Chapter 1

Introduction - setting the scene

Within the Royal Australian College of General Practitioners (RACGP), the institutional context for this study, there is intense professional interest in the relationship between professional practice and communication. 'Communication skills and the patient-doctor relationship' is the first of five domains of General Practice[1] assessed through the College Examination that measures and confirms a doctor's competence to enter unsupervised general practice (2009a, p. 102).

'Communication skills and the patient-doctor relationship' is similarly fore-grounded as the first of five domains of practice in the RACGP Curriculum for Australian General Practice (RACGP, 2007). The curriculum, implemented by Registered Training Providers (RTP's) who are charged with the responsibility of preparing registrars for unsupervised practice, defines a core set of clinical characteristics and practices that are unique within medicine. It details what a vocational general practitioner needs to learn throughout their learning life, a journey that begins as a medical student considering General Practice and moves through pre-vocational, vocational and continuing professional development stages.

In part, this institutional focus on communication and the patient-doctor relationship can be understood as a response to findings from a large number of research studies from within the medical world that set out evidence for links between the quality of patient-doctor communication and a range of desirable clinical outcomes. These outcomes include patient satisfaction, adherence to treatment, knowledge and understanding of a condition and its management, ability to cope, improved quality of life, and recovery. See Ong, de Haes, Hoos, & Lames (1995), and Stewart (1995) for a review of this literature.

In part, this focus on communication can be accounted for by concerns amongst practitioners to avoid litigation in light of studies that link specific communicative

[1] Other domains assessed are applied professional knowledge and skills, population health and the context of General Practice, professional and ethical roles, and organisational and legal dimensions of practice.

behaviours with fewer malpractice claims in primary care (Levinson, Roter, & Mullooly, 1997).

But beyond this, the institutional focus on communication is in keeping with the principles and practices of a medical specialism that defines itself in terms of relationship (Mc Whinney, 1996), perceives the consultation to be the 'crucial core of medicine' (Middleton, 1989), and increasingly characterises the General Practice consultation as a unique, complex, potentially unpredictable and unstable event that demands much of the communicative capacity of the practitioner (Hammond, 2005; Innes, Campion, & Griffiths, 2005).

It is to be noted that in clinical contexts language and discourse function to mediate the practitioner's medical knowledge and accumulated clinical experience. The good communicator does not necessarily equate with the good doctor and clinical expertise can never be reduced to matters of language and communication (Sarangi, 2004). Nevertheless, General Practice is amongst those health care specialisms where "...the display of communicative ability by the professional is central to the profession's self-definition, not merely some necessary adjunct" (Candlin & Candlin, 2002b, p. 218).

But what constitutes this communicative ability that is considered within the profession to be integral to clinical practice? This thesis sets out to explore this question. The thesis examines the nature of expert communication as it is required by the RACGP for the General Practice of medicine and as it is illuminated by means of fine-grained analysis of the discourse of video-recorded consultations submitted for evaluation by experienced practitioners seeking College Fellowship. The discourse of these consultations is analysed in light of examiners' evaluations of the candidates' communicative performance. The objective is to uncover discursive evidence for these judgements, as well as to offer grounded explanation of how broad categories of communicative expertise, as perceived by examiners are actually achieved in interaction.

Analysis that is set out in the thesis focuses on the discourse of a small number of whole consultations representing three clinical situations that practitioners participating in the study consider to be particularly communicatively challenging, and, as a consequence,

particularly revealing of communicative expertise. These 'crucial sites'(Candlin, 1987), where the communicative abilities of doctors are set at a premium, include consultations where the patient's explicit reason for presentation masks underlying emotional and psycho-social concerns, those involving dissent between patient and doctor over the nature of the patient's condition and how it is to be managed, and triadic consultations where a reticent adolescent patient is accompanied by a third party.

The study aims for outcomes of practical relevance to practitioners. To this end, the discourse analytical study at the heart of the thesis is embedded in an ethnographic project that has enabled the researcher to gain insight into the 'communicative ecology' (Gumperz, 1999) of General Practice. Data from this ethnographic research have informed the analytical process by providing directions along which to look that align with matters of professional interest and concern. 'Focal themes' (Roberts & Sarangi, 2005) which are salient in the discourses on communication that circulate in the profession, specifically those of 'empathy', 'rapport', and 'finding common ground', are a particular focus for analysis. Discourse analytical findings offer evidence for how these 'focal themes' are interactionally, collaboratively, and cumulatively accomplished, and how they interplay in purposeful ways in the specific, challenging encounters under study to shape the trajectory of the consultation.

Ethnographic data has also highlighted those 'professional stocks of interactional knowledge'(Peräkylä & Vehviläinen, 2003) relating to patient-doctor interaction that are to be found in text books, training manuals, and curriculum documents, and that are invoked in clinical teaching and training. These abstract, normative models, communication guidelines, mnemonics and associated phrases suggest a further professionally relevant focus for analysis. How these play out in situ, how they are transformed and expanded upon in practice, and how their salience and substance is challenged in co-constructed, situated interaction is a focus of attention.

This introductory chapter to the thesis sets the scene for the study to follow. The chapter begins by briefly tracing the evolution of General Practice as a distinct specialism within the medical profession that is characterised by a 'communicative mentality' (Sarangi, 2004), and that demands much of the communicative capacity of its practitioners. The patient-centred-clinical model is introduced as an influential paradigm of communication

in General Practice and an over arching 'focal theme' for the study. Turning to the broader institutional context of General Practice, and specifically to the examination and teaching sites, the chapter then sets out how clinical communication is evaluated and how it is taught within the institution. This insight into 'the institutional order'(Berger & Luckmann, 1967) of General Practice including institutionally sanctioned ways of evaluating clinical communication, and professionally recognised teaching practices, provides background knowledge that is necessary for interpreting the study to follow. The chapter then draws upon preliminary ethnographic observations at examination and training sites that led to the development of an initial proposal to the RACGP to carry out a study that aligned with professional interests. Against this backdrop, research aims and research questions are presented. The chapter concludes with an outline of the thesis structure.

1.1. The evolution of General Practice – a communicative trajectory

In tracing the evolution of General Practice as a distinct classification within the medical world, one is also tracing shifts and changes in professional conceptualisations of what makes for effective and appropriate clinical communication. The development of General Practice as a medical specialism reflects a communicative trajectory that involves movement away from doctor-directed communication towards the valuing of collaborative co-constructed patient-doctor interaction as a measure of clinical expertise.

Up until the 18th Century, medicine could be described as person-centred and community based. Doctors based their diagnosis largely on the stories their patients told them. Physical examination was restricted to taking the patient's pulse, and further investigations to the analysis of excreta (Hogarth & Marks, 1998). In such a context the patient's experience of illness was of central importance to the doctor's reasoning about what was wrong and what was to be done. Patient-doctor interaction was crucial and the patient's contribution to talk of particular significance. By the late 18th Century however, there was a shift in focus away from the patient's unique situated illness story. A new kind of doctor-patient relationship, a new system of thought, and a new medical language were developing, brought about by the emergence of the teaching hospital (Foucault, 1973; Marinker, 1998).

For the first time, large numbers of the ill were assembled under one roof and organised to bring together those cases that were considered to be most instructive. Through observation and comparison of numerous cases, doctors began to classify conditions and to develop abstract, ideal disease models. Whilst doctors in the hospitals continued to listen to their patients' stories, their focus and purpose in doing so had changed. "In hearing what patients had to say, they were no longer trying to understand the unique histories of individuals. They searched instead for what may have been the common characteristics of the same disease in different people" (Hogarth & Marks, 1998, p. 142). Under this new 'clinical gaze'(Foucault, 1973) what the patient said was of less importance than what the doctor could see and perceive.

As scientific knowledge developed and signs and symptoms associated with abstract disease classifications were increasingly specified and defined, a new technical discourse was generated. This new language constrained what doctors could describe and fragmented what they heard. The standard diagnostic method began to evolve and as it developed the patient's individual story and illness experience was increasingly refracted through the lens of ideal disease categories. Informed by positivist scientific reasoning, this method involved the formulation of differential diagnoses and the gradual exclusion of competing diagnoses as doctors elicited signs and symptoms of biological dysfunction through a process of doctor-led question-answer sequences and objective observation (Greenhalgh & Hurwitz, 1998). The disease rather than the patient's experience of illness was now the primary focus of medical attention, and the eliciting of physical symptoms the primary goal of interaction.

It was against this backdrop that the classification 'General Practitioner' was introduced in the late 18th Century to describe those doctors who combined the role of surgeon working in the hospital with the previous role of community apothecary (Louden, 1983; Marinker, 1998). Practising within the community, the General Practitioner was inevitably engaged in the circumstances of patients' lives and their experiences of illness and, as a consequence, less able to disentangle signs and symptoms of biological dysfunction from the social and emotional aspects of a patient's story. In this context, the patient's illness narrative was of significance and the construction of this narrative required a responsive communicative orientation on the doctor's part.

From these historical roots, General Practice evolved in the 20th Century to become a distinct medical specialism with a broad sphere of interest that encompasses both disease and the patient's life-world experience of illness. Such dual focus on the patient's individual illness experience, as well as on those signs and symptoms of biological dysfunction that can be classified as disease, emerges in this study as a core principle of General Practice that shapes what is recognised within the profession as effective clinical communication. This dual focus, together with the orientation towards responsive interactive communication that it entails, is captured in the following vignette from a training session observed by the researcher at a RTP in Sydney.

> Training vignette 1
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> A number of medical students attached to a General Practice clinic in their final clinical term are gathered in a RTP classroom for a workshop on clinical communication. As the session begins, the medical educator invites the students to draw upon their clinical experience so as to brainstorm the characteristics that distinguish General Practice from hospital-based medicine. Comments spring readily from all corners of the room: 'more holistic', 'perceptive – GP's need to read the patient more', 'relationships are long term', 'there's more uncertainty and more working on probability', 'almost always seems to be an element of anxiety and depression', 'more need for empathy and insight'.
>
> The medical educator synthesises these perceptions so as to highlight the holistic patient-centred approach that is required for General Practice: 'In General Practice patients have diseases. In hospitals diseases have patients'.

In a similar way, Wearne (2004) focuses on the patient's experience of illness to account for the primary place of 'communication and the patient-doctor relationship' in the RACGP curriculum."First position is because we see people with problems, not diseases without personalities. Effective communication is a stepping-stone to quality patient care; without rapport and a trusting relationship, doctors are reduced to technicians"(2004, p. 858).

But how is the patient's illness experience to be woven into the discourse of the General Practice consultation? As Marinker points out, in order to address both the bio-medical aspects of the patient's condition and the patient's unique situated experience of illness, the General Practitioner requires a clinical model and communicative behaviours that do not leave behind "those many untidy facts and perceptions which persist beyond the discourse of tissues, organs and chemical reactions" (1998, p. 107).

During the latter part of the 20th Century, various influences converged that led to the development of the 'patient centred clinical model' (Stewart, Brown, McWhinney, McWilliams, & Freeman, [1995] 2003) as a means for melding bio-medical, emotional and social concerns. The model constitutes a salient theme in the Curriculum for Australian General Practice (RACGP, 2007) and a prevailing paradigm in the teaching and evaluation of clinical communication. As the following account will suggest, it relies for its implementation on responsive, co-constructed interaction.

1.2. The development of the patient centred clinical model - towards greater interactional complexity

1.2.1. Early influences

The construct 'patient-centred medicine' (Balint, 1969; Balint, 1964) was originally conceptualised by Enid and Michael Balint who were psychotherapists working closely with General Practitioners in London to examine the dynamics of the patient-doctor relationship. Michael Balint (1964) formally identified the therapeutic function of the doctor-patient relationship in primary care, thus stimulating interest in the behaviours of doctors that would help to develop such therapeutic relationships.

This work was taken forward by Byrne and Long (1976) who examined a large number of audio recorded primary care encounters to identify the stages of the prototypical medical visit. These researchers considered the behaviours of doctors at each stage of the consultation and were able to characterise 'doctor-centred' and 'patient-centred' consultation styles. A prevalence of 'doctor-centred' behaviours that involved interruption of the patients' life-world accounts in order to pursue a bio-medical agenda, was found to weaken the therapeutic potential of the consultation in the encounters that they examined. In light of this, Byrne and Long called for practitioners to take up a more 'patient-centred' style.

But it was the work of Engel (1977) that was particularly influential in the development of the patient centred clinical model as it is conceptualised today. Engel viewed illness as a result of the interaction of biological, social, and psychological factors. In a highly

influential critique of the standard diagnostic model as a method that focuses on disease and its assessment to the exclusion of the patient's life-world concerns, he called for a 'bio-psycho-social approach' to the consultation that considered psychological and social aspects of a patient's condition along with biological processes. This approach provided the platform for the development of patient-centred care.

1.2.2 Model and method

In essence, and ideally, the patient centred clinical model and its associated method (Stewart et al., [1995] 2003) requires that the doctor assess both the disease and the patient's experience of illness. As the doctor assesses the disease process by way of taking a history and conducting a physical examination, he or she also seeks to enter into the patient's world so as to understand and to appreciate their unique experience of illness. This includes the patient's feelings about the condition, how it affects their everyday functioning, as well as the broader contexts of home, work, personality, and relationships that might impact on the patient's experience. Through an interweaving of life-world and medical discourses, doctor and patient are to arrive at a wider conceptualisation of the patient's condition that incorporates both bio-medical emotional and social aspects. From this common ground, shared decisions about treatment, management, and the respective roles and responsibilities of doctor and patient are to be made.

Such a method, that involves a melding of the "voice of medicine", representing the technical-scientific assumptions of medicine, and the "voice of the life-world", representing the natural attitude of everyday life (Mishler, 1984, p. 14), is essentially interactive and 'inter-discursive' (Candlin, 2006). It calls upon the practitioner to speak not only as a doctor through invoking a professional discourse that highlights a professional identity, but also to invoke 'a personal voice' (Roberts & Sarangi, 1999a) so as enter empathically into the patient's world. It requires engagement in responsive, co-constructed interaction that contrasts with the simplicity of sequential doctor-controlled question-answer interaction that characterises the 'conventional medical model' (Stewart et al., [1995] 2003) or the 'unremarkable interview' structure of doctor initiated request, patient response, and doctor assessment of that response, as described by Mishler (1984).

The Curriculum for Australian General Practice (RACGP, 2007) prioritises such patient centred care and such responsive communication as a measure of a doctor's clinical competence:

> "... a competent General Practitioner needs to demonstrate a comprehensive patient-centred approach that applies not only to health and disease, but also to the individual's experience of illness in terms of their culture, family and community"[2].

To be accepted within the profession as competent practitioners, doctors need to display commitment to these principles, to varying degrees, as required by varying contexts of practice and through their interaction with patients.

Accordingly, the Curriculum identifies the development of patient-centred communication as a common learning objective that applies across all curriculum areas:

> "Good communication skills enable a GP to develop a relationship with their patients, in order to understand both the illness and the patient's experience of that illness, and to move freely between clinical problem solving and the patient's experience of the problem" (RACGP, 2007).

Such curriculum statements would suggest that within the profession of General Practice today, effective clinical communication is conceptualised not as a simple one directional transfer of medically relevant information between patient and doctor or doctor and patient, but rather as dynamic and interactive and requiring the active participation of both patient and doctor. Doctors are required to elicit signs and symptoms of physical disease, but also to create an interactional environment where it is possible for patients to talk about emotions and life-world concerns.

But how is such patient-centred communication actually accomplished in practice? How can the capacity for patient-centred communication be developed in training? Influential training texts (Kurtz, Silverman, & Draper, 1998; Neighbour, 2005; Stewart et al., [1995] 2003) that have been examined for this study provide medical educators and registrars with lists of skills, exemplar phrases, and communicative approaches as a means to implement the patient centred clinical method. Mnemonics, designed to assist recall of exemplar phrases for eliciting patient's feelings and life-world concerns are a popular teaching tool

[2] Citations from the RACGP curriculum were retrieved from the RACGP website that does not include page numbers.

that will be later discussed (See Section 3.3.4). Yet, despite the fact that notions of interactional and co-constructed clinical communication are implicit in patient-centred models, such lists of skills and teaching tools tend to focus solely on the doctor's contribution to talk. By setting aside the complexities that arise in co-constructed interaction, they risk reducing the realities of practice to idealised versions of what should happen that may not reflect what actually occurs.

One objective of this thesis is to examine how abstract idealised models, including the patient-centred clinical model, actually play out in the discourse of the specific challenging consultations under study. How far do such models and theories actually match the empirical reality? How are such models transformed or challenged in dynamic co-constructed interaction?

As will be discussed in Chapter 2 of the thesis, discourse analysis has evolved as a methodology that is adequate to describe the complex interactions of real world practice. Just as developments in General Practice reflect a trajectory towards more interactional conceptualisations of communication, so too discourse analysis has undergone an evolution in recent decades towards "... increasingly more interactive and dialogic notions of contextually situated talk" (Goodwin & Duranti, 1992, p. 1). As a methodology it has evolved to offer the researcher, and indeed practitioners as well, a view of language and an analytic method that is able to capture the complexity of patient-doctor interaction as it is displayed in situ in challenging clinical contexts. Language has come to be viewed, not as a formal abstract system that is divorced from its context of use, but as a means for action. It is conceptualised as a multimodal resource from which participants in particular situations make conscious or unconscious choices about how to express themselves so as to accomplish their goals. Such purposeful action is collaboratively achieved, turn by turn, through a process of dynamic interaction in which recipients as well as speakers play an active role in shaping the trajectory of the encounter. Further, discourse is conceptualised as 'social practice' (Fairclough, 1992b). Through language and other ways of meaning, participants in interaction bring practices such as the General Practice consultation into being, in socially and institutionally recognisable ways.

But a study of discourse as social or professional practice requires attention not only to the fine grained detail of talk, but also to the broader institutional context in which such

discourse is embedded. In order to approximate 'ecological validity'(Cicourel, 1992, 2003, 2007), that is, in order to arrive at a position where interpretations and explanations of discourse data have authenticity and value from the perspective of the profession under study, the researcher needs to move out into the institution to gain knowledge about those practices that shape and regulate what is professionally recognisable as effective and appropriate clinical communication (Sarangi & Roberts, 1999b). In this study, insights derived from ethnographic observations at a range of institutional sites are required so as to describe, interpret, and explain patient-doctor communication, as it transpires at the local level of interaction, in valid and useful ways.

The ethnographic project that informs the discourse analytical study that is central to this thesis is comprehensively described in Chapter 2. Here, in this introduction, institutionally ratified practices for assessing and teaching clinical communication are set out as a necessary context for the study to follow. Against this backdrop, insights from preliminary observations at assessment and training sites, that shaped the formulation of broad research aims and initial research questions, will be described.

1.3 The assessment site

Two assessment pathways are available to doctors seeking Fellowship of the RACGP. The capacity of registrars for unsupervised practice is invariably assessed by way of the College Examination that combines a written knowledge component with an Objective Structured Clinical Examination (OSCE) made up of fourteen stations that engage candidates in simulations reflecting clinical situations that are held to be typical of General Practice in the Australian setting (RACGP, 2009a). Assessment at each station is carried out by two examiners, who are themselves experienced General Practitioners.

Practice Based Assessment (PBA) offers an alternative assessment pathway for experienced practitioners and, in particular, for those working in locations that are remote from examination centres. This assessment pathway is often chosen by older, experienced doctors who entered General Practice before it became a specialism and now wish to attain Fellowship. The PBA combines a recorded viva examination, examiner observation of a General Practice session, and evaluation by two examiners, working independently, of 15

video-recorded real world consultations. For the video-recorded component, candidates are required to submit 90 consultations recorded in their own practice following written consent from the patient. From this corpus, examiners select 15 consultations that are deemed to be representative of a range of case types and to mirror gender and age distributions reflected in the patient population of Australian General Practice. Selection of the consultations is in accordance with criteria set out in the chapter headings of the International Classification of Primary Care (ICPC). ICPC classifications capture the wide range of reasons for patient visits to a GP and encompass general unspecified problems, bio-medical problems across all physical systems, psychological problems, problems associated with pregnancy, childbirth and family planning, and social problems (Atkinson, Salamone, & Nasso, 2004; RACGP, 2009b). Thus the range of consultations assessed is deemed to reflect the unpredictability, variability and complexity of General Practice.

PBA recordings, accompanied by written examiner evaluations on the parameter 'communication and rapport', constitute the primary discourse analytical data for this study. As previously mentioned, and as later discussed (See Section 2.3.4.1), the selection of specific consultations for detailed analysis was informed by practitioners' views about consultation types that are considered to be particularly communicatively challenging. These views were expressed in ethnographic interviews.

1.3.1 Early observations at the examiner training site

Preparatory research for this study, that preceded the development of a research proposal and the formulation of research questions, included observation of examiner training at RACGP headquarters in Sydney. The purpose of this training was to familiarise new examiners with examination procedures and to engage all examiners in standardisation and moderation activities. During the training session, participants viewed video-recorded examination re-enactments so as to simulate the evaluation process, rating each performance individually along a continuum from 'poor' to 'outstanding' and then pooling their evaluations in a process of standardisation.

A considerable degree of consensus was observed amongst examiners in their ratings of candidates' performance on the communication parameter. Whilst some discrepancies

occurred, for example between a 'borderline pass' and 'pass', examiners largely agreed on the 'outstanding' or 'fail' performance, and communication checklists offered some evidence for these global assessments. But these checklists made use of broad categories, such as 'empathy', 'sensitivity to patient's needs', 'is non-judgemental', and 'ability to maintain rapport'. When considered from a discourse analytical perspective, such categories could be seen to distil a quality such as 'empathy' from the interaction in which empathy is achieved, and to condense into a word or phrase the co-constructed interaction through which patient and doctor might, for example, establish and maintain rapport, or arrive at common ground. As Silverman aptly suggests (1997, p. 24) "the phenomenon escapes" because pre-defined checklists and abstract descriptors cannot do justice to the abilities that professionals display in interaction. Examiners' global judgements of communicative ability supported by checklists may not bring us closer to understanding how processes such as empathy and rapport, are actually achieved. Nor can such ratings and descriptors provide explanatory detail of what constitutes, in more specific terms, expert communication for clinical practice.

As the RACGP handbook for candidates and examiners sets out, the assessment of clinical communication relies on professional judgement.

> "We can fairly easily measure how much history candidates obtain or how many physical findings they elicit, but it is a matter of judgement how well they pick up subtle cues, how at ease they are, and how lucid their explanations are. We have no scales, ruler or counter that will do that for us" (RACGP, [2005] 2008, p. 5).

For examiners it would seem that the evaluation of communication is intuitive and something of an art that cannot be readily explained, a view that is supported by College examiners participating in this study, as the following comment suggests.

> Extract 1. Interview 1
>
> "... It would be really useful to see what actually is it you're looking at...because at the moment it's [the assessment of communication] very much on a how it feels sort of basis"(RACGP examiner).

Yet such professional judgement and such an intuitive 'feel for the game' (Bourdieu, 1994) is informed by a kind of 'tacit knowing' (Polanyi, 1967) that is derived from experience. For experienced practitioner-examiners, the 'feel for the stuff with which [they] are

dealing' (Schön, 1983, p. 49) alludes to the many particulars relating to communication that they have interiorised through experience.

Insights derived from these initial ethnographic observations and early interviews suggested a potentially useful line of enquiry. Might discourse analysis of examination data, carried out in light of examiners' judgements bring to light some of the evidence on which judgements are based? In this way, discourse analysis might provide a greater understanding of how broad categories of expertise, such as the communication of empathy, or the ability to pick up subtle cues, or the ability to establish and sustain rapport are actually achieved in interaction. Further, as these judgements are made by experienced practitioners, such a study could uncover much about the nature of expert communication as it is perceived by the profession.

In an earlier study, Roberts and colleagues (Roberts, Wass, Jones, Sarangi, & Gillett, 2003) examined the performance of undergraduate medical students rated as 'good' and 'poor' in a series of OSCE examination role-plays. Results of their study, that identified characteristics of strong and weak communication, fed back into clinical training. In a similar way the current study sets out to describe features of expert General Practice communication by analysing the discourse of real world PBA consultations that were rated highly by examiners on the parameter 'communication and rapport'. As will be discussed in the methodology chapter to follow, a proposal to carry out such a study was submitted to the RACGP for their consideration. Once the proposal had been accepted, and ethics approval had been obtained, the study could proceed. This allowed for further ethnographic study, at training sites in particular, that refined the direction of the project.

1.4 The clinical training site

Across Australia twenty one Registered Training Providers located in rural and urban areas deliver the Australian General Practice Training Program that implements the RACGP Curriculum. Through this program, registrars are supported and prepared for unsupervised practice. The three year full time program combines an initial hospital based year with two years in-practice education in General Practice placements.

During these placements, registrars are mentored and supported by experienced practitioner-trainers who facilitate their on-going clinical learning. Regular classroom-based courses conducted by medical educators who are also practitioners complement this in practice learning with a program that integrates communication with the development of clinical abilities. In addition, medical educators regularly visit registrars in their placements to observe them with patients and to provide immediate feedback on their clinical practice. In a comprehensive program, each RTP also provides support to the network of trainer-mentors in their region.

1.4.1 Early observations at the clinical training site

Early ethnographic observations of classroom based teaching at RTP sites provided insight into an innovative teaching-learning program that integrates information provision with problem-solving experiential learning and opportunities for registrars to reflect on practice in the company of mentors and peers.

Classroom teaching focuses on situations that are potentially communicatively challenging so that registrars might develop the capacity to manage such situations successfully in their clinical placements. The following vignette from one such training session, on the topic of adolescent health, illustrates teaching-learning practices that are representative of those observed throughout the ethnographic phase of this study.

> Training vignette 2 – registrar training
>
> A small group of registrars are gathered in a classroom at a RTP site for a day release session on the theme of adolescent health. As training gets under way, the medical educator invites the registrars to talk about their recent experiences with adolescent patients. From these accounts, the educator distils recurring themes including the frequency of underlying psycho-social issues in adolescent health, the challenge of building rapport and relationships of trust and assuring patients of confidentiality, and the need to nurture the development of patient autonomy.
>
> Focussing on what she terms 'micro-skills of communication', the educator then engages the registrars in brief role-plays of potentially challenging moments in adolescent consultations. These include the moment when a doctor assesses that it is appropriate to see a young patient alone and asks a parent or other third party to leave the consultation. In debriefing these role-played interactions, the educator offers exemplar phrases from her own repertoire to manage such a face threatening task, as illustrated below:

"Mrs Brown I'd like to spend five minutes talking with Annie by herself, as she's growing up now and she needs to take responsibility for herself as she grows up. So if that's ok, could you leave us together for a few minutes? Then you can rejoin us".

A little later the topic shifts to the crucial place of the psycho-social history in adolescent consultations and the registrars are introduced to the mnemonic HEADSSS[3] that represents the domains to cover and a model to draw upon so as to carry out a youth health risk assessment. Handouts drawn from a resource kit of materials on adolescent health (Chown, Kang, Sanci, Newnham, & Bennett, 2008) provide registrars with an extensive and comprehensive repertoire of questions that they might draw upon at each phase of this risk assessment. As illustration, questions for assessing drug use are set out below:

Assessment area	**Questions**	**Patient's responses**
Drug-use Cigarettes/Alcohol	Many young people at your age are starting to experiment with cigarettes/drugs/alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances? How about you, have you tried any? **If yes, explore further** How much do you use? How often? How do you (and your friends) take/use them? ...	

(Chown et al., 2008, p. 170)

The training session culminates with a series of extended role-plays that require registrars to apply the skills that they have developed and the principles that they have learned in the context of simulated consultations. Following each role-play, educators facilitate discussion that encourages the role-playing doctor to reflect on their performance.

From these observations it can be seen that clinical communication training is designed to assist registrars to manage authentic communicative challenges that arise in practice. Role-plays are selected to point up 'crucial communicative sites', and skills are developed to address 'critical moments' within these sites (Candlin, 1987).

[3] HEADSSS is a mnemonic designed to prompt recall of the following aspects of a comprehensive assessment of a young person's psycho-social health. **H**ome, **E**ducation/**E**mployment, **E**ating and **E**xercise, **A**ctivities and peer relationships, **D**rug use including cigarettes and alcohol, **S**exuality, **S**uicide/ **S**elf harm/depression/mood, **S**afety and **S**pirituality

Further, such an experiential, problem-solving approach to teaching and learning is designed to allow registrars to try out pertinent communicative behaviours in a safe and supported environment so as to develop the capacity to manage such situations in practice.

Yet, from a discourse analytical perspective, the skills development that was observed to be a feature of training might be considered to be reductionist. The suggested phrases that educators provide are expertly crafted. But can they be relied upon in complex, co-constructed interaction where the patient's contribution cannot be anticipated? As Goffman suggests "an individual may "rehearse" in his mind what he is going to say on a particular occasion, but unless his speech is a long one to which a passive response can be anticipated, "rehearsal" is a figurative use of the term" ([1974] 1986, p. 60).

Clearly, mnemonics, such as HEADSSS, together with exemplar questions, are of crucial medical and clinical importance in orienting registrars to the procedure for assessing a young person's psycho-social state and in suggesting questions that they might draw upon in practice. But, from a communicative perspective, as Peräkylä and Vehviläinen (2003) point out, such models and accompanying phrases, tend to represent idealised versions of reality. Like the mnemonics and skills sets associated with the patient-centred model (referred to in Section 1.2.2), these phrases may not readily and easily apply in the dynamic co-constructed interactions of real world consultations. In practice, the effectiveness of such models lies in the doctor's ability to integrate the model responsively into the flow of the interaction in a contextualised and 'veiled fashion' (Sarangi, 2007b, p. 46). This would suggest that communication training might be enhanced by providing novice doctors with opportunities to closely examine the real world discourse practices of their more experienced colleagues where such responsive communication is displayed.

In line with these observations, there has been growing disquiet amongst medical educators themselves about the applicability of simple reductionist communication skills to practice, and a call for a shift in focus from skills development to the development of the communicative capacity to engage with uncertain, unfamiliar, and complex interactional contexts in meaningful ways (Fraser & Greenhalgh, 2001; Hammond, 2005; Skelton, 2005). Observations of training would suggest that the Australian General Practice Training program is responsive to this call. In the classroom, role-plays are designed to develop the capacity of registrars to respond creatively and effectively to critical moments

in communicatively challenging encounters. In the workplace, registrars and their mentors jointly reflect on the registrar's performance in real world consultations as a means to develop the novice doctor's communicative capacity. But as yet, such training and such reflection is not informed to any considerable degree by insights derived from empirical studies of the discourse of patient-doctor interaction.

Accordingly, in the view of this thesis, there is a place for a discourse analytical study that closely examines patient-doctor interaction in specific situations that are considered within the profession to be particularly communicatively challenging. Results of such a study could offer a resource for reflection that is of practical relevance and value for medical educators, registrars and potentially examiners as well.

1.5. Research aims and research questions

The direction for this project was not specified in advance. Initial research aims, formulated in light of early ethnographic research were broadly defined. As the ethnographic phase of the project continued and the researcher's insight into the communicative ecology of General Practice deepened, research questions were increasingly specified and the direction of the project was refined.

As previously discussed, early observations at the examiner training site, together with perusal of examiner handbooks and discussions with examiners suggested a line of enquiry that aligned with professional interests. The evaluation of clinical communication emerged from this early research as a matter of professional judgement rather than technical expertise in the assessment of interaction. This perception was affirmed in later interviews with RACGP examiners and by further observations of examiner training. Yet such judgements are informed by tacit understandings that are derived from experience and practice. Discourse analysis of examination data, might render the basis for examiners' judgements tractable. The following questions arose: Could discourse analysis, carried out in light of examiners' evaluations of a candidate's communicative performance, shed light on the nature of expert communication as it is required for General Practice? What could such analysis reveal about communicative expertise in specific challenging interactional

contexts? Could results derived from such a study be of practical value to practitioners? These questions led to the formulation of broad research aims as follows:

1. To enhance understanding of the nature of expert communication as it is required for the General Practice of medicine by closely examining the discourse of specific PBA consultations in light of examiners' judgements of the candidate's communicative performance

2. To consider how new understandings about the nature of expert communication arising from the study might be of practical relevance to educators, examiners and registrars.

On-going observations at training sites as well as interviews with educators and examiners led to the specification of particular clinical scenarios that challenge communicative expertise. As previously mentioned, these included consultations involving hidden concerns, those characterised by dissent, and triadic consultations involving adolescent patients and an accompanying party. Thus the scope of the project was narrowed to focus on examination data that reflected these consultation types, and the following research questions were formulated: Could discourse analysis offer explanations of why interaction at these sites is communicatively challenging? What could discourse analysis reveal about the interactional complexity of these sites? Could such analysis shed light on how expert practitioners manage complex interaction in these contexts? How could results of such analysis contribute to communication training?

On-going ethnographic work also deepened the researcher's awareness of those 'stocks of interactional knowledge'(Peräkylä, Ruusuvuori, & Vehviläinen, 2005; Peräkylä & Vehviläinen, 2003), including models and theories of communication, mnemonics, and skills sets that, as previously noted, are invoked in clinical training. It focussed attention on those salient themes, including empathy, rapport, and finding common ground, that are associated with communication, and that arise in classroom discussions, in examiners' feedback to candidates, and in ethnographic interviews. This led to the specification of further research questions that aligned with the interests of practitioners: How far do abstract models of communication match the realities of practice? How are they realised or transformed in practice? How is their salience challenged in complex co-constructed

interaction? What can discourse analysis reveal about how themes such as empathy, rapport, and finding common ground are interactionally accomplished in the challenging sites under study? How can results of analysis that attends to these models and themes be of value to practitioners?

This thesis seeks to offer a response to these questions. The structure of the thesis will now be outlined.

1.6. Outline of thesis structure

Chapter 2 sets out the methodological choices made for this study, and describes the research process. It begins by drawing from the literature on professional discourse to arrive at a view of discourse that can adequately capture the multi-modal complexity of patient-doctor interaction. An analytical framework is presented that can accommodate the constraining institutionally and socially recognised structure of the consultation as well as the dynamic movement and strategic action that goes on within it. The central place of ethnography is described in a study that strives for outcomes of practical relevance. The chapter then argues for a hybrid analytical method that combines techniques from distinct but commensurate sub-disciplines of discourse analysis to arrive at a comprehensive method for analysing clinical interaction.

Chapter 3 takes up the themes of empathy, rapport, and finding common ground that emerged as salient during the ethnographic research phase. Drawing upon ethnographic data as well as clinical communication literature from within the medical world, each theme is described in turn from the perspective of the profession. Drawing upon the discourse analytical literature, analytical themes are identified that shed light on how these themes are accomplished in interaction.

Chapters 4, 5, and 6 present results of the discourse analytical study that is central to the thesis. Each chapter focuses on a specific, crucial communicative site. Each provides evidence for how focal themes play out and interplay in purposeful ways to shape the trajectory of the consultation. Chapter 4 sets out results of the analysis of two comparable consultations, each involving a patient who presents with underlying emotional and

psychological concerns. The Chapter is presented in two parts. Part A examines the accomplishment of an interactional environment in which matters of sensitivity, that are initially hidden, gradually emerge. By way of contrast, Part B presents analysis of an encounter in which issues that are of potential clinical significance are marginalised from the discourse. Chapter 5 is a case study of a consultation involving patient-doctor dissent over the nature of the patient's condition and the need for behavioural change. It examines how doctor and patient collaborate to sustain a relationship of rapport in face of dissent. It reveals how dissent is managed proactively so as to move the consultation towards a measure of mutual understanding and common ground. Chapter 6 examines the discourse of a triadic consultation involving a reticent adolescent patient accompanied by his mother. It traces how a degree of patient autonomy is achieved in this complex interactional environment, and how the accomplishment of rapport and empathy contribute to an atmosphere of trust.

The final chapter (Chapter 7) takes up the question of practical relevance to consider how results of the thesis might benefit the General Practice profession. A model for incorporating discourse analysis into the clinical communication curriculum is outlined. A place for discourse analysis in examiner training is suggested.

Chapter 2
Methodology

This is a study that seeks to use discourse analysis to uncover the nature of expert communication as it is required for the General Practice of Medicine and as it is perceived by practitioner-examiners and educators who represent the institution of General Practice. It strives for outcomes of practical relevance to medical educators and examiners engaged in the development and evaluation of the communicative abilities of General Practice registrars.

My first task in carrying out such a study is to arrive at a view of discourse and a framework for analysis that will be adequate for the task of describing, interpreting and explaining the complex discourse of a range of challenging clinical consultations in ways that are relevant and meaningful to the General Practice profession.

In this Chapter I will draw upon a review of the literature on professional and institutional discourse to characterise institutional discourse and to arrive at:

- The position of this thesis in respect of the theory and practice of discourse
- A feasible framework for analysis

I will then go on to chart the research process used to carry out this study.

2.1 Towards a view of discourse that is adequate for the task

The term "discourse analysis" was first used by the linguist Zelig Harris (1952) who was concerned to know how we are able to recognise a sequence of sentences as a cohesive text rather than as a random sequence of unrelated units. The objective of discourse analysis was to make clear the logical relations existing between units of language above the sentence that allow for meaningful discourse. Thus discourse came to be defined as "language above the sentence or above the clause" (Stubbs, 1983, p. 1). Stubbs went on to add that discourse analysis, as a study of larger linguistic units such as conversational exchanges, is also concerned with language in use in social contexts. None-the-less, early

discourse analysis took place within a formalist paradigm and was primarily concerned with structure rather than social function. As Cameron (2001) and Schiffrin (1994) suggest, language within this formalist paradigm was viewed as an autonomous system rather than in relation to its social function.

But this thesis is concerned to describe, interpret and explain what doctors, together with their patients, use language to do in the context of General Practice consultations, to accomplish personal and professional goals and to realise their identity as General Practitioners. A more adequate definition of discourse for the task at hand reflects a functionalist perspective and is provided by Brown and Yule: "The analysis of discourse is, necessarily, the analysis of language in use. As such, it cannot be restricted to the description of linguistic forms independent of the purposes or functions which these forms are designed to serve in human affairs" (Brown & Yule, 1983, p. 1).

Such a definition connects form and function. It holds that "...language has a certain kind of formal organization because of the purposes it is designed to serve"(Cameron, 2001, p. 13). It accommodates my concern as an analyst to describe and interpret language features as resources that participants draw upon to achieve their purpose on a particular occasion of use.

The following interaction between a doctor and patient drawn from a study of questioning in primary care consultations conducted by Boyd and Heritage (2006) clearly illustrates the melding of linguistic form and professional purpose inherent in the notion of discourse as language in use. The doctor is taking the social history of an over-weight, hypertensive patient who has gained eleven pounds and works at least 60 hours a week in a restaurant. The doctor knows this.

D Tk Do you exercise at all?
(2.5)
P N::o, uh huh huh huh (.hh [.hh huh [huh (.hh huh huh)
D [hm [$not your thing
[ah:
P [.hh $Would you believe me if I sai(h)d y(h)e(h)s
(Boyd & Heritage, 2006, p. 167)

Given the patient's life world a bald, checklist type question such as "Do you exercise?" would risk being heard as ill-fitted and insensitive. But this doctor's question is designed

with the particular patient and their situation in mind. By adding the item 'at all' the doctor changes the polarity of the question. It is natural to respond negatively to a question designed in this way. Negation is the expected response. In choosing this form, the doctor displays his expectation that the patient is likely to tell him that she doesn't exercise, and his insight into life circumstances that would make exercise difficult. The doctor's use of a particular question form on this particular occasion is purposeful. It contributes to the achievement of an empathic relationship by displaying the doctor's sensitivity to the patient's circumstances.

Discourse as 'language in use' captures the purposeful nature of the language choices doctor and patient make, on site, in the here and now, at the micro-level of interaction. But discourse viewed simply as language in use does not take the analyst beyond the text to consider the broader social and institutional context within which interaction takes place. My study seeks to enhance understanding of professional communication, as it is institutionally required for General Practice. A view of discourse is needed that will enable explanations to be offered of the social and institutional significance of language use at the micro level of interaction.

Further, discourse as language use does not merely encompass the social function of discourse. As defined by Fairclough, "'Discourse' is ... more than *just* language use: it is language use, whether speech or writing, seen as a type of social practice" (1992b, p. 28). It is through discourse, including language and other semiotic means such as gaze, body orientation, gesture, and the use of tools, that doctor and patient bring the consultation into being as socially and institutionally recognisable practice. Discourse viewed as social practice "... allows analysis of social structures to be brought into connection with analysis of social interaction"(Fairclough, 2010, p. 172).

Gee ([1999] 2005) and Gee, Hull and Lankshear (1996) offer a useful distinction that clarifies this view of discourse as social practice and links interaction with the broader institutional realm. They distinguish between "Discourse", with a capital "D" and "discourse" with a little "d", reserving the term "discourse" for the general category, 'language-in-use'. "Discourse" with a capital "D" refers to particular discourses associated with members of a particular group such as social workers, or nurses or general practitioners. In their view, "Discourses" include but go beyond language. Discourses meld

and integrate language in use with other ways of meaning so as to realise a specific practice and a specific social identity in ways that are recognisable within a particular 'community of practice' (Lave & Wenger, 1991). As Gee states, "To "pull off" being an "X" doing "Y" (and this includes being a General Practitioner breaking bad news to a patient, or being a General Practitioner managing a patient who is seeking unwarranted prescription drugs, or being a medical educator giving feedback to a registrar) "....it is not enough to get just the words "right", though that is crucial. It is necessary, as well, to get one's body, clothes, gestures, actions, interactions, ways with things, symbols, tools, technologies..., and values, attitudes, beliefs and emotions "right" as well, and all at the "right" places and times"(Gee, [1999] 2005, p. 7).

By defining discourse as more than language in use, by incorporating such factors as values, attitudes, beliefs, emotions and ways with technologies and tools into his definition, and by specifying the requirement to get such features "right", Gee alludes to the connection between discourse at the micro level of interaction and its broader institutional context. Values, beliefs, attitudes as well as appropriate ways of doing, being and feeling are constitutive of "the institutional order" (Berger & Luckmann, 1967; Sarangi & Roberts, 1999a), defined as "...the sum total of 'what everybody knows' about a social world, an assemblage of maxims, morals, proverbial nuggets of wisdom, values and beliefs, myths and so forth...knowledge that supplies the institutionally appropriate rules of conduct" (Berger and Luckman 1967, p. 83). In studies of communication in institutional settings, a wider conceptualisation of discourse that incorporates the 'broad' context of the institutional order, enables the analyst to interpret interaction at the local level in light of those organisational constraints and normative expectations that surround the unfolding interaction and lend meaning to what it is that is going on (Cicourel, 1992, 2007).

Within the institution of the Royal Australian College of General Practitioners, values including patient-centredness and whole-person care, attitudes such as being non-judgemental, beliefs including belief in patient autonomy, and emotions such as empathy are set down in curriculum documents, referred to in examiners' reports, described in training manuals and enjoined in training sessions. Most recently, the computer has begun to appear on the desk of every General Practitioner, generating concern amongst practitioners, educators and examiners about its effect on communication (Pearce, 2007). The 'right way' of orienting to this tool is emerging as a further constituent feature of the

institutional order that informs and constrains what counts as appropriate clinical communication in the varying contexts that make up General Practice.

Thus, as doctors engage in interactions with their patients in ways that are institutionally recognisable they are not acting simply on their own account but realising their identification with and membership of their 'community of practice'. To accomplish being a General Practitioner doing General Practice, to be acknowledged by medical educators as an accomplished communicator and to be accepted by examiners into the community of General Practitioners involves using the Discourse of that community in institutionally acceptable and recognisable ways. Further, it is through situated patient-doctor interaction that recognisable entities such as the General Practice consultation are brought into being. Through the Discourse of consultations institutionally sanctioned values, beliefs, attitudes and norms are enacted, confirmed and reproduced. "Micro–level social actions realise and give local form to macro-level social structures" (Jaworski & Coupland, 2006, p. 10).

Yet, the General Practice consultation as a recurring entity is not fixed and consultations do not appear to involve mere instantiations of pre-existing institutionally sanctioned norms and conventions. As suggested in the introduction to this thesis, practitioners themselves increasingly characterise the consultation as complex, dynamic, variable and transformable at any moment (Hammond, 2005; Innes et al., 2005), a perspective that is born-out by data analysed for this study. A view of discourse is needed that will accommodate the variability and creativity that appears to characterise expert communication for General Practice.

2.1.1. A view of discourse that accounts for variability and creativity

As Gee states, "...language-in-action is always and everywhere an active building process" ([1999] 2005, p. 10). Through their interaction doctor and patient create the consultation and bring it into being, sometimes in more or less routine and expected ways. In this way, over time, the consultation has come to exist as an entity independent of its specific enactment. But activities such as the consultation have to be continuously rebuilt, and as doctors and patients co-construct interaction in the here and now, to achieve their purposes or to address particular communicative dilemmas, they may deploy language and other

ways of meaning in new and unfamiliar ways. Thus the consultation is not just re-enacted but constructed afresh. It is this that accounts for its variability. As Fairclough states, "there is a dialectical relationship between discourse and social structure...On the one hand, discourse is shaped and constrained by social structure...On the other hand discourse is socially constitutive"(Fairclough, 1992a, p. 64). The reflexive, reciprocal relationship between micro level interaction and its macro level institutional context is captured in the following definition of discourse offered by Candlin (1997, p. iix).

> " Discourse is a means of talking and writing about and acting upon worlds, a means which both constructs and is constructed by a set of social practices within these worlds, and in so doing both reproduces and constructs afresh particular social-discursive practices, constrained or encouraged by more macro movements in the overarching social formation".

Institutionally recognised values, beliefs, attitudes, conventions and norms are not simply instantiated through the interaction between doctor and patient. Discourse at the micro level of interaction may transform Discourse practices and construct them anew reinvesting the institutional order. It is this that accounts for discourse change.

Fairclough (1992a, 2010) provides insights into the mechanism of discourse change and in so doing offers the analyst a way of accommodating the creativity and variability that characterises much of the Discourse of General Practice consultations. An institution, such as the institution of General Practice provides its members with a frame for action without which they could not act. But such frames are 'regulative'(Fairclough, 2010), and members are constrained to act within the frame. Nevertheless, the boundaries of such Discourse frames are neither fixed nor impermeable. Participants in an interaction might respond to a communicative dilemma by pushing the boundaries of a Discourse. To achieve their purposes at a particular moment they may cross boundaries by drawing upon other discourses in strategic ways, or adapt existing conventions, or put them together in new combinations. Through the constantly available possibility of drawing upon such 'inter-discursive resources' (Candlin, 2006, p. 6), creativity is built into discourse as an option. This dynamic view of discourse provides the analyst with a way of interpreting and explaining unexpected practices as an integral part of the Discourse of General Practice. Take the following extract from a Practice Based Assessment consultation that will be analysed in full in Chapter 5 of this thesis.

The patient has Type 2 Diabetes. Despite test results that indicate a worsening of his condition he is resistant to making changes in his life style and in particular to making changes in his diet. In light of this, and the potentially serious consequences for his health, the doctor is attempting to persuade him to see a dietician, an option he had soundly rejected earlier in the consultation.

Extract 6. PBA Consultation 3

155 D: ((facial gesture of mock disgust)) Would you at least try my nice dietician [who's very sensible]
156 P: [No no no] not at the moment (.) I'll see how I go in the next six months
157 D: ((Drops head)) (0.3) ((raises head to gaze directly at patient)) Would you give it three months
158 P: No ((fall rise tone)) Six months
159 D: Four months :
160 P: No
161 D: ((sighs; turns gaze back to computer screen))
162 P: ((chuckles)) ## this is like sale of the century
163 D: ((loud peel of laughter)) Worth a try ((Directs gaze towards computer records then returns gaze to patient's face)) because you're not ideally treated

Conventionally, patient-centredness in a life style change consultation is enacted through the discourse of negotiation. Doctor and patient explore options together to arrive at an achievable lifestyle change plan. Here the doctor, confronted by the dilemma of the patient's continuing resistance to her suggestions, responds by invoking a discourse that might conventionally be precluded from a consultation. Strategically, and perhaps unconsciously, she crosses Discourse boundaries to bring the jousting Discourse of bargaining into the interaction. In the voices of doctor and patient interacting in the here and now we hear echoes of other voices from another world, a phenomenon that Bakhtin has defined as 'heteroglossia' ([1935]1981). These voices, expropriated ironically from the Discourse of a television game show, are put to use to sustain rapport in face of the patient's face threatening resistance to the doctor's advice. For a time at least it would appear that bargaining constitutes an addition to the 'chains of speech communication' (Bakhtin, 1986) that make up the Discourse of General Practice consultations.

But the variability and creativity that appears to be inherent in expert communication as required for General Practice poses a dilemma for a researcher from outside the profession. It is difficult to know when the boundaries of the Discourse have been transgressed in such a way that the doctor is no longer considered to be "in" the Discourse. What are the limits

of the frame that constrains professional practice? How are discourse practices constrained and encouraged? One might look to the interaction order to find evidence in the patient's response to a particular use of discourse by the doctor. But as Drew and Heritage (1992, p. 22) point out, institutional interaction may often involve "special and particular constraints" on what makes for an allowable contribution to the professional task at hand.

Gee suggests that "the key to Discourses is recognition" ([1999] 2005, p. 27). In his view, if a participant combines the features of discourse, including language, action, interaction, values and beliefs, attitudes and feelings and ways with tools, in such a way that others recognise a particular type of identity engaged in a particular type of activity, then they have 'pulled off' a Discourse and sustained its existence. If what they do is different to what has been done before but remains recognisable to others then the Discourse has been transformed. If however, it is not recognisable then the participant is not "in" the Discourse.

Professional Discourse necessarily involves recognition by experienced members of a community of practice. In considering 'recognition' as a key to what makes for General Practice Discourse, I will turn briefly to ethnographic observations from a workshop for new examiners conducted at the RACGP office in Sydney during the early stages of this study. The workshop, referred to in Chapter 1, took place in the weeks leading up to the College examination through which registrars are admitted to Fellowship. Experienced examiners led the workshop that combined moderation activities following observation of video recorded examination re-enactments with presentations and discussions.

Early in the session a senior examiner advised new examiners against rigid adherence to pre-conceived checklist categories and to specified key features when evaluating the clinical communication skills of examination candidates: "There are difficulties in specifying communication features as there are many valid but different approaches to the same task". The examiner went on to illustrate this variability with reference to candidates' performances in an OSCE role-play at a recent College examination. The case involved "a doctor-shopper", that is a patient who goes from General Practitioner to General Practitioner presenting a set of subjective symptoms in order to seek out prescribed drugs. At the critical moment when the patient's status as a doctor shopper became clear, most candidates responded with what the senior examiner termed "a text book response" that

adhered to the following features that were specified in the pro-forma provided to examiners to guide their evaluation:

> Assess to make sure there is no physical problem
> Make sure you are the only doctor treating him
> Only give him small amounts
> Engage him and get him to a rehab facility

As described by the senior examiner, most candidates attempted to engage with the role-playing patient. They acknowledged the patient's pain and distress, expressed willingness to help and stated clear professional boundaries using 'I statements' such as " I'm sorry but I'm not able to give you X" or " I want to help you. I'm prepared to do X but I'm not prepared to prescribe Y". Such an approach is held to defuse tension and to avoid inflaming the situation. However one candidate set aside this institutionally recognisable norm, responding to the moment in a direct and confrontational style reported by the examiner in this way:

> Training vignette 3 - Examiner Training
>
> ' Look Fred you're conning me. It's clear. I can tell from my notes that what you're telling me isn't true and I can't do much for you. I'm not going to give you drugs. I'm sure you can get them from someone else but it's not going to be me. However, you have some medical problems and you need a doctor and I'm happy to be that doctor. But I tell you I'm not going to give you the drugs so you can forget that. But if you want a doctor I'll be your doctor. You can do that today or come back another day and not only that, one day you might even want to get off the drugs and when you're ready to do that I've got some things I can help you with but otherwise we're wasting each other's time. Goodbye.'
>
> The senior examiner then went on to encourage the new examiners to recognise this unorthodox approach:
>
> "The opposite approach to everybody else but probably ten times more effective. So if someone does something like that for God's sake don't fail them. If you think it's effective even if he didn't address the key features, even if it doesn't fit the checklist. I'd never thought of that approach till I saw someone use it and geez it was good".

Whilst this candidate's approach was contestable in that it deviated from conventional practice and did not fit the features specified on assessment pro-forma, it was recognised by this examiner and his colleagues as effective and "in" the Discourse. Thus, to use Foucault's term (1972), it had become part of the 'archive' of discourses for General Practice, that is "the totality of discursive practices" that falls within a domain (Fairclough, 1992a, p. 227).

A further example illustrates institutional constraints on Discourse. On this occasion, a doctor's way of combining talk with gesture, gaze, body orientation and use of space takes his performance beyond recognisable Discourse in the eyes of his examiners. The extract, which forms part of the discourse data for this study, and supplements the key consultations examined for the thesis, is taken from a naturally occurring consultation submitted to the RACGP for Practice Based Assessment. It is a follow up consultation involving a mother who presents with recurrent symptoms including swollen glands and cough. Her two small sons accompany her.

Extract 1. PBA Consultation 5 (Supplementary data)

19	D	You still have glands and
20	P	Yeh well I think so
21	D	Sore throat and something like that
22	P	Yeh but now I'm actually really [((coughs))]
23	C:	[((coughs in imitation of mother))]
24	P:	((laughs))coughing up really bad stuff that's gotten worse
25	D	((Puts out arm and draws child to him as he continues to direct gaze towards mother)) Come here sweet heart (.) ok how do you find the antibiotics is it useful
26	P	Um yesterday I didn't feel too bad=
27	D:	=yeh
28	P	Today I feel a little bit worse and my temperature is up I just took my temperature and it's up a bit.
29	C	((coughs))
30	D:	((looks towards child and kisses him on the top of the head. Releases child. Rolls chair closer to the mother focussing his gaze on her face, bringing his hands together under his chin to frame his gaze))
31	P	But Monday night I thought I'd gone to hell and back (.) my temperature went way up to eighty(.)thirty eight high or something and I was trying to bring it down (.) so I felt better the next day

This doctor was rated as 'doubtful' on the parameter 'communication and rapport' by two examiners working independently who supported their assessment with these written comments:

> "inappropriately affectionate to children (These patients did not seem to mind. Others would)"
>
> "Could be a little close in seating for personal space comfort of some patients"
>
> "Invades patient's personal space. Kissing and cuddling the kids"

The doctor in this consultation is an internationally trained medical graduate. From the perspective of the discourse analyst, the proxemics or use of space that he displays,

together with gestures of affect towards the children might be explained in terms of his enculturation into what Scollon and Scollon refer to as 'a discourse system of involvement' (1995, p. 37). Such a discourse system emphasises attendance to positive face needs (Brown & Levinson, [1978] 1987) through strategies of high engagement. From the perspective of examiners, his use of space transgresses the boundaries of General Practice Discourse in unacceptable ways. Affective action, realised through the discursive features of gesture and close proxemics, is seen as the wrong action for this situation, placing the doctor outside the Discourse of General Practice.

It would appear that Discourse boundaries are not concrete. As these examples have illustrated, doctors may respond to particular problems and dilemmas, such as accompanying children who draw attention away from the clinical task, or a patient who is looking for drugs, by contesting the limits of a Discourse, pushing its boundaries to include other discourses. The extent to which such creative responses are incorporated into professional practice appears to depend upon institutional recognition. In the above extract, the patient and her children seemed comfortable with the doctor, and his examiners noted this. Nevertheless, rejection of the communication style he displayed served to narrow the boundaries of the Discourse of General Practice. On the other hand, institutional recognition of the confrontational style displayed by the doctor in the 'doctor shopper' case serves to widen the boundaries of Discourse for such a consultation type.

As Gee eloquently comments, and as Candlin also illustrates (2000a), "In the end a Discourse is a "dance" that exists in the abstract as a coordinated patterns of words, deeds, values, beliefs, symbols, tools, objects, times and places, and in the here and now as a performance that is recognizable as just such a coordination. Like a dance, the performance here and now is never exactly the same. It all comes down, often, to what the "masters of the dance" will allow to be recognised or will be forced to recognize as a possible instantiation of the dance" ([1999] 2005, p. 28).

Such a view of Discourse requires an analytical framework that will reach further than language to include other semiotic means that accompany or replace speech. It requires a framework that will accommodate the multiple discourses that doctors and patients creatively invoke to pursue their purposes. But it also points to the need for a framework that will allow the analyst to attend to the fine grained analysis of moment to moment

interaction between doctor and patient in light of those abstract principles, values and beliefs that constitute the broader institutional order. In considering the nature of expert communication as it is required for the General Practice of medicine, I will need an analytical framework and a research methodology that enables me to bring to bear on my own analysis the perspectives of the 'masters of the dance'.

In the next section I will consider an analytical framework and methodology that is adequate for this task.

2.2 Towards an analytical framework

In developing this thesis I have arrived at a view of discourse as 'a dance' (Candlin, 2000a; Gee, [1999] 2005). This metaphor invokes the notion of discourse as dynamic coordinated movement within a frame. It alludes to discourse as a co-constructed accomplishment of participants who respond to each other and to the moment as the interaction unfolds, even as they orient to and are constrained by the structure and purpose of the event they are in. It evokes the variation and creativity that characterises much expert communication for General Practice as doctors, and on occasion patients as well, strategically draw upon discourses from other contexts in response to the challenges of the moment. Like a dance, that is seldom a mere repetition of previous steps, a General Practice consultation is seldom a routine re-enactment of previous encounters. Rather, it is actively co-constructed afresh as doctor and patient interact in the here and now to achieve their purposes and to respond to communicative dilemmas as they arise.

In this section of the thesis, my task is to arrive at an analytical framework that can encompass both the purposeful and constraining structure of the General Practice consultation and the dynamic, creative processes that go on within it. Further, a framework is needed that will allow connections to be made between those principles, values, attitudes and ways of seeing that are constitutive of the institutional order of General Practice and their realisation and transformation at the micro level of the interaction between doctor and patient.

2.2.1 The consultation viewed as a relatively stable and structured event

In their path-breaking study, referred to in Chapter 1, Byrne and Long (1976) offered a way of looking at the General Practice consultation as a phased, sequential structure. The study, involving analysis of more than 2,500 General Practice doctor-patient encounters, identified the following sequence of purposeful phases that underpin the consultation, and described the verbal behaviours of doctors within each phase.

I The doctor establishes a relationship with the patient
II The doctor either attempts to discover or actually discovers the reason for the patient's attendance
III The doctor conducts a verbal or physical examination or both
IV The doctor, or the doctor and patient, or the patient (in that order of probability) consider the condition
V The doctor, and occasionally the patient, detail treatment or further investigation
VI The consultation is terminated, usually by the doctor

(Byrne & Long, 1976, p. 21)

In identifying the overall structure of the primary care consultation, Byrne and Long were not claiming that each of the phases would always occur or that each would occur in the given order. Whilst seeking to pin down a frequently occurring sequence they emphasised that such a structure is idealised. "The logical form finally agreed rarely appears in practice and should be seen as an ideal" (p. 21). Then, as now, the structure of the consultation was subject to a great deal of variation. Openings and closings might be a constant but the consultation is co-constructed and rarely follows a sequential, undisrupted progression from history to examination to diagnosis to treatment. Further, the framework reflects the sequential order of a typical acute care consultation, that is, one that involves presentation of a new medical problem. In follow up consultations such as those involving on-going management of a chronic condition, or in challenging consultations like those examined in this thesis that involve hidden emotional issues, or doctor and patient dissent over the nature and treatment of a condition, or the participation of a third party, such an underlying structure is more difficult to discern.

Nevertheless, it would appear that over time, and through learned experience, a prototypical primary care consultation, as described by Byrne and Long has come to exist in people's minds as an abstract entity in its own right independent of its specific and varied enactment. Doctors and patients can be seen to orient to this prototype, at least in acute care consultations. Robinson and Stivers (2001) have observed, for example, how the prototypical phase structure of the consultation can be made relevant to a patient through barely perceptible verbal or non verbal cues, such as the doctor's manipulation of a pen so that it is no longer in writing position. Patients respond to such cues as indexical of structure, in this case, orienting to the movement of the pen as the closing of the history taking phase, and positioning themselves for the next phase, that of physical examination. Thus, through participants' orientation to an expected

sequence, transition from the history taking to physical examination phase is accomplished. The strength of the prototypical consultation structure is further illustrated by the following extract from an acute care PBA consultation that forms part of the data base for the current study.

The patient in this consultation is a teenage girl who presents with a minor eye infection, in the company of her mother. At the point where the extract begins, the consultation has proceeded through Byrne and Long's sequential phases from reason for presentation, through verbal and physical examination, and discussion of treatment. Following a few turns in which practical problems relating to the patient's Medicare card are addressed, the doctor hands over the script to the patient (turn 179), action that is indexical of a shift to the termination phase of the encounter.

Extract1. PBA Consultation 6 (Supplementary data)

175	D:	(12.0) ((picks up pen with right hand as he takes script from the printer. Signs script)) Is this your Medicare number xxxx xx xx xx
176	M:	((Mother opens purse and takes out Medicare card))
177	D:	Can you read it for me
178	M:	xxxx xxx xx x
179	D:	((directs gaze to patient))Ok Just tell the girls at the desk to check your date of birth ok ((folds script and hands it to the patient))
180	M:	Ok ((leans forward)) and while I've got Cara here also her skin
181	D:	mmm
182	M:	acne=
183	D:	=yes
184	M:	Can doctors do anything for that o:r

Orienting to the doctor's move as an indication of the imminent closure of the consultation, the mother is prompted to raise a previously unmentioned concern. "....and while I've got Cara here also her skin" (turn 180). In Bourdieu's terms her action displays 'a feel for the game' she is in (1994, p. 63). Her sense of the prototypical consultation structure enables her to perceive the moment of imminent closure and this compels her to act. The consultation re-opens and the doctor and patient return to the examination phase.

The prototypical structure that Byrne and Long identified remains highly influential in both educational and research contexts. It informs a diagnostic model that is still taught in Australian medical schools today (Pearce, 2007), and has provided researchers in the

world of discourse analysis with an over-arching organising framework for the fine-grained analysis of co-constructed doctor-patient interaction at each phase of the acute primary care consultation (Heritage & Maynard, 2006b).

The framework is of value to the current study in that it alerts the researcher to the goal oriented purposeful structure of the consultation and the phased task-oriented activities that typically go on within it. It directs attention to how doctors invoke this prototypical structure so as to move the interaction forward in line with their clinical goals, and how patients also orient to structure in pursuing their own agenda. Yet, in its focus on a phased sequential structure, and on the doctor's contribution to the interaction, it represents an attempt to stabilise what is in reality a complex, dynamic, co-constructed process.

In the challenging consultations to be analysed in this study, structure appears often to be driven from within by participants' responses to unforeseen and changing communicative demands as they arise at the local level of interaction. For example, in PBA Consultation 1 that is analysed in Chapter 4, a patient's barely perceptible intake of breath together with a momentary quavering voice quality triggers a response from the doctor that transforms the trajectory of the consultation completely. The encounter begins as an apparently simple request for a screening test that engages the doctor in a verbal examination of the patient's symptoms. But through the doctor's responsive action to the patient's cue, what appears at first to be a relatively standard diagnostic consultation is transformed into a deeply therapeutic discussion about debilitating panic attacks and depression.

It is difficult for the analyst to stabilise such consultations so as to pin down an underlying prototypical sequence. Moreover, such a focus on the generic structure of the encounter may not be especially illuminating in a study that seeks to describe and to explain the nature of the doctor's communicative expertise at such moments and in such challenging clinical contexts.

What is needed is a framework that will accommodate the purposeful overarching frame of the General Practice consultation whilst bringing into focus the dynamic interaction within. As Cicourel points out (1992, pp. 307-308) a framework for research into

professional communication needs a dual focus that encompasses both the 'processual' and the 'structural' aspects of an event. Levinson's construct, 'activity type' (1979) expanded to encompass the construct of 'discourse types' (Sarangi 2000) and that of 'strategy' (Candlin, 2006; Candlin & Lucas, 1986) may provide such a framework.

2.2.2 Activity type

By 'activity type' Levinson refers to "a fuzzy category whose focal members are goal-defined, socially constituted, bounded events with *constraints* on participants, setting, and so on, but above all on the kinds of allowable contributions" (1979, p. 368) that participants can make.

When viewed as an 'activity type', the General Practice consultation can be seen to provide doctors and patients with an institutionally and socially sanctioned frame for action, without which they could not act. But in so doing, it also constrains them to act within that frame (Fairclough, 1992a). Within the consultation, doctors and patients are constrained in what they can say and do by setting, by the roles they are occupying, by socially and institutionally recognisable ways of behaving, and, above all, by the activity's overarching institutionally and socially recognised purpose, that is to attend to the patient's bio-medical, emotional and social concerns.

Whilst emphasising the proto-typicality of institutionalised activities, and the constraints that such activities place on participants, Levinson also acknowledges the potential for variability in style and structure at the local level of interaction. The construct 'activity type' encompasses events that fall along a continuum from highly formalised and pre-scripted institutionalised rituals such as the Roman Catholic Mass, through formal, public, institutionalised activities such as a jural interrogation wherein procedures such as turn taking are sharply defined and strongly constrained, to unscripted mundane activities such as a chance meeting between friends in the street. Along this continuum can be placed the General Practice consultation, a "less formal form of institutional interaction" (Drew & Heritage, 1992, p. 27) than for example a court interrogation, that takes place in private and where there is room for considerable

negotiation and stylistic variation as to how the encounter might come to be managed as participants orient to the moment and to the task at hand.

Yet, despite such room for variation and movement, "a notion of normality is ... presupposed in activity specific behaviour..." (Sarangi, 2000, p. 7). Whilst the interactional behaviours of doctors and patients are not fixed or rule governed, activity specific norms exist and deviations from such norms are noticeable and marked, as illustrated for example by the 'sale of the century' negotiation sequence described in Section 2.1.1. In so far as such deviations remain recognisable as in the Discourse of the consultation, they push the 'fuzzy' boundaries of the activity type. An 'activity type' as conceptualised by Levinson, is not a fixed and rigid structure but a construct that is permeable and can accommodate considerable variation and movement within the constraints of a purposeful frame.

Levinson's construct is of further value to a study of professional communication in that it invites the analyst to look not simply at language but also at other ways of meaning that participants deploy. It reaches beyond "speech event" (Hymes, 1972) to include activities constituted entirely by talk, such as a telephone conversation, but also those where talk is non-occurring or incidental, such as a cricket match, and those involving the purposeful integration of talk with action, such as occurs in the General Practice consultation. In this way it offers a framework that encourages the analyst to see discourse as "...one of many available tools with which people take action either along with discourse or separate from it" (Jones & Norris, 2005, p. 4). It focuses attention on the actions that are being taken with such tools at a particular moment, be these tools words, objects, use of space, gesture or other semiotic means. Thus, in the Robinson and Stivers'study (2001) referred to above, attention is focused on the doctor's manipulation of the pen not as an action in itself but as a means to accomplish the transition to a new phase in the consultation. This is 'mediated action' (Jones & Norris, 2005; Scollon, 2005; Wertsch, 1991) through which a social actor, in this case the doctor, takes an action through the use of some 'mediational means' (Scollon, 2001).

In the current study, as will be seen in the analysis of PBA consultations set out in later chapters, action is frequently accomplished by means of a multi-modal coordination of words, gesture, body-orientation, use of space and use of objects. For example, as will

be seen in analysis of the discourse of PBA Consultation 2 (See Chapter 4) the doctor's bodily action in re-orienting towards the computer screen at particular moments in the interaction can be seen as a means to control the trajectory of the consultation. In this way, for example, a shift from engagement with a patient's life-world issues to bio-medical topics is accomplished. 'Activity type' as conceptualised by Levinson offers a framework that encompasses actions taken not just by way of talk but by other mediational means.

Perhaps Levinson's most important insight for a study of situated interaction lies in the notion of 'activity-specific rules of inference'. Following Wittgenstein's doctrine of 'language games' (1958), Levinson argues that it is our awareness of a prototypical activity structure that enables us to make inferences, that is to work out from a range of possibilities what is meant by what is said or done at a particular point in the activity. In this regard, 'activity type' builds upon the early, seminal work of Mitchell (1957), who identified a five phased structure in the ritual activity of buying and selling amongst residents of Cyrenaica. Mitchell observed that the act of appreciating an item during the 'investigation of the object phase' was intended and interpreted as a request to purchase.

Extending upon this early observation, Levinson states, "types of activity, social episodes if one prefers, play a central role in language usage. They do this in two ways especially: on the one hand, they constrain what will count as an allowable contribution to each activity; and on the other hand, they help to determine how what ones says will be "taken" – that is, what kinds of inferences will be made from what is said" (1979, p. 393). Thus, the expectations associated with a particular activity type provide participants with an 'interpretive repertoire' (Goffman, [1983] 1997, p. 169) that is, a convention-based means for shifting from what is more or less literally said, or what is done, to what is meant.

Take the following simple example drawn from the opening phase of an acute care consultation that is part of the supplementary PBA data for the current study. As the interaction begins, the patient is entering the room followed by the doctor.

Extract 1. PBA Consultation 7 (Supplementary data)

1	P:	This way :
2	D:	This way yeah
3	P:	No worries
4	D:	And if you'd just like to take a seat there ((gestures towards chair))
5	P:	Cheers ((patient sits))
6	D:	Ok ((doctor sits)) I'm Doctor Wood
7	P:	John
8	D:	Yeah go ahead
9	P:	Um I've just got an earache
10	D:	Yeah
11	P:	I think I've got an ear infection I had one some months ago actually =
12	D:	Yeah
13	P:	= And I had some antibiotics to clear it up and I think I've (.) [got it back again
14	D:	[got it back again ok

Following a brief settling in phase in which seats are allocated and introductions made, both doctor and patient orient to phase II of Byrne and Long's prototypical structure (1976), that is, the patient's reason for presentation. The doctor's utterance "Yeah go ahead" (turn 8) takes its illocutionary force from expectations about the function that such an utterance can be fulfilling at this particular point in this particular activity. The patient readily infers that this is an invitation to present his problem and responds accordingly.

A more subtle illustration of activity specific inferencing is drawn from a study of interactions between health visitors and first time mothers in the United Kingdom (Heritage & Lindström, 1998; Heritage & Sefi, 1992). The purpose of such home visits is to support new mothers and to monitor mothering practices. Within the constraints of this activity type, the health visitor's contribution is likely to be interpreted as complaint or advice. At this particular moment in the activity, the baby is suckling on the mother's breast as the father and home visitor look on.

HV:	He's enjoying that [isn't he
F:	[°Yes he certainly is = °
M:	= He's not hungry 'cuz (h) he's ju(h)st (h)had iz bo:ttle .hhh

(Heritage & Lindström, 1998, p. 403)

In the context of an activity type in which the mother's competence as a parent is under evaluation, the apparently casual observation by the health visitor that the baby seems to

be enjoying his milk is interpreted by the mother as inferring some inadequacy in caring for the baby on her part and she responds defensively.

The construct 'activity type' is clearly of value in understanding communication in General Practice settings. It focuses attention on the prototypical structure of the activity whilst acknowledging the possibility of variations and deviations from the norm. It accommodates verbal as well as non-verbal modes of action and meaning. In addition, it offers a means of understanding how knowledge of the prototypical consultation structure enables participants to interpret each other's meaning and intent. Importantly, in its focus on those institutionally recognisable norms that constrain practice, it provides a way to link the macro-institutional order of General Practice with interaction.

Yet, despite the considerable value of 'activity type' as an analytical framework for this study, there remains a sense that with its emphasis on structure it may, like Byrne and Long's model, encourage the analyst to focus on the consultation as a relatively stable object, directing attention away from the complex interactive processes that go on within it.

As Candlin states (2006, p. 10) 'activity type' as it has been set down by Levinson "...may not give enough emphasis to the particular purposes of participants and the actions that participants perform[ed] in respect of such purposes *within* the activity type". It may not offer an analytical framework that is adequate to capture the way doctors and their patients engage with uncertain and unfamiliar situations that arise within the consultation, strategically and in meaningful ways, sometimes invoking forms of talk and ways of behaving that might appear to fall outside the boundaries of the consultation activity type.

The need for a framework that will capture such strategic and purposeful interactional work is underscored by the concerns of practitioners themselves. As indicated in the introduction to this thesis, the General Practice consultation is increasingly characterised by General Practitioners themselves as potentially complex, uncertain and unpredictable (Fraser & Greenhalgh, 2001; Griffiths & Byrne, 1998; Innes et al., 2005), a characterisation that is made evident in the discourse of the PBA consultations examined in this thesis where, by way of responsive co-constructed interaction,

consultations are transformed in unexpected ways. Further, from the perspective of practitioners, the capacity to respond effectively to such complexity and unpredictability is viewed as a marker of communicative expertise, as illustrated by the following extract from an interview with a RACGP examiner and medical educator participating in this study.

> Extract 1. Interview 2
> I mean good communicators can actually deal with the unpredictable... you can see that they're [examination candidates] in a position that they haven't been in before but they still do it very well (PBA examiner/medical educator).

This thesis seeks to use discourse analysis to make visible the communicative expertise of practitioners as they manage such unpredictability and complexity in specific challenging clinical contexts. A re-conceptualisation of the construct of 'activity type' to encompass notions of 'discourse type' (Sarangi, 2000), and 'strategy' (Candlin, 2006; Candlin & Lucas, 1986) might bring into sharper focus the strategic interactional work that goes on within the consultation activity frame.

2.2.3 Activity type, discourse type and strategy

In his reappraisal of Levinson's 'activity type', Sarangi (2000) draws upon the notion of 'discourse type' as a way of capturing the variety of purposeful discursive actions or practices that occur within a particular activity type but also across activity types. For Sarangi, activity type provides a means of characterising settings such as a General Practice consultation, or a training workshop, or a case meeting, whilst discourse type provides a means of characterising forms of talk that might be embedded in an activity, such as taking a history, explaining a diagnosis, advising, discussing treatment options, negotiating a management plan, counselling, or making small talk. A discourse type might conflate with an activity type. For example Counselling with a capital 'C' is an activity type that occurs in its own right and may draw upon other discourse types such as 'advising' and 'troubles telling', whilst small 'c' counselling will occur across a wide range of activity types, including the General Practice consultation, in activity specific ways.

'Discourse types' are conceptualised as resources that participants draw upon rather than as fixed, predetermined features of an activity that participants implement. Within a consultation, doctor and patient may purposefully invoke a variety of forms of talk or 'discourse types' in response to the demands of the situation and the moment. For example, doctors and patients might invoke discourses of banter and humour to sustain rapport at moments of dissent (See Chapter 5), or, as discussed in Section 3.3.3.3, a doctor might appropriate the discourse of non-directive counselling to assist the patient to make an informed independent decision in the context of a consultation involving disclosure of unexpected pregnancy, or, as previously described (See Section 2.1.1) doctor and patient, might creatively appropriate the light hearted discourse of game show bargaining to diffuse tension in a negotiation over the need for medication.

Candlin (2006) builds upon the notions of 'activity type' and associated 'discourse types' by extending the framework to include 'strategy' and its realisation through wording and other semiotic means. He uses 'strategy' to refer to how communication is done, that is how a discourse type is brought to life through the deployment of a repertoire of strategies associated with particular discourse practices within an activity type.

'Strategy' in this sense, was first introduced by Candlin and Lucas (1986) in their 1983 study of family planning discourse within a community health clinic attended by teenagers seeking advice on such matters as terminations of pregnancy. In that setting, the giving of direct advice was precluded from the Counselling activity type by ethical principles that prevented counsellors from making evaluative judgements, and by regulations that made advice giving the prerogative of physicians. Yet clients sought and required advice. Candlin and Lucas observed how counsellors, orienting to the constraints of the activity type, accomplished the delivery of messages of advice without compromising their professional position. For example, direct advice about contra-indicated behaviours such as smoking during pregnancy was avoided as such advice giving might be perceived as judgemental. Instead, messages about such behaviours were communicated obliquely and indirectly and through strategies that included recourse to personalised anecdotal stories about family or relatives that illustrated how smoking could have detrimental effects. Whilst couched as information,

such stories, voiced by the counsellor in the context of the counselling activity, were likely to be received by the client as advice.

Similarly, in the General Practice setting direct advice giving is precluded in some activity specific contexts. For example, in the context of an OSCE examination role-play involving disclosure of unexpected pregnancy that is to be described in detail in Section 3.3.3.3 of this thesis, doctors are expected to refrain from giving advice to the patient about how they should proceed. By virtue of ethical practices such as neutrality in this morally charged situation, and the principle of respect for patient autonomy in decision making, doctors are seen to invoke the discourse type of non-directed counselling so as to enable the patient to arrive independently at an informed decision. Such a discourse type is brought into being by a range of strategies that include the objective presentation of options available to the patient, realised as generalised statements of what others might do, rather than as the doctor's suggestions.

Within the activity type of the General Practice consultation, 'strategy' can be further illustrated by what Maynard and his colleagues refer to as 'perspective display invitations' (Maynard, 1991b; Maynard & Frankel, 2006), typically associated with the discourse type 'disclosing bad news'. In preparing patients to receive an adverse diagnosis, a doctor may invite the patient to describe their own perception of their condition as a precursor to giving the diagnosis. As Heritage and Maynard explain, the perspective display sequence not only prepares the patient for the difficult information they must receive, but also establishes "an auspicious interactional environment in which the doctor can build upon the patient's perspective through agreement rather than confrontation. The patient's perspective is *co-implicated* in the diagnostic presentation" (2006b, p. 17). Motivated by the demands of the discourse type disclosing bad news, the doctor in Heritage and Maynard's study draws upon the perspective display sequence as a strategic resource that he manages creatively and dynamically, in response to exigencies at the local level of the interaction.

The notions of 'discourse type' and 'strategy' broaden the construct of 'activity type' to offer an adequate framework for an examination of what makes for communicative expertise in specific General Practice contexts. Candlin describes such a framework as follows : " ... a *nested arrangement* in which activity types with their focus on *setting*

are realised through particular practices with their associated discourse types, themselves focussed on *forms of talk*, which in turn draw strategically upon a range of communicative resources, i.e. what people actually perform. These strategies are then realised by actual usages of language or in other semiotic modes, what they actually say, write, display, do" (Candlin, 2006, p. 12).

Such an analytical framework is appropriate for this study as it allows the analyst to focus on the General Practice consultation as a dynamic, creative activity that is internally shaped and developed. It captures what is going on within the activity type as doctor and patient invoke and combine a variety of discourses realised through a range of strategies and textual and semiotic means, but always within the constraints of what is recognisable as appropriate action within an institutionally and socially ratified activity frame.

2.3. Charting the research process

The research process that combined discourse analysis with an initial and on-going ethnographic project will now be mapped out. The steps taken to achieve ethical clearance will be outlined. The discourse analytical phase will be described, and an account provided for the choice of a hybrid analytical method that draws upon distinct sub-disciplines of discourse analysis so as to adequately capture the complexity of the clinical interactions under study.

2.3.1. The ethnographic phase

In order to understand and describe the nature of professional communication, insight into the institutional order that supplies institutionally sanctioned norms for appropriate conduct at the micro-level of interaction is required. In this study, discourse analysis was preceded and informed by a sustained period of ethnographic research, undertaken so as to become familiar with the 'communicative ecology'(Gumperz, 1999) of General Practice.

This is in keeping with a study that aims for insights that are relevant to the profession of General Practice and for outcomes that may be considered by medical educators, examiners and registrars to be useful in their day-to-day work practices. To achieve such 'practical relevance'(Sarangi & Roberts, 1999b), a researcher-outsider needs, as far as is possible, to take a consultative and collaborative stance (Roberts & Sarangi, 2003; Sarangi & Candlin, 2003b). A methodology that combines discourse analysis with an ethnographic project enables the researcher to draw upon insider knowledge at various stages in the research process, from the identification of issues to pursue and the formulation of research questions, to the selection of data for focussed analysis, to the description, interpretation and explanation of that data in meaningful and relevant ways, to the dissemination of findings in such a form that they might be considered for uptake by the profession.

This section of the thesis is an account of the ethnographic methods employed in working towards 'practical relevance'. It sets out the steps taken to approximate 'ecological validity' (Cicourel, 1992, 2003, 2007), that is, to arrive at a position where the claims that are made by the researcher have authenticity in the eyes of the researched. In so far as the researcher is able to approximate 'ecological validity', the descriptions, interpretations and explanations of discourse data that are offered are more likely to be deemed adequate, viable and useful from the perspective of the General Practice profession.

2.3.1.1. Attaining a 'threshold for interpretive understanding' (Sarangi, 2006)

As an outsider to the profession of General Practice I cannot see the discourse of a Practice Based Assessment consultation as a practitioner would see it. As I watch a video-recorded PBA consultation involving a child who has been brought along to see the doctor by her mother following an episode of fitting, I am aware that the doctor's questions and the physical examination that she conducts are designed to distinguish between competing clinical possibilities. I am aware that she is narrowing down to a provisional diagnosis of possible epilepsy that is to be confirmed or rejected by further investigations. But without medical training, I cannot know the bio-medical reasoning

that would lead the doctor to formulate a particular diagnostic question at a particular moment, and I cannot share in the medically informed processes through which she interprets the information that mother and child provide. General Practitioners like all professionals have been trained to use and to interpret language to accomplish ends that may not be transparent to the outsider.

Nevertheless, whilst the discourse analyst outsider cannot perceive what the practitioner perceives and the development of more than rudimentary medical knowledge is beyond the remit of most discourse analytical projects, engagement with the profession over a period of time, using a variety of ethnographic methods can facilitate a cumulation of insights into doctors' 'interpretive procedures'(Cicourel, 1974; Sarangi, 2007a) and a widening of the lens through which the discourse analyst perceives and interprets what is going on. This can allow the analyst to work towards achieving a 'thick description'(Geertz, 1973) of communication that encompasses not only the behaviour or use of language itself but the meanings that underlie and give force to that behaviour in a specific context and within a particular social or professional group.

As illustration, consider the following extract from a role-play observed by the researcher at a registrar training session conducted at a RTP. This role-play, that illustrates the registrar's response to the communicative challenge of building a therapeutic relationship with a taciturn adolescent patient, is analysed in detail in Section 3.2.5.3 of this thesis.

Extract 1. Registrar Training Role-play 1

87	R:	Mm you're year 10 is it =
88	P:	=Yeah yep
89	R:	Ok and how are you finding it
90	P:	Oh the teachers are all dickheads you know
91	R:	Really:
92	P:	yeah
93	R:	In all your subjects they're dickheads or
94	P:	Oh mostly you know um English is all right=
95	R:	=mm
96	P:	=but the rest you know
97	R:	So you get on ok with the English teacher :
98	P:	Yeah she's good yeah
99	R:	Mm and anything else at school you like um sport or [music or
100	P:	[Oh yeah I play a bit of sport I play a bit of music yeah
101	R:	Do you :

102 P: Yeah
103 R: What do you play
104 P: Oh bass
105 R: Excellent
106 P: yeah
107 R: Are you in a band
108 P: Yeah oh well I'm with a few mates we jam on weekends and [stuff
109 R: [cool=
110 P: = Yeah it's really cool=
111 R: =That' great yeah

From the discourse analytical perspective, the interaction displays the accomplishment of rapport by way of a range of discursive strategies. In summary, these include the registrar's invoking of a teenager's lexicon so as to align with the patient by foregrounding her own identity as a young person (turns 93, 105,109), as well as 'mutual affiliation sequences'(Clark, Drew, & Pinch, 2003) through which the participants display to each other that they are getting along (turns 108-111).

But when such analysis is informed by insights gleaned from ethnography, something more can be seen to be going on. As this registrar takes action to build rapport with the patient, she is simultaneously carrying out a mandatory assessment of his social and psychological state through questions that explore his sense of belonging, relationships, and engagement in activities. When seen through the General Practitioner's lens, clinical and relational goals are enmeshed as the registrar integrates aspects of the HEADSSS assessment into the discourse of rapport building. Ethnography enables the analyst to thicken up descriptions of the data so as to offer interpretations and explanations that incorporate professional perspectives.

Sarangi (2006) refers to the sustained engagement in a research site required for such 'thick description' as 'thick participation'. He holds that 'thick participation' is needed if the researcher is to attain 'a threshold for interpretive understanding'(Sarangi, 2006) that will enable an adequate description of the communicative practices of a profession. I will now turn to the steps taken in this study to achieve such 'thick participation' in the culture of General Practice so as to approximate Cicourel's 'ecological validity'(2003, 2007)

2.3.1.2 Early engagement with the world of General Practice

My engagement with the profession of General Practice pre-dates this PhD project and was sustained for the duration of the research phase. Over a four-year period leading up to the commencement of the project that is at the core of the study, I was employed as a teacher of English for Specific Purposes on a bridging course for Internationally Trained Medical Graduates (IMGs) seeking Australian Medical Council (AMC) registration. The program, conducted by the Sydney South West Area Health Service was based at a large teaching hospital in Western Sydney and aimed to prepare IMG's for the AMC Clinical Examination that represents the final stage in the process of attaining registration to practice medicine in Australia. In format and in content, although not in level of complexity, the AMC Clinical examination echoes the OSCE component of the RACGP College examination that was described in the introduction to this thesis. It involves performance in a series of role-plays that reflect clinical scenarios that arise in primary care settings in the Australian context.

The English language component of the AMC bridging course was tightly integrated into the clinical education program and, as a consequence, I was engaged in on-going field-work that constituted a sustained ethnographic project. For example, regular participation in bed-side teaching tutorials conducted by medical educators allowed for observation of the interactions between the students, patients and educators. This provided insight into such matters as what constitutes an appropriate doctor-patient relationship in the hospital context, what doctors do to establish and maintain rapport whilst carrying out intrusive procedures, and how instructions are formulated so as to elicit physical signs in a wide range of physical examinations. These insights fed back into the language curriculum.

Of specific relevance to the current study of communicative expertise in the context of General Practice was the opportunity that the bridging course afforded for long-term engagement with General Practice educators. The consultation skills component of the course was conducted by medical educators from the General Practice Unit attached to the teaching hospital in the region. The involvement of this unit in a program for doctors seeking AMC registration is in keeping with the position of General Practice as a 'foundation discipline' whose core values, including patient-centredness and a holistic

approach to managing the health of individuals, and specialist skills, including communicative expertise, are held to constitute 'a basic foundation of values and skills' required of all doctors regardless of the specialism that they will ultimately pursue (RACGP, 2007).

Attendance at weekly consultation skills workshops in the role of participant-observer constituted a level of socialisation into the culture of General Practice and allowed for a cumulation of insights into what makes for effective clinical communication in a range of clinical situations from the perspective of General Practice educators. Each week the IMGs participated in role-plays drawn from General Practice settings, ranging from routine acute care consultations involving clearly differentiated physical problems to communicatively challenging consultations such as disclosure of a terminal condition or the management of psycho-social problems. The teacher role-played the patient and was briefed by the medical educator on appropriate symptoms to describe, relevant signs to display, and communicative challenges to incorporate into the interaction that reflected those facing doctors in every day practice. Following each role-play, teacher and medical educator collaborated in providing feedback to course participants that integrated discourse analytical and clinical insights.

Participation in clinical education programs for IMG's and the cumulation of insights into practitioner perspectives that this affords, continued during the research phase of this study by way of opportunities to co-teach with an experienced educator and RACGP College examiner on short courses conducted for AMC examination candidates. This on-going working relationship with medical educators and examiners was partly instrumental in facilitating access to the RACGP as the primary research site for the current study.

2.3.1.3 . Towards joint problematisation – ethnographic spade work

The achievement of practical relevance in a study of professional discourse relies upon the identification of issues to pursue that align with the interests, concerns and motivations of practitioners (Sarangi & Candlin, 2001). This process of arriving at

issues that are jointly owned by the researcher and the profession is defined by Roberts and Sarangi (1999b) as 'joint problematisation'.

Ethnographic spadework described in the introduction to this thesis informed the development of an initial research proposal to the RACGP that reflected professional interests. Preliminary observations of examiner training and early discussions with educators and examiners had suggested a useful line of enquiry. Discourse analysis of recorded examination consultations, carried out in light of the judgements of expert practitioner-examiners, might uncover more of the evidence upon which such judgements are based and so provide a greater understanding of how broad categories of of communicative expertise, such as empathy or rapport, or being non judgemental are actually accomplished in interaction. These new understandings about the nature of expert communication could be made available to medical examiners and educators in a useful form.

Accordingly, a proposal to carry out such a discourse analytical study was developed and submitted to the RACGP.[4] The proposal was endorsed by the National Board of Censors of the RACGP in late March 2006. Following ratification of this initial proposal by the RACGP, the researcher was granted permission to contact RACGP examiners and Registered Training Providers with a view to inviting their participation in the project. In addition, the researcher and her supervisor were granted in principle access to an existing data-base of video-recorded Practice Based Assessment consultations together with accompanying written examiner feedback on a range of parameters including 'communication and rapport'.

Before proceeding with the study, ethical clearance was required.

[4]It was originally proposed and agreed that OSCE examination performances would constitute the primary source of data for discourse analysis. However, recording is not part of the OSCE examination process and examination performances would need to be specifically video-recorded for the purposes of the study. It was later considered that this recording process might impinge on the reliability of the assessment process or affect outcomes of this high stakes examination. Consequently, existing video recordings of PBA consultations submitted for examination were offered as an alternative data source. Video recording is part of the established PBA process and as recordings would only be provided to the researcher after assessment was finalised, the research process could not affect examination outcomes.

2.3.2 Ethical clearance

Consent for the researcher to access and make use of an existing data base of PBA video-recordings for the purposes of the current study was sought by the RACGP on the researcher's behalf. The RACGP advised the researcher in writing that they were satisfied that the written consents that they had originally obtained for use of the recorded consultations, was sufficient to encompass the current study. Approval was granted by the College for use of the recorded consultations on condition that the anonymity of participating patients and doctors was assured. Accordingly, it was agreed that recordings would be viewed only by the researcher, her supervisor and associate supervisor, and that all transcriptions of recordings would be carefully anonymised. Transcription of PBA recordings was carried out by the researcher alone. All identifying features, such as personal and place names were altered and identifying information was omitted. Visuals were also carefully anonymised by the researcher and vetted by the RACGP. To further ensure the anonymity of participants, and to protect confidentiality, the researcher undertook to limit access to the full PBA transcriptions by presenting them in a separate volume of the thesis to be made available only to thesis examiners. Extracts only are included in the main body of the thesis.

With the support and assistance of the RACGP, the researcher was to canvass participation in the ethnographic phase of the study by approaching General Practitioners directly. The RACGP provided access to email addresses for medical examiners and RTP educational managers, as well as opportunities to brief potential participants about the proposed project at RACGP forums and through publication of a short article in the College magazine. Draft information and consent forms were developed for medical educators, examiners and registrars and submitted to the RACGP for approval (Appendix 1 is a sample information and consent form).

Once permission to carry out the project had been obtained from the RACGP, ethical clearance was sought from the Macquarie University Ethics Committee. Approval was granted in May 2006. (Appendix 2 is a copy of the final ethics approval letter).

Following this approval, the study could proceed. An extended period of ethnographic research began, and PBA recordings were made available to the researcher for transcription and analysis.

2.3.3. Refining the research endeavour – on-going ethnographic work

The research aim and research questions as set out in the initial research proposal were broadly defined. The direction of the project was not set down in advance but was regulated by insights derived from an on-going ethnographic endeavour This ethnographic work deepened the researcher's understanding of the 'communicative ecology' of General Practice including the values, principles and attitudes that shape expectations about appropriate behaviours and ways of communicating in specific clinical settings, what gets talked about when examiners, educators and registrars discuss communication, and the prevailing paradigms and salient themes that arise in teaching and evaluating clinical communication.

It was anticipated that this deepening understanding of the 'conceptual world'(Geertz, 1973) of General Practitioners would assist the continuing process of 'joint problematisation' and the achievement of practical outcomes in a number of ways. It would inform the selection of PBA consultations for detailed analysis so that data selected aligned with consultation types considered by practitioners to be of particular communicative interest. It would focus analysis on themes of professional relevance. Further, it would assist the researcher to bring the perspectives of practitioners to bear on the process of interpreting and explaining the discourse data in relevant ways.

The ethnographic phase that preceded and accompanied discourse analysis of PBA consultations involved the following data collection techniques:

- Interviews with examiners, medical educators, and registrar trainers
- group discussion with practitioners, examiners, trainers and registrars
- further observation of examiner training and briefing sessions
- on-going observation of training programs conducted by RTP's for registrars

Interviews

In depth one on one interviews of between 40 minutes and 90 minutes duration were conducted with a total of thirteen practitioners including six RTP medical educators, three of whom were also educational managers, three registrar trainers, two of whom were also examiners, and four RACGP examiners including a senior examiner.

Interviews were 'semi-structured' in style to retain "...a high degree of flexibility according to the participant's experiences" (Broom, 2005, p. 66). An interview schedule of broad themes and open-ended potential questions was developed by the researcher and used as a guide to explore:

- What educators and examiners look for in communicative performance
- Aspects of communication they consider important to teach and to assess
- The types of clinical scenarios that present particular communication challenges
- Critical communication errors

In exploring these themes, the researcher adopted a flexible interview style that allowed for open dialogue about issues that extended beyond the parameters set by the original schedule. In this way the interviews were driven by participants' accounts and not restricted to the researcher's preconceived ideas. Each interview was audio-recorded and transcribed verbatim by the researcher.

Extracts from these transcribed interviews illustrate this thesis. Whilst the full interview transcriptions have not been included in the data, they are available on request to the researcher.

Appendix 3 is the interview schedule for educators and examiners.

Group discussion

A similar schedule exploring equivalent themes informed a semi-structured discussion with a group of practitioners at a regional medical centre. The practitioners who participated in this sixty-minute lunch-time discussion included two RACGP examiners, three registrar trainers and two General Practice registrars. The discussion was audio-

recorded and transcribed by the researcher. This transcription can be made available on request.

Further observation of examiner training

During the ethnographic phase, the researcher attended a variety of training sessions conducted by the RACGP for examiners and for examination candidates. These included workshops for new examiners to familiarise them with examination procedures and with the evaluation process, practice examinations that included examiner feedback to candidates on the parameter 'communication and rapport', and pre-examination briefings for all examiners on the eve of the OSCE where role-plays were practiced and evaluation criteria discussed. Observations of these sessions, captured in detailed field notes, constituted additional ways of getting a 'a better fix'(Richards, 2003) on those categories through which examiners perceive and interpret clinical communication.

On going observation of clinical training

Section 1.4 of this thesis refers to the role of RTP's in conducting the Australian General Practice Training Program through which the RACGP Curriculum for General Practice is implemented. One aspect of this training program is the provision of regular classroom based sessions for General Practice registrars that are designed to complement in practice learning. Over an extended period, the researcher attended two RTP sites to observe a series of half-day, full-day, and two-day training workshops conducted by medical educators for registrars.

The workshops integrated the development of clinical communication skills with the development of the clinical capacity to deal with diverse and complex situations that arise in practice. Each workshop combined formal presentation and problem-based discussions with opportunities for registrars to engage in clinical role-plays, often involving professional actors as 'patients'. Interventions by educators during these role-plays and feedback at their completion engaged educators and registrars in reflective discussion on the role-playing doctor's performance, including their communication.

The following workshops from this theme driven curriculum were selected for observation in consultation with senior educators because they address clinical contexts

that are seen by practitioners to be potentially communicatively complex and challenging:

- Chronic disease management
- Motivational interviewing
- Smoking cessation and alcohol counselling
- Counselling in General Practice. Depression, anxiety and hidden concerns
- Adolescent health
- Elderly care and dementia
- Ethical issues

A workshop for final year medical students undergoing a community placement term in General Practice was also observed. This workshop, referred to in Section 1.1, explored the distinguishing characteristics of General Practice as a medical discipline and engaged students in a process of reflection on their interactions with patients in consultation role-plays involving psycho-social issues.

Observations of all workshops were captured in detailed field notes. In addition, a number of role-plays together with educator interventions, feedback, and reflective discussions on communication were video-recorded and transcribed by the researcher. Extracts from field notes and from these transcribed training sessions illustrate this thesis. Full transcriptions are included in Volume 2 of the thesis.

Sarangi and Roberts suggest that in studies of professional communication "... a competent understanding of members' communicative practices relies on analysts' involvement in a range of data sites around the institutional 'theatre'" (Sarangi & Roberts, 1999b, p. 24). The ethnographic phase of this project has taken the researcher into the 'backstage' (Goffman, [1959] 1970; Sarangi & Roberts, 1999b) regions of the institution of General Practice, facilitating insight into the conceptual world of educators and examiners. It has allowed for the development of a considerable data-base of members' accounts and training vignettes that have been brought to bear on discussion of clinical communication throughout this thesis. It has informed the discourse analytical process by drawing attention to recurring themes that arise when

practitioners talk about, teach, and evaluate clinical communication. These 'focal themes'(Roberts & Sarangi, 2005), that include 'empathy', 'rapport', and 'finding common ground', are 'sensitising concepts' that have refined the discourse analytical process by 'suggesting directions along which to look...' (Blumer, 1969, p. 148) that align with issues of professional interest and concern.

Further, ethnography has informed the selection of PBA consultations for detailed analysis by highlighting those clinical scenarios that practitioners consider to be particularly telling of communicative expertise.

2.3.4. The discourse analytical phase

2.3.4.1. Data selection

The corpus of video-recorded PBA consultations made available to the researcher was extensive and highly variable encompassing a range of consultation types, patient characteristics and presenting problem. It was made up of over one hundred recordings that included both dyadic and multi-party encounters representing patients at each stage of the life cycle. Recordings reflected the wide variety of reasons that patients visit their General Practitioner, encompassing acute care consultations involving presentation of well differentiated physical problems, routine consultations such as requests for renewal of a script, follow up visits regarding management of chronic conditions, consultations involving psychological and social problems, as well as those associated with pregnancy, child birth and family planning. The recordings represented performances evaluated from 'poor' to 'excellent' by RACGP examiners on the parameter 'communication and rapport'.

Appendix 4 is a sample of a selected logbook of video-recorded PBA consultations for one candidate. It illustrates the many variables in the data resource made available for this study and so alludes to the problem of data sampling that faced the researcher. On what basis should consultations be chosen for detailed discourse analysis, given the overall aim of the study to contribute to understanding of the nature of expert clinical communication?

As previously noted, insights derived from ethnography provided direction. In interviews, and during registrar and examiner training, practitioners had identified specific clinical situations as particularly communicatively challenging. These included consultations involving the disclosure of bad news, ethical dilemmas, medically unexplainable physical symptoms, and hidden emotional and social issues. Scenarios that involved high emotion, such as anger, conflict and dissent, as well as those with adolescent patients who resisted engagement, were also considered to challenge communicative ability.

From the discourse analytical perspective, such encounters, that are potentially problematic and likely to be emotionally charged, constitute 'crucial communicative sites'(Candlin, 1987) where participants' positions, identities, abilities and face are placed on the line. They are likely to throw up 'critical moments' (Candlin, 1987, 2000a), that is moments within the discourse of the consultation which are particularly significant for the doctor or patient or both, and which, as a consequence, present challenges to both participants' communicative abilities. These may be moments wherein the consultation could turn so that a therapeutic relationship breaks down or crucial clinical communication is lost. An example might be the moment when a patient offers some barely perceptible clue to thoughts of self-harm, or where rapport is threatened so that trust is in jeopardy and the patient disengages from interaction. At such moments, challenges to the communicative abilities of doctors are at a premium.

With the notion of 'crucial sites', and practitioners' categories of challenging consultations in mind, the researcher viewed the PBA recordings to select for transcription and detailed analysis encounters that aligned most closely with professional perceptions of events that both challenge communicative expertise and allow for its display.

The data sampling process was as follows: First, the researcher viewed all recordings. At the first cut, thirty six recordings were excluded including sixteen where poor sound quality rendered accurate transcription impossible, and twenty where the camera was so placed as to capture only one party to the interaction.

At the second cut, routine consultations, such as brief visits to request script renewal or to address simple, clearly differentiated physical problems were also excluded. From the recordings remaining, the researcher selected nine consultations for transcription and analysis. Of these, four were identified as the central focus for the discourse analytical study because they most clearly represented 'crucial sites' from the professional perspective. Five consultations were selected for transcription as supplementary data that would be drawn upon to illustrate pertinent focal and discourse analytical themes.

As noted in the introduction to this thesis, consultations selected for close analysis were those that involved:

- Presenting problems that masked hidden emotional and psychological issues
- Dissent between doctor and patient over the nature of the patient's condition and how it was to be managed
- Reticent adolescent patients, specifically an adolescent who presents in the company of his mother with physical symptoms that cannot be medically explained

2.3.4.2. The decision to study whole consultations

My initial approach to this study was to examine particular features of clinical communication, such as the accomplishment of empathy or rapport, through analysis of a collection of short, 'finished' interactional sequences extracted from a large number of PBA consultations. Such an approach would have provided for a wide range of descriptions of particular phenomena. But it would also have sacrificed the broader interactional context that might display, for example, how an interactional environment is created that gives rise to a patient's cue for emotional support, or the ebb and flow of co-constructed rapport across an encounter. Further, clinical communication is strategic and purposeful. Extracting short sequences of talk from the overall context in which they are embedded would obscure the significance of a specific utterance in an individual case. It would leave behind evidence for the impact of participants' moves on the trajectory of the consultation.

As Candlin and Candlin suggest (2002a, p. 119), professional judgement and communicative expertise is always realised through 'some event and person sensitive performance'. It is displayed through the discursive choices that the practitioner makes in specific local interactional contexts, in response to the moment and in pursuit of clinical goals. By choosing to study a narrow selection of consultations in their entirety, I sought to preserve the narratives and arguments that unfold across the whole encounter. I aimed to make visible the processes by which features of communicative expertise, such as empathy or rapport or achieving common ground, are co-constructed in action, and the strategic, purposeful work of doctors in specific, communicatively challenging clinical situations.

Such a single case study approach, that resists aggregating results is, as Frankel points out (2001, p. 88) "...quite consistent with a fundamental feature of clinical medicine; that it is practiced one case at a time and that a physician's relationship with each patient is unique". It is further supported by Clarke (2005, p. 191), a Professor of Genetic Medicine who is also a discourse analyst and suggests that:

> ".....studies of talk-in-interaction whether labeled CA [conversational analysis] or DA [discourse analysis] would align more readily with the perspective of professionals if they could examine episodes of interaction as long as the whole consultation. ...Professionals will perhaps be more enthusiastic about collaboration if the lens used to study their activities could be switched to even a slightly lower power, so that the give and take of discussion over a longer period - perhaps even during the whole of a consultation - could be examined. This will still require the micro methods of CA to be employed, but to be placed and interpreted within the broader context of the clinical encounter".

Such a view is echoed less formally by a senior medical educator participating in this project.

> Extract 1. Interview 4
> It would be lovely to have a manual that has all these outlines (.) you know in this consultation these are the particular things that made it work and this is what put it off the rails. Specific examples you know cases (.) if this happens then this happens and this happens (.) the actual strategies used and specifics (.) how he lent forward or lent back, raised their voice or a phrase that was used (.) also the micro stuff (Senior medical educator).

Accordingly, this study takes a case study approach to examine the discourse of whole consultations. The discourse analytical method used will now be discussed.

2.3.4.3. Method of analysis

The method of discourse analysis used in this study draws upon techniques and constructs from the distinct but commensurate sub-disciplines of Applied Conversation Analysis (Antaki, (to appear); Peräkylä et al., 2005; Peräkylä & Vehviläinen, 2003; Richards & Seedhouse, 2005), Interactional Sociolinguistics (Gumperz, 1999; Roberts & Sarangi, 2005; Roberts et al., 2003; Tannen, 1989), and Mediated Discourse Analysis (Norris, 2008; Norris & Jones, 2005b; Scollon, 1998). Building upon the work of Goffman([1959] 1970) and Garfinkel (1967) who focused attention on the role of language in social formations and social behavior, each of these methods examines how social action is accomplished through interaction. But in doing so, each method focuses on different kinds of semiotic data. Taken together, they offer a comprehensive method for analyzing the use of language and other ways of meaning in the clinical setting.

2.3.4.3.1 Conversation analysis

Pioneered by Sacks in a series of lectures which were posthumously published (Sacks, 1992), and developed by Sacks and others in a number of places (Sacks, Schegloff, & Jefferson, 1974; Schegloff & Sacks, 1973), Conversation Analysis (CA) has its intellectual roots in ethnomethodology (Garfinkel, 1967), a branch of sociology that addresses the question of intersubjectivity, that is, how people come to share a common understanding of their world. Ethnomethodology is concerned with the competencies, interpretative procedures and common understandings that enable members of a culture to interact with and interpret each other. The goal of CA is to closely examine carefully transcribed, naturally occurring interaction, in both mundane and institutional settings, so as to describe, interpret, and explain those competencies and methods that members rely upon to participate in socially organized interaction. Thus CA is concerned to explicate the 'interaction order'(Goffman, [1974] 1986) that exists independently of individual participant characteristics but that participants orient to in order to collaboratively bring off social action.

CA is particularly concerned with the sequential organization of talk and the mechanics of turn taking. It has revealed that people accomplish the actions of everyday life by the

way they design their turns at talk so as to "... set up normative expectations of what is to follow, which fellow interactants abide by or flout" (Antaki, (to appear)). CA focuses on the turn by turn unfolding of talk in interaction. The construct of 'adjacency pair'(Sacks et al., 1974) is central. Utterances are perceived as 'paired actions', such as greeting and response, or advice and acceptance/rejection that are socially related because together they accomplish social actions. Further, each sequential turn in an encounter is both 'context shaped' and 'context renewing'(Heritage, 1984b) in that it both displays the interactant's understanding of the previous utterance and creates a framework for the next action in a sequence. Thus each utterance provides the analyst with evidence to warrant statements about what is going on and what is being achieved by participants in the unfolding interaction.

The CA research program has revealed the deep orderliness of interaction at all points and at all scales of interactional detail. It has shown that participants in interaction orient to orderliness in producing and interpreting not only talk, but such fine grained features as silence, overlapping talk, intake or expiration of breath, laughter tokens, and prosodic features such as pitch direction, volume, and word stress. Accordingly, such features are represented orthographically in detailed transcriptions of recorded data, and are attended to, described and interpreted in the analytical process.

In addition to its focus on the sequential order of talk, and the delicacy of interactional accomplishments, CA studies highlight 'membership categorization'(Sacks, 1992) as a further dimension of the work that members do in interaction. Categorization is a meaning making process that is deeply embodied in human experience and understanding (Sarangi & Candlin, 2003a), and language and discourse are central to this process. In talk, participants in interaction use categorizations and categories in order to construct themselves and others as being part of a particular group or community of practice. Thus, for example, a doctor might invoke a technical lexis or the institutional pronoun 'we' to construct and foreground their identity as a member of the medical profession. 'Membership categorization analysis' (MCA) focuses on how such social categories are used in interaction and the interactional mechanisms whereby social identity is claimed by a participant, imputed to others, affirmed or challenged.
Social identity and category membership are not fixed features of interaction. Rather, as Housely and Fitzgerald point out "...identities and role can be understood to be situated

interactional achievements and important resources for undertaking various tasks within different settings" (2002, p. 63). In the current study, membership categorization analysis reveals how doctors and patients, through their talk, claim different memberships, constructing and reconstructing a variety of identities in purposeful and consequential ways. For example, in PBA consultation 1 to be analysed in Chapter 4, the doctor momentarily foregrounds her identity as a woman, rather than as a doctor, in order to affiliate with an anxious female patient at a critical moment when the therapeutic relationship is in jeopardy. In the training role play, introduced in Section 2.3.1.1 and analyzed in Section 3.2.5.3, the registrar makes salient her co-membership of the category 'young person' so as to build rapport with a resistant adolescent patient. Membership categorization analysis focuses researcher attention on categorization as an expert communicative resource.

CA has greatly influenced the current study by providing procedures and techniques for representing, describing and interpreting the fine grained detail of co-constructed interaction as it unfolds across a consultation (Hutchby & Wooffitt, 2008; ten Have, 1999). It has provided the researcher with an accumulation of empirically derived findings about the practices and methods that interactants use in order to construct identity and to bring off action. It has revealed detail of practices from ordinary conversation, such as those involved in troubles telling (Jefferson, 1988), or disclosing bad news (Maynard, 1989, 1991b) that are carried across into the General Practice setting, as well as findings from a growing body of research into interactions in primary care settings (Heritage & Maynard, 2006a, 2006b) that have been brought to bear on analysis of how action is accomplished in the specific situations examined for this thesis.

But in its canonical form, CA takes a restricted view of context that is limiting for a study that seeks to explore the nature of communicative expertise as it is required by and recognized within the institution of General Practice. Traditionally, Conversation Analysis attends to the interactional order, whilst back-grounding the institutional order. Context is viewed as 'essentially local' (Hutchby & Wooffitt, 2008), interactionally constructed, and to be understood only through the fine grained analysis of talk. As McHoul points out (2008, p. 823) those conversation analysts who take an extreme position on context hold that "...one must scrutinize the conversational text and nothing

but the text". For proponents of canonical CA, aspects of context that are not attended to by participants in interaction should not be considered as part of the analysis. From this perspective, findings from ethnographic study of the wider institutional context are seen as irrelevant (Bhatia, Flowerdew, & Jones, 2008).

In its approach to ethnography, the current study aligns more closely with Applied Conversation Analysis (Antaki, (to appear); Collins, 2005; Moerman, 1988; Peräkylä & Vehviläinen, 2003). In their concern to shed light on the workings of an institution and how institutional work is carried out, conversation analysts working within this tradition are open to the use of non language data derived from ethnographic research. As Antaki asserts in reference to the place of ethnography in studies of interaction in institutional settings (Antaki, (to appear)), "The fact that participants will be bringing off some recordable institutional achievement means that the analyst will have to get a grip on what the institution counts as an achievement....Only ethnographic background – gleaned from documents, interviews, and observation of the site will provide that".

The Applied CA concept of 'professional stocks of interactional knowledge' (SIKs) (Peräkylä et al., 2005; Peräkylä & Vehviläinen, 2003) has been particularly influential for this study. SIKs refer to the organized knowledge concerning interaction that is shared by a profession and through which members view their own communicative practice. Such 'stocks of interactional knowledge' include theoretical models, guidelines, maxims, mnemonics and related exemplar phrases, that are to be found in professional texts and training manuals, that are invoked by educators in training and supervision, and that are referred to in professional forums where communication is discussed. Ethnography has familiarized the researcher with a range of these constructs including models for empathic communication (Suchman, Markakis, Beckman, & Frankel, 1997), the 'stages of change model'(Prochaska & DiClemente, 1983) that relates to motivational interviewing, guidelines and principles for communicating with adolescent patients (Chown et al., 2008), and an array of mnemonics associated with implementing patient-centred care. As previously noted, how such normative models and guidelines actually play out in situ, how they are transformed, and how their salience and substance is challenged in the co-constructed interaction of challenging PBA consultations has been a focus for discourse analysis, suggesting directions upon which to look that align with professional interests.

2.3.4.3.2. Interactional sociolinguistics

Like Conversation Analysis, Interactional sociolinguistics (Gumperz, 1999; Roberts & Sarangi, 2005) shares the objective of understanding how people interact and interpret each other is situated interaction. However, whereas CA focuses on the relationship between turns of talk in order to demonstrate the effects of conversation empirically by way of overtly lexicalized data, IS suggests that the sequential analysis of talk can account for only one of the indexical processes that enable understanding. IS responds to Garfinkel's observation (1967) that everyday talk can never be precise and detailed enough to convey all that we mean and all that others need in order to interpret what is going on, to infer what is intended, and to attune their talk in response. Interactants therefore "...inevitably and necessarily rely on 'practical reasoning' and unstated, taken for granted background knowledge to fill in for what is left unsaid (Gumperz, 1999, p. 456).

IS was developed primarily to shed light on processes of understanding and misunderstanding in contexts of workplace diversity, where interactants from different linguistic and cultural backgrounds might bring different background knowledge and different communication styles to the interpretation of meaning (Roberts, 2008; Roberts, Moss, Wass, Sarangi, & Jones, 2005). Whilst the current study does not focus on intercultural communication, constructs including 'frame'(Goffman, [1974] 1986; Tannen, 1993) 'footing'(Goffman, 1981) and 'contextualization cue' (Gumperz, 1982, 1999) have been highly influential in understanding and describing how participants in interaction interpret each other, how roles and relationships are reworked in the unfolding interaction between patient and doctor, and how shifts in the direction of a consultation are accomplished.

The term 'frame' was first introduced by Bateson (1972) who, on observing otters playing at the zoo, asked how it was that the otters and those observing them were able to appreciate that what was going on was playing rather than fighting. Goffman uses the construct 'frame'([1974] 1986) to refer to the cognitive structures of accumulated experience that enable people to interpret what it is that is going on at a particular moment in an interaction and so to take up a particular alignment in relation to this activity. For example, our experience will allow us to know that someone is teasing or

joking rather than criticizing. We can thus label the frame as 'non-serious' and respond accordingly.

But as Goffman points out, participants in an activity may differ in their perspective on what is going on. Particularly in circumstances where participant roles are differentiated, as occurs for example in a doctor-patient encounter, different interests may generate 'different motivational relevancies' ([1974] 1986, p. 8). At a particular moment, participants may display that they are alive to different aspects of what is happening. They may take up different perspectives on the activity in which they find themselves and reframe it through the roles that they play. For example, in PBA Consultation 3 to be examined in Chapter 5 of this thesis, doctor and patient take up different positions to frame what counts as being 'well' in different ways. How such frame mismatches are negotiated and how a shift in the patient's perspective is gradually accomplished is an indicator of the doctor's communicative expertise.

Frames may be multiple, frame built upon frame, some more fundamental than others, and each participant can have different layers of definition of the same situation at one and the same time. For example, in PBA Consultation 3, a more fundamental oppositional frame involving dissent between doctor and patient over the nature of the patient's condition and how it is to be managed, is over-layed by a frame of banter and teasing that increases the complexity of the interaction whilst functioning purposefully to sustain rapport in face of dissonance.

The concept of 'frame shift' and the associated concept of 'footing' have been particularly influential in this study in directing attention to the strategic work that doctors do in order to shape the trajectory of the consultation or to effect purposeful changes in participant relationships. 'Frame shift' refers to the dynamic movement between frames that is occasioned by way of the subtle use of language and other semiotic means. Thus, for example, in Consultation 1 to be analyzed in Chapter 4, the doctor's response to the patient's indirect cue for emotional support, occasions a shift to a frame of more open discussion about previously hidden concerns.

'Footing' (Goffman, 1981), a related concept that focuses on changing relationships and roles, is defined by Goffman as ".. a change in the alignment we take up to ourselves

and others present as expressed in the way we manage the production or reception of an utterance"(1981, p. 128). Through the way a participant produces or responds to an utterance, they may strategically put the interaction on to a new footing and into a new frame.

In Chapter 6 of this thesis that examines interaction in a triadic consultation involving an adolescent patient and his mother, 'footing' in combination with the construct 'participation framework'(Goffman, 1981), constitute particularly relevant 'analytical themes'(Roberts & Sarangi, 2005). As the parties take up different alignments with each other, roles and relationships shift and change and participation frameworks are configured and reconfigured. For example, through the actions of the doctor, the mother is repositioned from a 'ratified participant'(Goffman, 1981, p. 226) who is addressed by the doctor and speaks on her son's account to the position of 'non- official' listener or 'bystander' (Goffman, 1981, p. 132) to the interaction. The concepts of footing and participation framework are central to understanding and explaining how a measure of patient autonomy is gradually achieved.

Associated with 'footing' and 'frame', and central to IS is the notion of 'contextualization cue' (Gumperz, 1982, 1999), a key concept in describing and explaining how people interpret each other in interaction. Any utterance may be understood in a variety of ways. At any particular moment in interaction interpretations of what is meant by what is said rely not simply on grammatical and lexical signs. Interpretation relies also on the ability of speakers to invoke, and listeners to retrieve, the background knowledge needed to construct possible scenarios of what is going on. 'Contextualizaton cues' are subtle verbal, vocal and non vocal signals, that, when processed along with wordings, serve to construct the contextual ground that affects how a message is understood. They work to "... retrieve the frames that channel the interpretive process by 'trimming the decision making tree' and limiting the range of possible understandings" (Gumperz, 1999, p. 465).

As illustration, take the following fragment from a training role play observed by the researcher during the preparation phase for the current study. In this scenario, the doctor is interviewing a patient believed to be experiencing post natal depression. He is assessing her mood and has arrived at a point where he needs to rule out thoughts of suicide.

Dr: ... and can you tell me Margaret, have you ever thought about harming yourself
P: No (.) no I've never thought about harming myself ((rise-fall tone))

The patient's marked stress on 'self' together with an accompanying rise fall tone constitutes a prosodic 'contextualization cue' that marks departure from a simple statement of fact. This cue, probably produced without reflection, constitutes a signal that functions as a '... a nudge to the inferential process' (Levinson, 1997, p. 27). It is designed to prompt the listener to engage in the process of seeking a possible scenario or interpretive frame, for example that the mother might be fearful of harming others and possibly her child.

Interactional sociolinguistics offers an analytical method that incorporates, but also complements CA to enable a thicker description of patient-doctor interaction. It uses techniques from CA to find evidence for how people interpret each other in the turn by turn sequential organization of talk. But it also recognizes that the observable verbal accomplishments of speakers can account for just one of the processes whereby contexts are created and inferences made. IS considers not only the context that is brought about moment by moment in the unfolding interaction, but also the brought along context of lived experiences and background knowledge that speakers invoke in order to frame moments in interaction, and that listeners draw upon to interpret what is meant and intended.

As an analytical method, IS also embraces data derived from the wider, institutional context. It asserts that a period of ethnographic research must precede discourse analysis to familiarize the researcher with the 'communicative ecology' (Gumperz, 1999; Sarangi & Roberts, 1999b) of the workplace. In this way, knowledge of those principles, values, attitudes, and ways of seeing communication that constitute the 'institutional order'(Berger & Luckmann, 1967) can be drawn upon to shed light on interpretations of discourse at the micro-level of situated interaction. Such a position has been particularly influential for the current study that seeks to illuminate the nature of expert communication as it is institutionally required, and as it is perceived and recognized by members of the community of General Practice.

2.3.4.3.3. Mediated Discourse Analysis

In carrying out this study, I do not claim to have made comprehensive use of the theoretical framework and analytical method of 'Mediated Discourse Analysis' (Norris & Jones, 2005b; Scollon, 1998, 2001). Nevertheless, Mediated Discourse Analysis (MDA) is referred to here because, in its approach to discourse as just one of many means whereby social action is accomplished, it has considerable resonance with the view of discourse that I have arrived at for this study and has influenced my orientation to the interactional data.

In this thesis, as earlier stated, discourse is understood to exist not just in the use of language, but in the coordination of words, gestures, actions, ways with tools, emotions, values, and attitudes, that come together in a performance that is recognizable within the community of General Practice as the right action for a specific moment in a specific situation. This study is about the complexity of communication required for General Practice and MDA strives to preserve the complexity of the social situation (Jones & Norris, 2005). In order to do so, it gives primacy to the action being taken at a particular moment in interaction, by whatever meditational means, rather than restricting its focus to the role of discourse in that action. Following Goodwin (1994), MDA considers phenomena such as talk, gesture, gaze, bodily actions, and the location and use of objects and physical features of a setting as integrated components of a common activity. In essence, MDA takes an approach to the analysis of interaction that does not privilege discourse. Rather, it sees discourse "... as one of many tools with which people take action, either along with discourse or separate from it"(Jones & Norris, 2005, p. 4).

Thus, MDA broadens the analytical lens to encompass the many ways action is accomplished. For example, in analyzing the video recorded PBA consultations for this study, the computer that is consistently present on the doctor's desk is not viewed simply as part of the physical context for the talk that is going on. Rather, it is perceived to be a means through which actions such as engagement or disengagement with the patient are taken, and shifts in frame are accomplished. To further illustrate, in PBA Consultation 1 to be analysed in Chapter 4, the action of accomplishing empathy is

mediated by means of coordinated actions involving an array of tools that include words, attitude, gesture, gaze, body orientation and use of physical objects, such as a box of tissues. These actions intersect as a 'nexus of practices' (Scollon, 2001) to accomplish empathy. Discourse is merely part of what it is that is going on at this particular moment in time and place or, to use Scollon's term (2001), at this particular 'site of engagement'

MDA, in common with Applied CA and IS, allows for a way of linking actions at the level of interaction with the wider institutional order. Concepts such as 'tools' and 'mediated action' that are central to MDA are derived from the work of Wertsch (1991, 1998), a psychologist who asserts that all actions are mediated through 'cultural tools' that include objects, technologies, practices, identities, language and other semiotic systems, and even social institutions that both 'afford' and 'constrain' action. As Norris and Jones explain (2005a, p. 5) "...these tools come with histories that have shaped the kinds of things that can be done with them and the kinds of things that cannot: that is they embody certain *affordances* and *constraints*". Through the ways that people use such tools in a particular cultural context, they show themselves to be a competent member of a particular community of practice. In this study, insights gained from ethnography have afforded some insight into the 'affordances' and 'constraints' that are embodied in the communicative practices of doctors and that allow them to be recognized by examiners and educators as competent members of the community of General Practice.

Mediated Discourse Analysis (MDA) incorporates techniques and concepts from CA and IS. Indeed, it might be argued that rather than departing from these traditions, it simply brings a different orientation to their shared focus on the micro-analysis of interaction(Candlin & Byrnes, 2007). In line with these traditions, MDA takes a 'discourse as social action' perspective on language as a set of tools through which people realize particular social functions. It shares a concern with how people construct and manage their identities in interaction, through their categorizations of self and others, as well as by way of the alignments, footings and positioning they take up in relation to each other. But by not privileging discourse, it also directs the analyst to attend to the multi modal complexity of interaction in General Practice consultations and the gamut of modalities with which social action is accomplished.

Applied CA, IS and MDA produce different forms of knowledge that together contribute to a broader understanding of interaction. By drawing upon these different approaches and harnessing their techniques and analytical concepts, I have set out to achieve as comprehensive a picture of General Practice communication as is both possible in a thesis, and relevant in relation to the themes and processes being examined and discussed.

2.3.4.4 The process of analysis

The procedure for analyzing the discourse of PBA consultations that was used in this study closely follows the process developed by Roberts and Sarangi (2005) in their paper introducing the concept of 'Theme oriented discourse analysis'.

Following the period of ethnography that had informed the selection of PBA recordings for detailed analysis, each video recording was viewed repeatedly in order to identify the distinct phases of the interaction that together constitute the whole (Roberts & Sarangi, 2005). Through attending to the content, and to the shifting frames, the researcher was able to gain an overall impression of the trajectory of the consultation. In viewing each consultation, 'focal themes'(Roberts & Sarangi, 2005) and professional communication theories that had been made salient through ethnography were kept in mind, so that analysis might be directed towards matters of professional interest. But care was also taken to remain open to unforeseen themes that the data might reveal.

The next stage involved transcribing the data turn by turn, in accordance with CA conventions designed to capture meaningful verbal and vocal features of the interaction. Once these features were in place, the researcher again examined the recorded consultations, focusing on the physical actions of the participants. As will be discussed below, a decision was made to represent these features with descriptors, supplemented in some instances by visual representations.

In line with Roberts and Sarangi's approach, each transcription was then examined as a whole in order to examine the outcomes of the interaction. At this stage the researcher also focused closely on those features that could be seen to shape the direction of the

interaction and the trajectory of the consultation towards these outcomes. Roberts and Sarangi suggest (2005, p. 633) that where possible, the analyst should seek feedback from participants at this point in order to gain their interpretation of the events. In this study, it did not prove possible to consult with the patients and doctors involved in the PBA consultations. However, as detailed below, the opportunity to gain feedback from participating medical educators and examiners was built into the research process. Thus, professional perspectives on two key consultations have been brought to bear on analysis and incorporated into the results.

The final stage of analysis involved repeated examination of the transcriptions. In undertaking this close, fine grained analysis, the researcher constantly asked the questions "Why am I reading this passage this way? What features produce this reading? " (Potter & Wetherell, 1987, p. 168). In this way, the analytical process was driven by the data. But it was also constantly informed by 'analytical themes' (Roberts & Sarangi, 2005) that is, by concepts drawn from the literature, such as 'frame' or 'contextualization cue', or 'perspective display invitation' that shed light on the interpretation of what was going on. As Watermeyer cogently states "... a delicate balance needs to be maintained between using the data as evidence and the literature as a guide" (2008, p. 121). The researcher worked to sustain this balance during the process of analysis. The analytical process led to a focus on a series of case studies of whole consultations.

2.3.4.5. Transcription

Video recordings of PBA consultations were transcribed by the researcher using the standardized CA transcription notation system developed by Jefferson and set out in Heritage and Maynard (2006b, pp. xiv - xix). These notation symbols are designed to capture all significant features of talk that contribute to meaning, including elongations, emphasis, overlap, pitch rises and falls, pauses, interruptions, laughter and intake of breath. A list of transcription symbols used in this thesis is included in the introductory pages to the thesis.

In the complex video-recorded interactions examined for this study, action can be seen to be accomplished by a range of semiotic means that function in concert with language, including gaze, gesture, body orientation, use of space, and use of objects. Whilst CA has developed a standardized means for representing verbal interaction, no such universally recognized system exists for visual actions. Accordingly, the researcher was faced with the question of how to represent these features in the transcriptions. A system of notation developed by Heath was considered (Heath, 1986). This system makes use of a series of lines, dashes, commas, dots, and close dashes in order to capture such features as gaze direction towards and away from a face or object, the turning of the body away from or towards a co-participant or object, as well as movements that include nodding, gesture, and lean. The interactivity of these features and their relationship with the talk going on is captured in the following way. The visual behaviour of the speaker is transcribed above the turn at talk. The behavior of the co-participant is transcribed below. In multi-party interactions, the behavior of the second co-participant is represented below that of the first.

Whilst Heath's system offers a way of accurately mapping many of the non-verbal behaviours that are of significance in the current study, the researcher was concerned about the visual complexity of the transcriptions that are produced by such a method. Heath(1986) advises that non-verbal features should be represented only where they are crucial to interpretation Nevertheless, transcriptions using his method cannot be quickly read. This thesis aims to present results in a form that is readily accessible to a readership that includes medical professionals as well as applied linguists. It was therefore decided to forego Heath's transcription method.

Instead, visual features of interaction are represented in the transcription by means of descriptions, following the method used by Greatbatch (2006) in his study of the coordination of talk-based and task-based activities in a medical consultation, as well as by other scholars working with video recorded data from clinical contexts, including Maynard and Frankel (2006).

Researchers within the tradition of Mediated Discourse Analysis (Norris, 2008), as well as some CA researchers who take a multi-modal approach to analysis (Beach & LeBaron, 2002) make use of stills from video recordings to provide graphic evidence

for sequentially organized visible actions. In the current study, use of such evidence was constrained by the imperative to protect the anonymity of participants in PBA consultations. All identifying features would need to be erased, and, in consequence, the depiction of actions such as gaze and gaze direction would be compromised. However, it proved possible, working within these constraints, to make use of a small number of carefully anonymised video stills to supplement verbal descriptions of visible features at critical moments in some consultations.

Throughout the analytical process, the researcher was conscious of the fact that transcriptions are necessarily an incomplete representation of original data (Antaki, 2009; Heath, 1986; Ochs, [1979] 2006). Transcription cannot provide evidence for all that is going on. The solution to this problem was to work with the PBA video recordings always available to hand as a means to complement the evidence captured in the transcribed interactions.

2.3.4.6. Feedback

The researcher aimed for a consultative and reflexive methodology that would, to the extent that was possible within the constraints of the project, bring the perspective of medical practitioners to bear on the interpretation of the discourse analytical data. To this end, two discussion papers were developed during the research phase and distributed to educators, examiners, and other practitioners participating in the study. The purpose of these papers was to update participants on the progress of the project, to present interim results from the analysis of specific consultations, to invite comment on this analysis and its practical relevance, and to seek suggestions about future directions for the project.

Appendix 5 is Discussion paper 2
Appendix 6 provides extracts from emailed feedback on this paper.

The discussion papers triggered a heightened interest in the study, leading to invitations for the researcher and her supervisor to conduct a seminar for RACGP examiners in Melbourne, and two workshops for RTP educators and trainers in Sydney. At these

sessions, the medical practitioners and discourse practitioners engaged collaboratively with transcriptions of PBA Consultations 1 and 2, and with the researcher's analysis.

This process generated new insights for both practitioners and researcher. For practitioners, it offered a new way of looking at communication, as the following comment suggests:

> "The linguistic slant gets one thinking outside our usual box, constructed by traditional medical education theory" (Medical educator and PBA examiner).

For the researcher, it broadened the lens through which the discourse data was perceived, enabling the perspectives of practitioners to be incorporated into the final analysis of PBA consultation data that is set out in the results chapters of this thesis.

In addition, engagement with educators at one RTP site generated interest in the application of discourse analysis to training interactions between educators/supervisors and registrars. This led to a related collaborative project involving the training provider WentWest Ltd, the Department of General Practice at the University of Sydney, and the Department of Linguistics, Macquarie University[5]. Whilst this project represented a departure from the current project in which patient-doctor interaction is the focus for analysis, it demonstrated the broader relevance of discourse analysis to professional practice and professional development. Further, it provided the researcher with the opportunity for sustained ethnographic study at the training site. As educators and trainers drew upon discourse analytical themes to reflect on video-recorded training interactions, the researcher's insight into the 'communicative ecology' (Gumperz, 1999) of General Practice training was deepened.

[5] The process and outcomes of this project were the focus for presentations at the 7th Interdisciplinary Conference, Communication, Medicine &Ethics, Cardiff University, Candlin,C., Candlin,S., Gunter, C., O;Grady, C., Senior, T., Usherwood, T (2009), and the General Practice Education and Training Convention, Adelaide (Senior et al., 2009).

2.4. Summary of chapter

This chapter set out the reasoning for the methodological choices made for this study and described the research process. It began by establishing a view of discourse that would capture the multimodal means whereby action is accomplished in General Practice consultations. This view incorporates values, beliefs, attitudes, and practices that are institutionally recognizable, thus linking discourse to the broader institutional context. The chapter then argued for a nesting of activity type, discourse type, and strategy as a theoretical framework that would encompass both the purposeful and constraining structure of the consultation and the dynamism and creativity of the complex interactional processes that go on within it. A central place for ethnography was asserted in a study that aims for practical relevance, and the ethnographic research process was described in detail. In describing the discourse analytical traditions that have influenced the study, the researcher argued for an approach that combines techniques from CA, IS and MDA so as to provide a comprehensive picture of the interactional complexity of General Practice consultations. The chapter concluded by referring to the steps taken to incorporate the perspectives of practitioners into analysis.

Results of analysis are to be presented in four case studies across Chapters 4, 5, and 6. Chapter 3 takes up themes that are associated with clinical communication within the General Practice profession, and that have been a focus for this analysis.