) were analysed using conversation analysis (CA), a methodologically distinct approach to studying naturalistic interaction. CA treats talk and visible conduct, such as gestures, as social actions that make up sequences of actions. Those sequences show stable patterns so that talk/conduct has a broadly predictable outcome through which participants co-construct shared understanding [11]. For a detailed overview, see [12,13], and [11]. We build on CA work on sequence and turn design, specifically the notion that turns often implement primary actions but may also have secondary activities and components [8].

3. Results

We found that sometimes the content of the cue is sequentially foregrounded and this exerts sequential pressure to respond to that content. This type of production and corresponding response occurred in 36 cases. Conversely, the cue may be sequentially backgrounded by producing it in service of another action and this exerts pressure to respond to that action rather than the content of the cue. This production and response occurred in 37 instances. Because the HCP responds to the cue in the same way as it is produced, these are *unmarked cases*. However, HCPs may not engage with the content of the cue even when it has been foregrounded topically (15 cases) or HCPs may foreground the EoL aspect even when it has been backgrounded (12 cases). Because the HCP responds in a different way to how it is produced, these are *marked cases*.

Over the five extracts analysed, this foregrounding and backgrounding will be demonstrated. The interactional environment in which the cue is deployed introduces constraints and affordances for HCPs' responses. However, it is not determinative; patients may foreground a cue, but HCPs may avoid engaging with it (Extract 3). Conversely, HCPs can foreground cues that patients have produced in the service of other actions (Extract 5). Table 1 provides a summary.

3.1. The cue is sequentially foregrounded and the HCP maintains that foregrounding

There are features of turns that sequentially foreground the cue and increase the pressure to respond to its content. Features of sequence and turn design that frame the cue as the primary action include being part of a sequence initiating action [8] and being the central focus of an interactional activity such as a telling or problem presentation. Extracts 1–3 exemplify this.

Extract 1 shows a turn that foregrounds a cue, which increases the interactional expectation to respond to it (despite some delay, discussed later), and it results in response to its content. Therefore, it is an unmarked case. The cue occurs during an extended telling in which the patient (with a diagnosis of frailty from historical treatments) complains about ongoing difficulties. The first indication of possible concerns is the description of tendency towards depression (lines 18–19). The repair from the mitigated positive ("a wee touch…" line 18) to the negative ("I wouldn't say depressed," line 19) downgrades the severity and projects more to tell, which is produced (line 21). The doctor receipts but no more, thereby providing for patient expansion without actively soliciting it. The patient draws on warrants for the topic: referencing a supportive third party (line 24, see [14]); describing extensive experience of ill health (lines 31–33); and claiming awareness of problem escalation (line 45). EoL relevance is reflexively constituted and often ambiguous. In the context of the hospice, for a patient with a life-limiting diagnosis, reference to depression can be hearable as EoL implicative (thus, a cue) [15]. There is interactional expectation to respond to the cue: it is placed at possible end of the telling (lines 47–48), it is a reiteration, and it is the main focus of the problem presentation. The patient thus frames it as an

Table 1
A summary of cues with EoL foregrounded/backgrounded and the foregrounded/backgrounded responses.

	Cue is foregrounded in the interactional activity	**Cue is backgrounded in the interactional activity**
	Unmarked case (Extracts 1 and 2)	Marked case (Extract 5)
HCP foregrounds the EoL content of the cue in their response	Applies sequential pressure for the HCP to attend to the potential EoL concern embedded within the talk and the HCP does so. (36/100 of cases)	Lower (or no) sequential pressure for the HCP to respond to the potential EoL concern embedded within the talk but the HCP does responds to the EoL implications (12/100 of cases)
	Marked case (Extract 3)	Unmarked case (Extract 4)
HCP backgrounds the EoL content of the cue in their response	Applies sequential pressure for the HCP to attend to the potential EoL concern embedded within the talk but the HCP does not do so. (15/100 of cases)	Lower (or no) sequential pressure for the HCP to respond to the potential EoL concern embedded within the talk and HCP responds to an ongoing interactional activity instead (37/100 of cases)

object for further talk.

Extract 1. [VERDIS_DOC16.1 04,09 VT83 VL]

[Pat: Lynn, a diagnosis of frailty from a long history of treatments. HCP: Mick, Doctor]

```
1.    Pat:    I still go to the toilet still myself, on my frame, bu[:t
2.    Doc:                                                         [Yeah¿
3.              (0.5)
4.    Doc:    So you can't manage that now?
5.              (.)
6.    Pat:    I do:. Yes:.
7.    Doc:    You still manage that.
8.    Pat:    M:↓m.
9.              (0.4)
10.   Doc:    °°Okay.°°=°But you notice your breathing,
11.             (0.3)
12.   Pat:    M:[↓m.
13.   Doc:       [much more.
14.             (1.2)
15.   Pat:    (.k) It's:: (0.5) hhh (1.0) a big effort.
16.   Doc:    Okay.
17.             (1.1)
18.   Pat:    U:m (2.1) I ave been a- (0.3) weee:: touch (0.8)
19.           (>> 'u know) I wouldn't say .hhhhh depressed but (0.2)
20.   Doc:    M[:
21.   Pat:     [I've been aware of a mood swing down, (.)
22.   Doc:    Right.
23.             (0.5)
24.   Pat:    And I said to Michael that I would mention it to yahh.
25.   Doc:    Okay.
26.             (0.8)
27.   Pat:    ((coughs))/(0.5)
28.             (1.5)
29.   Pat:    ((coughs))/(0.6)
30.             (4.5)
31.   Pat:    O'viously with (0.2) having (.) had so much experience of
32.           ill health, (0.8) I I know when this: (0.8) >can
33.           come< on
34.           and (.) a[nd I (know I) shouldn't ignore=i:[th.
35.   Doc:             [Yeah.                          [Right.
36.             (0.2)
37.   Doc:    °Okay¿°
38.             (0.5)
39.   Pat:    And ay- I know I need to tell youh.
40.   Doc:    Okay.
41.             (0.4)
42.   Pat:    It's not (0.5) #u:m# (0.9) a desperate problem >or
43.           anything< like tha:[t.
44.   Doc:                     [No
45.   Pat:    But we don't want it to get that way do w[e        s:]o (0.8)
46.   Doc:                                             [(Okay./No.)]
47.   Pat:  → I'm just telling you tha~: (0.4) um my mood has dripped- (0.4)
48.         → dropped a #bi:t.#
49.             (0.8)
50.   Doc:    Do you think that's re- that's (a-/all) around your
51.           breathing getting wo:rse o:r (.) something e:lse?
52.   Pat:    tk If you wan'- (that was fear I think) just fear.
53.   Doc:    Fear_
54.   Pat:    Just fear.
55.             (0.7)
56.   Pat:    Juss (.) ~the reality of knowing what's happening a:n:' (0.2)
57.   Doc:    (fine/ay/M:h.)=
58.   Pat:    =not being able to (0.6) >↑DO anything about it.<
```

The doctor does not respond immediately, and a silence emerges (line 49). We account for this as the doctor giving the patient the opportunity to say more. The patient nevertheless does not continue, which tacitly renews the relevance of response from the doctor. The response relevance of a cue is thus mutually worked up interactionally, through turn design, but also through practices of turn taking and sequence management [16].

The doctor's response promotes elaboration by inviting an explanation for the low mood (lines 50–51), thus maintaining the cue foregrounded. He offers the candidate "your breathing getting worse" as a possibility linking to prior talk, however, he adds "or something else" which provides for another reason without proposing what that might be. The patient offers "just fear", which is receipted with a partial repeat. 'Fear' in the context of the hospice can be heard as EoL implicative as becomes clearer in the subsequent elaboration (lines 56 and 58). Following this extract, the doctor builds on this to promote focused EoL talk.

Similarly, Extract 2 shows a cue foregrounded. The patient (who has cancer and is in bed) is evidently in pain, and she and the doctor are waiting for a nurse to bring a painkiller. They have been discussing the patient's deterioration. The doctor moves slightly to the positive with a question about the patient's friends visiting (line 1) and follows up with a question regarding their supportiveness (line 6). These attempts to engage the patient in positive talk are undermined by the patient resisting the presupposition that anyone can alleviate her situation (lines 12–13, 15 and 18). The cue (lines 20–21) is foregrounded. It is a telling and it is an extreme formulation in which the patient frames her experience as unbearable. Having described not wanting to be in pain (line 18), her pronouncement of getting to where she does not want to be "here" (line 21), is hearable as possibly alluding to dying. There is high interactional expectation to respond to this cue: it is at possible end of turn (lines 47–48), a reiteration, and the main topic.

Extract 2. [VERDIS_DOC04.2 09,18 VT169 MP]

[Pat: Lucy, diagnosis of cancer and here is in bed. HCP: Audrey, Doctor]

```
1.    Doc:    Are your friends visiting you?
2.            (0.2)
3.    Pat:    .hh ~(>They say<) they are toni:::ght?~
4.    Doc:    °°Mm:.°°
5.            (4.4)
6.    Doc:    °tkl (Are they being/Have they been) supportive.°
7.    Pat:    Yea~::~h.=
8.    Doc:    =°°Mm:°°
9.            (0.4)
10.   Pat:    Very.
11.           (3.8)
12.   Pat:    .hh They keep asking ~me if I need~ (.)
13.           if they can do anything,
14.           (1.3)
15.   Pat:    But I don't ~nee:d~ anything?
16.   Doc:    °°No:.°°
17.           (1.2)
18.   Pat:    I just don't want to be in p~ai::n_~
19.           (1.2)
20.   Pat:  → And if I'm honest (0.3) .hh (.) I don'- I'm getting
21.         → where I don't want to be here a~nymore_~
22.           (1.4)
23.   Doc:    Here¿
24.           (0.6)
25.   Pat:    Just- (0.3) ali::ve.
26.   Doc:    Alive.
27.           (0.9)
28.   Pat:    Not li:ke °thi:s.°
29.   Doc:    °°(Mm mm.)°°
30.           (1.1)
31.   Pat:    It's just too ↑horri°ble.°
32.           (2.2)
33.   Doc:    Do you think about dying a lo:t.
34.           (1.2)
35.   Pat:    A ↑bi~:t?~=
36.   Doc:    °A bit.°
37.   (Pat?:) hh
38.           (0.5)
39.   Pat:    .hh I feel like it's coming to the e:n:d,
40.            (1.9)
```

The ensuing 1.4 s silence (line 22) is consistent with Extract 1. It ends with the doctor's repetition of "here" (line 23), which treats the meaning as potentially ambiguous, with slightly rising intonation inviting clarification [17]. At least two possible understandings are available: not wanting to be alive or not wanting to be in the hospice. The doctor thus responds to the content of the cue, maintaining its foregrounding, offering the opportunity to expand. The patient disambiguates "here" with "alive" (line 25). The doctor's repeat (line 26), without rising intonation, receipts and hands the turn back to the patient and, after a short gap (line 27), the patient moves to more explicit EoL talk.

In Extracts 1 and 2, there is sequential pressure to respond to the cue as it is the central focus of a patient's problem presentation/report. The context and the patient's condition contribute to hearing this as a cue. The HCPs respond to the cue, thus maintaining its foregrounding, providing for further elaboration. In both extracts, there is delay after the cue and before the HCP responds. This offers the patient an opportunity to expand. By withholding talk, the patients produce the interactional expectation of a response, which the HCPs produce in both cases by promoting elaboration. This careful navigation paves the way for the subsequent EoL talk.

3.2. *The cue is sequentially foregrounded and the HCP backgrounds it*

Mostly, when there is sequential pressure to respond to the content of

the cue (e.g., it is in first position, a telling or problem presentation, and/or the main focus of the talk) it does result in HCP engagement with the cue content. However, it is not determinative, as Extract 3 demonstrates.

In Extract 3, the patient has motor neurone disease (MND) and the physiotherapist (PT) is performing acupuncture. After mutual orientation to the task-at-hand (lines 1–6), the patient initiates a telling about a person in the news who is undertaking a legal battle for the right to euthanasia. The PT claims familiarity with a newsmark (line 12) [18]. This receipts and claims knowledge, without taking a stance. The patient pivots from the third party to himself with the cue, "I am entirely with him" (line 14). This pronouncement is ambiguous as it could mean that he supports the man's case, or that he would choose euthanasia for himself. Consistent with the previous two extracts, the HCP provides for the patient to continue. Here, she does that with a 'mm' (line 15) [19], which passes taking a full turn and returns the talk to the patient (in Extracts 1 and 2, provision for more from the patient is achieved through silences). The patient disambiguates the relevance of the High Court case for his own situation (lines 16–7 and 20–21).

Extract 3. [VERDIS_AHP18.1 08,56 VT269 VL]

[Pat: Jon, diagnosis of Motor Neurone Disease (MND). HCP: Christine, Physiotherapist]

```
1.    PT1:    .h It >was< just those (.) ones I
2.            wanted to put in (.) while you'[re sitting there,=
3.    Pat:                                   [Mm.
4.    PT1:    ='cause I know you'll be more comfy when we put
5.            your legs around here won't (you).
6.    Pat:    Yeah?
7.             + (2.1)
      PT1:     + puts something in the bin
8.    Pat:    There's that (0.2) there's a bloke in the High
9.            Court, and (                ) (0.5) and he wants
10.           the right to be (0.4) euthanized,
11.            (0.5)
12.   PT1:    + Oh yes, I heard about [him on the n[ew:s yeah,
      PT1:    + positions herself in front of the patient
13.   Pat:                           [Y:eah.      [An:d
14.   Pat: →  .hhh And I a, I am entirely with him.
15.   PT1:    Mm[:_
16.   Pat:      [Because (.) I just think (.) "(Hold on) I'm, I'm
17.           not gonna walk away," I [know that.
18.   PT1:                          [Mm:_
19.   PT1:    Mm:_=
20.   Pat:    =So (0.5) the sooner I can make the decision now while
21.           I ca:n
22.   PT1:    Mm mm.
23.   Pat:    I'm capable of doing it, (.) and making sure
24.           it's all in place, and it's right?
25.   PT1:    Mm:.
26.   Pat:    And (1.3) if I can't do that, (.) then what chance
27.           have I got?=I've got tuh (2.0) #bu# (.) either go full
28.           term or commit suicide well before I need tuh.
29.             (0.9)
30.   PT1:    Mm:.=
31.   Pat:    =To make sure I don't get there.
32.             (1.0)
33.   PT1:    What a decision though.
34.             (0.8)
35.   Pat:    (          ) I know. (.) But it's gotta be done.
36.             (0.6)
37.   Pat:   ((sniff))
38.             (0.7)
39.   PT1:    Is your doctor Mick Johnson.
40.             (0.8)
41.   PT1:    O:[:r
42.   Pat:      [Here¿
43.   PT1:    Michelle Mor- yeah?
44.   Pat:    I've had both.
45.   PT1:    Okay.
```

The progressive elaboration of the cue (line 14) moves from ambiguous to explicit. This incremental building, silences and PT's minimal responses are consistent with Extracts 1 and 2. However, in Extract 3 the PT consistently postpones responding (see silences on lines 29 and 32). The patient's telling is potentially complete at line 28. After nearly a second of silence the PT passes the opportunity to comment fulsomely with, "mm" (line 30). The patient adds the increment "to make sure I don't get there" (line 31) thereby renewing the relevance of response. In contrast to Extract 2, where the doctor targets the ambiguous element to prompt expansion, the patient here does all the interactional work of elaborating. Tellings are normatively built for recipient response to their content and here the topic is dramatic. Moreover, the recompletion (line 31) pursues a response. Although the PT physically positions herself in front of the patient (having previously stood behind him to perform the acupuncture), suggesting recipiency (line 12), she does not engage with the content. When the PT responds (line 33), it is not encouraging further elaboration. Instead, she foregrounds the difficulty of the decision and, therefore, not even the activity itself. Also, even though it is likely to be hearable as responding to the most proximate telling (reports of his thoughts of suicide), the phrasing of the assessment maintains ambiguity of whose difficult decision it is (the man in the High Court or the patient), and it does not take a stance on or engage with the decision at all, thereby backgrounding the EoL relevance for the patient. The PT moves the topic onto practical questions about the patient's ongoing care (line 39) preliminary to suggesting that he talks further with his doctor, which conveys that EoL talk as not within her remit.

From the initial telling about a third party, the patient gradually disambiguates to foreground EoL issues for himself. The PT displays passive recipiency through minimal responses. There are many reasons for non-engagement: taboo/illegality of euthanasia, timekeeping, or the remit of the session (physical therapy). A cue is produced as main business of the talk and elaborated with clear patient-relevant EoL meaning thereby increasing pressure to engage with that EoL content. Yet, the PT uses a non-committal assessment as a strategy to acknowledge but avoid engagement. The PT backgrounds what the patient has foregrounded.

3.3. The cue is backgrounded in the interactional activity and thus HCP maintains that backgrounding

Cues can occur in service of another interactional activity. In such environments there is no intentional expectation to respond to the cue as it is backgrounded. In Extract 4, the patient is attending a breathlessness clinic. He has reported communication problems with his wife, eating difficulties, and his reluctance to use aids. He stated, "my motto is 'I can, and I will'" (not shown). Therefore, following assessment of his capacity to manage his daily routine (lines 1–19), when the OT asks how he feels about it and continuing it (lines 20–22), it is hearable as a precursor to suggesting change [20]: a pre-recommendation [21]. Moreover, the turn final 'or' of the OT's second question epistemically downgrades the question [22], indicating expectation of patient resistance.

Extract 4. [VERDIS_AHP02.1 21,32 VT574 VL]

[Pat: Reece, diagnosis of heart disease. HCP: Jane, Occupational Therapist]

```
1.    Pat:     Twelve o'clock. [(Go for my walk)
2.    OT1:                     [So you have (.) q-quite a
3.             clear routi:ne.
4.    Pat:     Yeah. Yeah.
5.    OT1:     Each day.
6.    Pat:     Ye: Every day.
7.    OT1:     Y[eah.
8.    Pat:      [Yeah, yeah. Nothing .hh much alters.  Only
9.             [once a week,
10.   OT1:     [No.
11.   OT1:     No.
12.   Pat:     We go to a different Sainsbury's to meet .hh
13.            the wife's cousin.
14.             (0.5)
15.   Pat:     But no, nothing.= That's
16.            ju[st— that's virtually [.h s-six days a week.
17.   OT1:       [◦Yeah.◦              [So you always-
18.            So you know what's happening.
19.   Pat:     Yeah.
20.   OT1:     .hhh hhhh How do you feel about that routine. =
21.            Is it something: that you want to continue
22.            with [or:
23.   Pat: →        [Well (0.8) if I (1.0) didn't continue with
24.        →   (1.0) to me (0.5) I would be surrendering.
25.   OT1:     Okay.
26.             +(1.5)
      Pat:      + purses lips then raises eyebrows and nods head down
27.   Pat:     I'd be surrenderin[g.
28.   OT1:                       [Yeah:.
29.   Pat:     Uhm (0.5) admitting (0.8) which as I say with
30.            +that  (0.2) >I don't wanna use it but<
      Pat:     +points with thumb to rollator
31.            + .h (0.5) +that's admitting >I don't
      Pat:     + points again
32.            wa[nna use it.< I don't want to =
33.   OT1:       [Mm.
34.   Pat:     = admit that I'm +[pfft going (t) =
      Pat:                       + hand/finger gesture downwards
35.   OT1:                       [Yeah.
36.   OT1:     =tcht I'm j- just wondering, just as a
37.            suggest[ion whether there are .hh (.) just =
38.   Pat:           [Mm.
39.   OT1:     = small changes, so you could still go to
40.           Sainsbury'[s and get your shopping and come =
41.   Pat:             [Yeah.
42.   OT1:     = home and do those things, but whether .hh maybe
43.            not do it—  If you had somebody to scan the
44.            food for you and pack it for [you.
45.   Pat:                                  [(Uh/Well) no,
46.            there was [som—
47.   OT1:              [Might be helpful.
```

The "well" preface (line 23) suggests upcoming disagreement [23,24] perhaps through a 'my-side telling' [25], and is associated with potentially inapposite responses while also privileging the current speaker's perspective [26]. Here, the patient has already highlighted the importance of his routine and reticence to change. His conditional response is not outright rejection but rather invocation of an unfavourable outcome of any projected changes (see [27]). It is more subtle than a clear block as it pre-empts the projected recommendation. The patient resists the implied suggestions by characterising them as "surrendering" (line 24). Surrendering alludes to deterioration and/or moving closer to death but retains ambiguity; it is thus a cue. The OT receipts but does not take a stance (line 25) and, after a silence, the patient elaborates further (lines 30–32 and 34). The 'pfft' (line 34) indicates expiration/deflation and is accompanied by a downwards hand gesture, readable as going downhill or demise towards death.

Unlike Extracts 1–3, the statement about not wanting to surrender is not presented for further elaboration. Features of turn design and sequence mean the EoL implication is available but backgrounded: it is in sequence-responding position (answering the OT's question) and it is in service of resisting a projected suggestion of change. After the patient 's elaboration, the OT disattends to the EoL implications in favour of attending to the main business of the sequence in progress by pursuing lifestyle changes (line 36). The cue is consequential in that the suggestion is articulated in mitigated form: three instances of minimizing "just" (lines 36 and 37), reduced to a "wondering" (line 36), framing as "just a suggestion" (lines 36–37), characterising the proposed changes as "small" (line 39), and confirming the parts of the routine that would remain unchanged (lines 39–40 and 42). The OT maintains the backgrounding by not attending to the EoL implication. The ongoing action is at the forefront of this interaction rather than the EoL-implicative content.

3.4. The cue is sequentially backgrounded and the HCP subsequently foregrounds it

HCPs may respond to the EoL implications of the cue even when it is in service of another ongoing activity. This requires considerable interactional work. In Extract 5, the doctor picks up EoL implications where there is low sequential pressure to do so as there are other interactional activities underway.

In Extract 5, the doctor treats the patient's wife's absence as problematic (lines 1–2) through a negative interrogative, which are often associated with complaints [8]. The patient denies the grounds of that observation, positing the situation as normative and therefore not accountable (lines 5–6). The patient is generally provocative, demonstrated here with joking about having seen enough of HCPs (line 10), claiming it is not doing him any good (line 13), and a rhetorical question (line 17). It is a strong case for undermining the doctor's complaint. The doctor's responses are minimal. Line 14 is a post-laugh inbreath, not preparation to speak, so the first attempt at a rebuttal occurs at line 18, halted as the patient starts a turn containing the cue (lines 19–20).

Extract 5. [VERDIS_DOC36.1 15,45 VT434 VL]

[Pat: Peter, diagnosis of Chronic Obstructive Pulmonary Disease (COPD). HCP: Michelle, Doctor]

```
1.    Doc:   .hh Did your wife + (1.5)
      Doc:                     + hand moves backwards and forwards
2.    Doc:   not think about coming with you this morning?
3.    Pat:   I told her not to.
4.    Doc:   Did you.=
5.    Pat:   =I always tell her not to come t'hospital or anything with
6.           mih.
7.    Doc:    Right.
8.    Pat:   (Y'know/Yeah:).
9.    Doc:   Okay.
10.   Pat:   No: I said, "I've seen enough of these. You don't wanna
11.          see + them."
      Pat:        + gestures to the HCPs
12.   Doc:   Uh[(h)h h h huh huh huh [huh
13.   Pat:     [(Y'know?)           [Well (it's) doing me no good is ↑it.
14.   Doc:   .hh[h
15.   Pat:      [You know.
16.           (0.4)
17.   Pat:   + What does my wife wanna come for.
      Doc:   + reaches for stethoscope
18.   Doc:   We[ll-
19.   Pat:     [We're at that age now where (.) if anything's going'a
20.          happen, it's going to happen.
21.           (.)
22.   Doc:    Okay.
23.   Pat:   When you get nearer eighty, (0.2) (uhuh) th'n seventy,
24.          then phhh phhh you don't bother. Well I don't anyway.
25.   Doc:   So you don't worry about +(0.4)
      Doc:                           +slight shaking of the head
26.   Doc:   dying and things like that.
27.   Pat:   ↑Oh ↓no. God no.
28.   Doc:   Okay.
29.   Pat:   If you've got to go, you've got to go. = That's what I've
30.          said to tha wife all the time.
31.   Doc:   ◦Okay.◦
32.   Pat:   You know. I mean I've been lucky really. Tha've had
33.          .hh three aneurisms.
34.   Doc:   ↑Mm.
```

The tautology at lines 19–20 is a further instance of the patient undermining the doctor's action. Death is alluded to with the indexical "it" (line 20). Idiomatic phrasing is generally used to close sequences and make disagreement more difficult [28]. There is lower sequential pressure to respond to the content of the cue as it is produced as part of a counter to complaint and to close the matter; it is not offered for further elaboration.

Like Extract 4, the cue in Extract 5 is an account for something counter to the HCP's position. The patient is challenging the expectation that his wife should be present. But, in Extract 5 – unlike Extract 4 – the doctor responds to the content of the cue (lines 25–26), foregrounding what was backgrounded. The 'so' (line 25) ostensibly builds off the

patient's talk and, coupled with the negative phrasing, is hearable as almost challenging the patient's position. It is an explicit reference to death, although the silence and head shaking prior to 'dying' and addition of 'things like that' (line 26) mitigate it. After this extract, the doctor promoted focused EOL talk by asking about preferred place of dying.

In Extract 5, the patient alludes to death but does so in response to the doctor's implied complaint and not for further development, thereby backgrounding the EoL implication. However, the doctor uses it as an interactional opportunity to initiate EoL talk. This is significant as it represents a strategy for HCPs to facilitate EoL talk, we will consider this in the discussion.

4. Discussion and conclusion

4.1. Discussion

In the existing literature, cues are often conceptualised as subtle ways of raising a topic. Our analyses confirm that some utterances can be treated as 'cues' in context, meaning that responding to them (by proposing a meaning for them, like Extract 5, or inviting the patient to say more, like Extracts 1 and 2) can lead to talk about EoL matters. But previous literature disregarded where they happen and how they are designed. This led to the misconception that every cue that is not responded to is a missed opportunity to promote discussion about such emotionally charged matters as the patients' thoughts, feelings, values, and preferences surrounding EoL matters. In contrast, our findings show that only cues that are foregrounded through features of turn design and sequential placement are designed to be responded to (Extracts 1–3). We have also shown when cues are backgrounded, there is lower (or no) sequential expectation to respond to their content as these oblique or ambiguous references are in service of other interactional projects. Significantly, we have also demonstrated that HCPs can foreground a backgrounded cue as a resource for initiating EoL talk.

In a hospice setting, the relevance of EoL discussion is omnipresent. Invocation of troubles and concerns are primed to be potentially hearable as EoL implicative. For example, "I'm worried about what's going to happen" might be considered to allude to other possible worries in most settings, whereas in the hospice, patients, companions and HCPs are primed to interpret the worry as potentially – but not definitively – EoL related. "My mood has dropped" (Extract 1), "I would be surrendering" (Extract 4) and "if anything's going to happen, it's going to happen" (Extract 5) are all oblique references which, in another setting, could be cues to some other concern or worry but in the hospice are hearable as EoL implicative, because of the patients' diagnoses of life-limiting conditions and the remit of palliative care. The EoL relevance of the setting is both oriented to and reproduced in this way in a hospice setting. Nonetheless, the phenomenon described here has relevance beyond the setting.

Across the extracts, HCPs give space after patient cues, regardless of whether maintaining or disrupting the patient's foregrounding/backgrounding of the EoL implications. Silences and minimal recipiency routinely occur after the cues. Silence after an initiating action (such as an invitation or suggestion, for example) often projects a less preferred response [29] and is associated with interactional trouble. However, in these cases it seems that the HCPs are being interactionally cautious about raising sensitive topics without explicit indication that prior talk has provided for it [15].

4.2. Conclusion

Patient cues involve allusive or ambiguous reference to EoL. The end-of-life aspect may be foregrounded or backgrounded through the content and through turn design and sequential features of the talk. There is sequential pressure for HCPs to maintain that foregrounding or backgrounding in their responses. In this way, the sequential environment in which the cue is deployed shapes how HCPs respond to it. However, it is not determinative, and HCPs may resist that pressure to avoid engaging with EoL or to pursue EoL talk.

4.3. Practice implications

Responding in a way that promotes further articulation of the cue (which could lead to explicit and sustained EoL talk) is a situated decision. The key practice implication is that it is important for HCPs to have awareness of the interactional expectations introduced by the design and placement of the cue. Some are designed to be responded to and thus present the opportunity potentially to engage in EoL talk; others are not. A field of choices is available to HCPs - this includes backgrounding a foregrounded cue and foregrounding a backgrounded cue. It is a situated choice, which is highly contextual, depending on the patient's circumstances, context of the interaction, and the agenda or project the HCP may wish to pursue. Our analyses offer a mapping of how these choices can be implemented and some of the interactional consequences they can lead to. Additional research would be useful to further investigate the consequences of the four configurations.

The HCPs in this dataset specialise in palliative care so these strategies might not be easily transferable to staff who do not have the same specialist skills. However, there is significant evidence that HCPs can acquire these skills [30].

CRediT authorship contribution statement

Marco Pino: Writing – review & editing, Visualization, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Victoria Land:** Writing – review & editing, Writing – original draft, Visualization, Project administration, Methodology, Formal analysis, Data curation, Conceptualization.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A

Transcription key

?	Talk ending with rising intonation
¿	Talk ending with slightly rising intonation
.	Talk ending with falling intonation
,	Continuing intonation
underline	Emphasised talk
° °	Talk inside the symbols is quieter than surrounding talk
> <	Talk inside the symbols is faster than surrounding talk
[]	Overlapping talk
(word)	Unclear talk, words contained within are the transcriber's best estimate
(/)	Alternative hearings
(())	Descriptions of non-verbal information
+	Gestures and physical activities
.hhh	Inbreath
hhh	Outbreath
–	The sound prior to the hyphen is 'cut off'
:	The sound prior to the colon is lengthened
=	Talk is 'latched' to preceding talk so there is no silence at all in between
(0.8)	Length of silence, measured in seconds
(.)	A silence of less than a tenth of a second
↓	Raised pitch
#	Talk with a creaky voice quality
~	Shaky voice

References

[1] Almack K, Cox K, Moghaddam N, Pollock K, Seymour J. After you: conversations between patients and healthcare professionals in planning for end of life care. BMC Palliat Care 2012;11(1):15. https://doi.org/10.1186/1472-684X-11-15.

[2] Ngo-Metzger Q, August KJ, Srinivasan M, Liao S, Meyskens FL. End-of-Life care: guidelines for patient-centered communication. Am Fam Physician 2008;77(2):167–74.

[3] Uitterhoeve R, Bensing J, Dilven E, Donders R, deMulder P, van Achterberg T. Nurse-patient communication in cancer care: does responding to patient's cues predict patient satisfaction with communication. Psychooncology 2009;18(10):1060–8. https://doi.org/10.1002/pon.1434.

[4] Zimmermann C, et al. Coding patient emotional cues and concerns in medical consultations: the Verona coding definitions of emotional sequences (VR-CoDES). Patient Educ Couns 2011;82(2):141–8. https://doi.org/10.1016/j.pec.2010.03.017.

[5] Giroldi E, Timmerman A, Veldhuijzen W, Muris J, Van Der Vleuten C, Van Der Weijden T. How doctors recognise that their patients are worried: a qualitative study of patient cues. Patient Educ Couns 2020;103(1):220–5. https://doi.org/10.1016/j.pec.2019.09.023.

[6] Pino M, Land V. How companions speak on patients' behalf without undermining their autonomy: Findings from a conversation analytic study of palliative care consultations. Sociol. Health Illn. 2022;44(2):395–415. https://doi.org/10.1111/1467-9566.13427. PMID: 35157323; PMCID: PMC9306617.

[7] Mazeland H. Conversation analysis. In: Brown K, editor. Encyclopedia of language & linguistics (Second Edition). Oxford: Elsevier; 2006. p. 153–63. https://doi.org/10.1016/B0-08-044854-2/00314-X.

[8] Schegloff EA. Sequence organization in interaction: a primer in conversation analysis, vol. 1. Cambridge: Cambridge University Press; 2007. https://doi.org/10.1017/CBO9780511791208.

[9] Pino M, Land V, Hoey E. Moving Towards (and Away From) Possible Discussions About Dying. Soc. Interact., Video-Based Stud. Hum. 2024;7(3). https://doi.org/10.7146/si.v7i3.144611.

[10] Jefferson G. Glossary of transcript symbols with an introduction. In: Lerner GH, editor. Pragmatics & beyond new series, 125. Amsterdam: John Benjamins Publishing Company; 2004. p. 13–31. https://doi.org/10.1075/pbns.125.02jef.

[11] Drew P, Chatwin J, Collins S. Conversation analysis: a method for research into interactions between patients and health-care professionals. Health Expect 2001;4(1):58–70. https://doi.org/10.1046/j.1369-6513.2001.00125.x.

[12] Sidnell J, Stivers T. The handbook of conversation analysis. John Wiley & Sons; 2012.

[13] Antaki C. Six kinds of applied conversation analysis. In: Antaki C, editor. Applied Conversation Analysis: Intervention and Change in Institutional Talk. London: Palgrave Macmillan UK; 2011. p. 1–14. https://doi.org/10.1057/9780230316874_1.

[14] Heritage J, Robinson JD. Accounting for the visit: giving reasons for seeking medical care', in Communication in Medical Care: Interaction between Primary Care Physicians and Patients. In: Maynard DW, Heritage J, editors. Studies in Interactional Sociolinguistics. Cambridge: Cambridge University Press; 2006. p. 48–85. https://doi.org/10.1017/CBO9780511607172.005.

[15] Pino M, Parry R, Land V, Faull C, Feathers L, Seymour J. Engaging terminally ill patients in end of life talk: how experienced palliative medicine doctors navigate the dilemma of promoting discussions about dying. PLoS One 2016;11(5):e0156174. https://doi.org/10.1371/journal.pone.0156174.

[16] Sacks H, Schegloff EA, Jefferson G. A simplest systematics for the organization of turn-taking for conversation. lan 1974;50(4):696–735. https://doi.org/10.1353/lan.1974.0010.

[17] Kitzinger C. Repair. The handbook of conversation analysis. John Wiley & Sons, Ltd; 2012. p. 229–56. https://doi.org/10.1002/9781118325001.ch12.

[18] G. Jefferson, The abominable ne?: an exploration of post-response pursuit of response, 1981. Accessed: Jan. 20, 2025.

[19] Schegloff EA. Discourse as an interactional achievement: some uses of" uh huh" and other things that come between sentences. Analyzing discourse: Text and talk/Georgetown University Press; 1982.

[20] Barnes RK. Preliminaries to treatment recommendations in UK primary care: a vehicle for shared decision making? Health Commun 2018;33(11):1366–76. https://doi.org/10.1080/10410236.2017.1350915.

[21] Sacks H. Lectures on conversation. Oxford, UK; Cambridge, Mass.: Blackwell; 1992.

[22] Drake V. Indexing uncertainty: the case of turn-final or. Res Lang Soc Interact Jul. 2015;48(3):301–18. https://doi.org/10.1080/08351813.2015.1058606.

[23] Davidson J. 'Subsequent versions of invitations, offers, requests, and proposals dealing with potential or actual rejection', in Structures of Social Action. In: Atkinson JM, editor. Studies in Emotion and Social Interaction. Cambridge: Cambridge University Press; 1985. p. 102–28. https://doi.org/10.1017/CBO9780511665868.009.

[24] Pomerantz A. Agreeing and disagreeing with assessments: some features of preferred/dispreferred turn shapes', in Structures of Social Action. In: Atkinson JM, editor. Studies in Emotion and Social Interaction. Cambridge: Cambridge University Press; 1985. p. 57–101. https://doi.org/10.1017/CBO9780511665868.008.

[25] Pomerantz A. Telling my side: "limited access' as a "fishing" device. Sociol Inq 1980;50(3–4):186–98. https://doi.org/10.1111/j.1475-682X.1980.tb00020.x.

[26] Heritage J. *Well*-prefaced turns in English conversation: a conversation analytic perspective. J Pragmat 2015;88:88–104. https://doi.org/10.1016/j.pragma.2015.08.008.

[27] Robinson JD. Revisiting preference organization in context: a qualitative and quantitative examination of responses to information seeking. Res Lang Soc Interact 2020;53(2):197–222. https://doi.org/10.1080/08351813.2020.1739398.

[28] Drew P, Holt E. Complainable matters: the use of idiomatic expressions in making complaints. Soc Probl 1988;35(4):398–417. https://doi.org/10.2307/800594.

[29] Pomerantz A, Heritage J. Preference. The handbook of conversation analysis. John Wiley & Sons, Ltd; 2012. p. 210–28. https://doi.org/10.1002/9781118325001.ch11.

[30] Parry R, Whittaker B, Pino M, Jenkins L, Worthington E, Faull C. RealTalk evidence-based communication training resources: development of conversation analysis-based materials to support training in end-of-life-related health and social care conversations. BMC Med Educ 2022;22(1):637. https://doi.org/10.1186/s12909-022-03641-y.