Chapter 3

Themes

This chapter sets out three 'focal themes'(Roberts & Sarangi, 2005) that have emerged from the ethnographic phase of this study as representing salient concerns that General Practitioners associate with clinical communication. These themes that inter-relate in the realisation of patient centred care, have been deduced from wide ranging interviews with educators and examiners, from observations of registrar and examiner training, from curriculum guidelines and from professional texts that are referred to by educators and recommended to registrars and examination candidates. They also arise in examiner rating forms and are frequently announced in examiner reports that provide feedback to the institution and to examination candidates on the parameter 'communication'. These focal themes are:

- Empathy
- Rapport
- The achievement of common ground as a basis for shared decision making

In this chapter, ethnographic findings will be combined with insights derived from a review of literature from within the medical world so as to describe each theme from the perspective of the profession. In addition, professional 'stocks of interactional knowledge'(SIK's) (Peräkylä et al., 2005; Peräkylä & Vehviläinen, 2003) including models, concepts and theories that General Practitioners associate with these themes will be identified and discussed.

Drawing upon findings from the discourse analytical literature and with reference to findings from the current study, 'analytic themes' (Roberts & Sarangi, 2005) will be identified that can be drawn upon to shed light on how focal themes are actually played out in the interaction between doctor and patient.

Ensuing chapters of the thesis will present analysis of the discourse of a series of whole consultations that represent challenging clinical case scenarios from the perspective of practitioners. Focal themes arising from the ethnography will serve to focus this

analysis on professional concerns and communicative challenges. Analytic themes suggested in the discourse analytical literature will serve to transform these concerns into discourse analytical concepts. Whilst focal themes will provide directions along which to look and discourse analytical themes from previous studies in clinical communication will guide the analysis, care will be taken to approach the data with an open mind so that these concepts do not narrow the lens through which the researcher perceives the data and restrict what the data itself reveals. In this way new knowledge may emerge about how these themes inter-relate in consequential ways in the co-constructed interaction of situated, challenging clinical contexts so as to shape our understanding of the trajectory of the consultation as a whole.

3.1. Empathy

Empathy is a focal theme that animates the discourse of General Practice. From within the profession empathy is considered to be "... the over arching skill that is at the heart of caring" and central to achieving patient-centred care (Frankel, 2009, p. 1).

More directly, in studies of clinical communication empathy is tied empirically to clinical outcomes. Stewart (1995) carried out a review of studies of the relationship between doctor-patient interaction and clinical outcomes to conclude that outcome is improved when the doctor shows support and empathy for the patient.

Further, empathy is a key construct in teaching and assessing clinical communication. In the RACGP curriculum for General Practice that informs the education and training of registrars for unsupervised practice, 'empathy' is a pervasive feature of curriculum statements related to a wide range of clinical topics (RACGP, 2007). In addition, ethnographic research carried out for the current study found that examiners and educators frequently invoke the concept of 'empathy' in their written and verbal feedback to examination candidates and registrars with such comments as '[make]more empathetic statements', 'excellent communication skills empathy and concern', 'very good empathy with patient'.

'Empathy' is a category through which General Practitioners perceive and evaluate communicative expertise and it is an objective of this study to uncover more about how it is accomplished in interaction in specific clinical situations. But what is empathy and how is it conceptualised within the clinical world and in particular by General Practitioners?

3.1.1 Empathy as a concept

The concept of empathy originated in the German Aesthetics movement of the late 19th century when the term 'Einfühlung' was proposed to refer to a person's projection of real psychic feelings into the objects and people they perceive (Duan & Hill, 1996; Frankel, 2009; Neumann et al., 2009). In the early 20th century the concept was translated into English when the psychologist Tichener (1924) coined the neologism 'empathy' using the Greek root 'pathos' for 'feeling' and 'em' for 'inward'.

In ensuing years 'empathy' developed into a key concept in clinical psychology and psycho-therapy where it was described as the ability "to sense the client's private world as if it were your own, but without losing the 'as if' quality" (Rogers, 1961, p. 284). The words 'as if' are significant in this definition and reflect a distinction between 'sympathy' and 'empathy' to be found in the literature that sets out procedures for counselling in clinical and medical contexts (Barrett-Lennard, 1981; Rogers, 1957). Whereas 'sympathy' is an affective state that involves sharing the other person's feelings and relating to that person, 'empathy' is seen to be an intellectual attribute that involves cognitive understanding and 'detached concern', a distinction that resonates with Sacks' observation about the inappropriateness of self disclosure in clinical contexts, "It is absolutely not the business of a psychiatrist, having had some experience reported to him, to say 'My mother was just like that too'" (Sacks, 1992, p. 260).

3.1.2 Empathy as a concept in General Practice

> Training Vignette 4- registrar training
>
> You can say 'that must be difficult' but not 'I understand how you feel' [addressing registrars] How on earth do you understand? Have you ever had this? No. Well we can't sit where the patient sits. I can say 'My heart goes out to you' but I can't say that I've actually been there.
> (RTP Medical educator talking to General Practice registrars at a workshop on pain management)

From this comment, it appears that in the profession of General Practice, as in psychotherapy and psychology, 'sympathy' is similarly distinguished from 'empathy'. Empathy in General Practice is about recognition of the patient's experience rather than participation in that experience. Further to this, in General Practice, joining the patient's emotions through self disclosure is generally ill advised of the doctor as it is seen to detract from a focus on the patient's problems and to place clinical objectivity and effectiveness at risk (Neumann et al., 2009). In a study of the consultation style of one particular primary care physician, du Pre (2001) found that a high degree of self-disclosure about the doctor's own health and life experiences functioned to encourage patients to raise life-world concerns. However a doctor's disclosure of personal feelings and experiences is atypical in General Practice (du Pre, 2001) and in the current study instances of self-disclosure have been found to be rare.

Despite such constraints on the expression of sympathy and the sharing of experiences, General Practitioners are uncomfortable with the notion of empathy as 'detached concern'. In an article that has been influential in the General Practice training literature, Halpern (1993) introduces the term 'emotional resonance' to suggest that clinical empathy requires emotional engagement as well as cognitive understanding and that the doctor should seek to understand what the patient is feeling 'in a detailed and experiential way'(Halpern, 1993, p. 162). This view of empathy is reflected in professional texts that educators participating in the current study cite as widely used and influential in teaching and in practice (Stewart et al., [1995] 2003; Usherwood, 1999). For example, in discussing 'empathy' Stewart and her colleagues reject the concept of the 'detached physician' asserting that empathic understanding that involves openness to the patient's feelings is a requisite of patient-centred care. They suggest that the notion of 'the detached clinician' who keeps a safe emotional distance be replaced

by the notion that doctor and patient are interconnected in such a way that the doctor can immerse him or herself in the concerns of the patient. (pp. 118-119) This perspective is echoed by Usherwood, a leading General Practice educator who points out that whilst understanding a patient's feelings in an experiential way does not necessarily involve sharing those feelings "....it does imply awareness of the range and complexity of the patient's feelings and of the issues to which they relate". To achieve this awareness involves "....seeking to comprehend what it would be like to be that person, living that person's life and feeling the way that she or he does"(Usherwood, 1999, p. 28). As succinctly summarised by Ruusuvuori (2005, p. 205) empathy as it is conceptualised in General Practice involves maintaining 'a dual perspective', imagining oneself in the same situation as the other so as to achieve the detailed understanding of a patient's feelings required for 'emotional resonance' without forgetting that this experience is not one's own.

As the above discussion indicates, in the debates that circulate through the clinical literature, empathy is conceptualised largely as something that is experienced by the clinician rather than as action. Usherwood offers a more active and co-constructed picture of empathy when he notes that "empathic understanding is more accurately seen as a mutual understanding that is jointly developed by patient and doctor working together" (1999, p. 34). However, whilst empathy is claimed by practitioners to be a joint accomplishment, this joint accomplishment is not described and the question remains as to how empathy is collaboratively achieved in situ.

3.1.3 From empathy as disposition to empathy as action

The following extract from an interview with an RACGP examiner participating in this study resonates with the conceptualisation of empathy as a capacity or disposition.

> Extract 1. Interview 3
>
> I really think it's something [empathy] you may well be born with. It's like any facility. You can improve on your natural ability but if you haven't got that natural ability, you're really up against it. You can learn and you can become better at doing it but like if you're a good sprinter that's great and you can improve on that but if you're a lousy sprinter...(RACGP examiner).

The implicit assumption that underlies this view is that some individuals are by nature or through development more empathic than others. Empathy is conceptualised as a capacity that one has naturally and can improve upon. It is a capacity that the doctor brings to the consultation rather than something that is achieved through situated interaction.

A more co-constructed conceptualisation of empathy emerges in the following extract from an interview with a RTP senior medical educator.

> Extract 2. Interview 4
>
> I think one of the things I found interesting was one of the registrars who'd just started working. [quotes registrar] 'It's funny but most of my patients sit down and start to cry'. So what you're asking is what is it in the consultation that allows the patient to feel so comfortable that they would unload such an emotionally disturbing element to a perfect stranger? And yet to other doctors that would never have happened...Some people might say 'I don't ever have depressed patients in my surgery'. But is it because [they] don't pick up on the cues or is it because those patients choose to go elsewhere because of some personality trait that they have or [is it because] linguistically that environment has been set up and that problem is never even presented because there has been a barrier set up? (RTP medical educator).

As this educator ponders the reasons why emotions might rise to the surface in consultations conducted by one doctor rather than another, she appears to suggest that empathy may be situated and co-constructed rather than simply a matter of a doctor's pre-existing disposition. She alludes to a particular and locally produced context that might be conducive to a patient's offering some perceptible cue to an emotionally disturbing situation, and to the doctor's contribution to the achievement of empathy through the action of picking up on and responding to such a cue. Thus, whilst she conjectures that an empathic personality is a contributing factor to accomplishing empathy, she also seems to suggest, as did Usherwood (1999) that empathy is an activity that patient and doctor jointly achieve, or fail to achieve, through interaction.

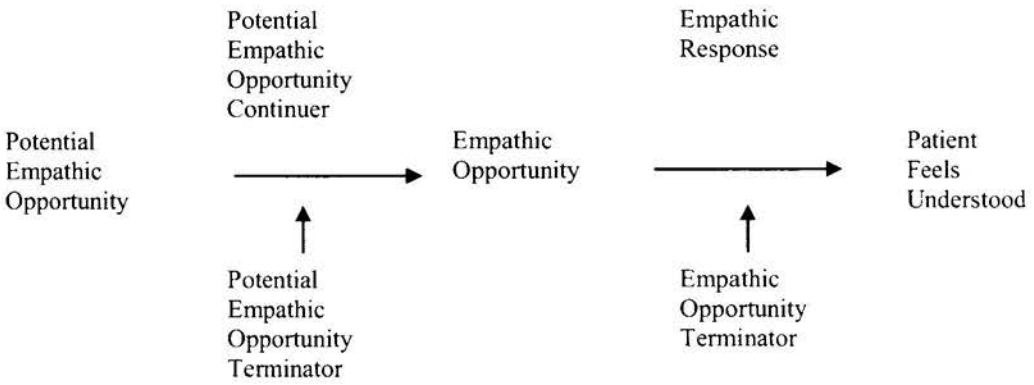
3.1.4 **An empirically based model of empathy as interaction**

In an influential study of empathy published in the Journal of the American Medical Association, Suchman, Markakis, Beckman and Frankel (1997) set out an empirically based model of empathy as interaction. Whilst Suchman and his colleagues

acknowledge that a doctor's intrinsic capacity and motivation to attend to the emotional experiences of others are essential pre-conditions for the achievement of empathy, their study focuses on empathic communication which they define as in essence "the accurate understanding of the patient's feelings by the clinician and the effective communication of that understanding back to the patient so that the patient feels understood"(p. 678). Thus empathy is framed as an interactional and sequential activity rather than an experience or disposition, as illustrated in the following data example from their study involving a two part sequence of empathic opportunity offered by the patient and empathic response on the part of the doctor (p. 679).

Physician: How do you feel about the cancer – about the possibility of it coming back?
Patient: Well, it bothers me sometimes but I don't dwell on it. But I'm not cheerful about it as I was when I first had it. I just had very good feelings that everything was going to be all right, you know. But now I dread another operation [empathic opportunity]
Physician: You seem a little upset; you seem a little teary-eyed talking about it [empathic response]

In carrying out their study that involved observation and analysis of both video recorded and transcribed primary care consultations, these researchers aimed to develop a practical model of empathic communication derived empirically from observations of how patients raise emotional topics and how clinicians effectively respond. The finding that patients' explicit and implicit expressions of emotion were usually allowed to pass without acknowledgement particularly concerned them. Generally, clinicians in their study closed off empathic opportunities and inhibited the emergence of emotion and 'life-world' (Mishler, 1984) concerns by reverting to a previous topic so as to pursue a bio-medical agenda through diagnostic questioning. Through locating and analysing sequences where patients expressed emotions directly or indirectly and where doctors responded to or terminated these empathic opportunities, they generated a model that named and so brought to awareness those moves in an interactional sequence that led to the achievement of or failure to achieve empathy. By transforming the phenomena that they had observed into 'objects of knowledge' (Goodwin, 1994) they aimed to make these phenomena visible and available for teaching and for further research into empathic communication.



An interactional sequence pertaining to patients' expressions of affect and physicians' responses in primary care office visits. Potential empathic opportunity and empathic opportunity represent explicit and implicit expressions of emotion by patients. Verbal behaviours by physicians that facilitate progression are indicated by right-oriented arrows; behaviours that inhibit progression are indicated by ascending arrows.

Figure 1: A model of empathic communication (Suchman et al., 1997, p. 680).

The model together with the study that informs it has been of value to the current project in a number of ways. It has directed the researcher's attention to those 'critical moments' (Candlin, 1987) in a consultation wherein empathic opportunities arise and has highlighted the implicit, indirect nature of the clues that patient's tend to offer to their underlying emotions and concerns. This is of particular significance to the current study given that consultations involving patients' hidden concerns have emerged from the ethnography as crucial communicative sites that call for focused and detailed examination. In addition, the model has made available to the researcher a taxonomy of terms, including 'empathic opportunity' and 'empathic response' that are familiar to practitioners for identifying the moves in those interactional sequences whereby empathy is facilitated or inhibited.

However, in generating their model of empathic communication, Suchman and his colleagues were concerned to draw general conclusions from a broad collection of interactional sequences. Their interest was to identify, collect and study instances in which emotion was expressed rather than to consider empathic sequences in the context of the consultation as a whole. Further, in analysing these de-contextualised sequences so as to develop a model, their focus was on the clinicians' moves rather than on the fine-grained detail of how empathy is collaboratively constructed by both patient and doctor in situ. Significantly, the extracts of interaction from which their model is derived do not include patient uptake of the doctor's empathic response and do not

encompass the patient's action in acknowledging or rejecting the doctor's expression of empathy. In a later editorial article, Frankel (2009) widened the circumference of the empathic sequence, asserting that the achievement of empathy in fact involves a three part interactional sequence: an empathic opportunity initiated by the patient; an empathic response on the part of the doctor and the patient's receipt of this response as an acknowledgement that their feelings and situation have been accurately understood.

3.1.5 Between model and practice – teaching empathic communication

General Practice educators participating in this study refer to 'reflecting' as a particular strategy whereby the empathic communication model can be transformed into practice. Through accurately reflecting a patient's feelings, the doctor's understanding of the patient's emotion can be made explicit and empathy can be achieved. In training, some educators provide a repertoire of exemplar phrases, drawn from practice and held to have empathic value, so as to assist registrars to develop the ability to reflect a patient's emotions and situation.

> Extract 2. Interview 2
>
> I actually give everybody it doesn't matter if they're from overseas or not I actually give them a list of empathetic sort of statements and um you know when you actually use certain things and so on and non-verbals. I spend a whole tute a whole hour on empathy and then um then they've actually got some tools that they can use. (Medical educator/PBA examiner)

However, modelling and memorising a repertoire of stock phrases that have been extracted from the particular interactional context wherein they have meaning, force and 'perlocutionary effect' (Austin, 1962) and then transposing them into another context, can prove to be problematic. Such an approach can lead to a standardised response that is inappropriate in a specific interaction. As educators participating in this study acknowledge, and as was also noted by examiners in a study of the interactions of medical students in clinical examination role-plays (Roberts et al., 2003), the repetition of a learned and rehearsed response can in fact communicate the exact opposite of empathy.

Extract 3. Interview 2

> But to give you an example of how it [repetition of empathic statements] can back fire One of the things I teach is 'That must be hard for you' [referring to a registrar] 'If you use the phrase 'That must be hard for you' just one more time I'm going to strangle you. You need to be more adaptable. It can't just be by numbers' (Medical educator/PBA examiner)

Use of specific forms of language that do not accurately reflect the patient's emotion and attitude at the moment of interaction can be received by the patient as a sign of lack of engagement and attention, and consequently perceived as a failure by the doctor to fully grasp and fully to understand their true position or state of mind. Use of such routine phrases can suggest the 'detached physician', undermine 'emotional resonance', and run counter to the achievement of empathy.

Clearly, empathy is a complex interpersonal process and needs to be studied and taught in context. Discourse analytical studies that involve detailed examination of moment-to-moment interaction can shed light on how normative models such as the 'empathic communication model' play out in practice, and may offer medical educators and registrars useful descriptions of what the achievement of empathy entails in interaction.

3.1.6. Previous discourse analytical studies of empathy in clinical practice

In recent years, a number of studies using a variety of discourse analytical methods have examined empathy as an interactional achievement in a range of clinical contexts including psychotherapy (Wynn & Wynn, 2006), health appraisal interviews (Beach & Dixson, 2001; Beach & LeBaron, 2002), general practice (Harres, 1998), homeopathy and general practice (Ruusuvuori, 2005) . These studies offer detailed descriptions of how those generalised features of the abstract 'model of empathic communication' are enacted, and highlight discourse analytical themes that contribute to an understanding of how empathy is accomplished. They include studies that focus on empathic sequences extracted from a wide range of encounters as the data for analysis, as well as those that consider the achievement of empathy in the context of whole consultations.

3.1.6.1 Studies that focus on empathic sequences extracted from a diverse range of consultations

Drawing upon video recordings of 20 psychotherapy sessions, Wynn and Wynn (2006) identified and extracted for close analysis interactional sequences where empathy was an issue. Using conversational analysis as an analytical method, they were able to demonstrate how empathy was jointly accomplished by describing the processes whereby therapist and patient interpreted and responded to each other, moment to moment, utterance to utterance as these sequences unfolded. Using this method they provided empirical evidence of conversational resources that interactants used in expressing and receiving empathy. For example 'echoing' was identified as a resource involving the therapist's repetition of elements from the patient's prior turn as illustrated by the following excerpt from their study. By building on the patient's prior utterance and so aligning with the patient's perspective, 'echoing' (line 6) functions as an empathic response that is consequential in creating a local environment in which the patient offers further clinically relevant information.

1	T:	We just started talking about it last time … and what I understood from
2	T:	your relationship is that it went quite well to begin with
3	P:	at the end it became a little ..I'm not up to saying anything more
4	T:	yes just say it …it's OK
5	P:	a living hell (ha-ha)
6	T:	a living hell yes…and that hell consisted among other things in him hitting you
7	P:	yes and threatening me with a knife and
8	T:	mm he threatened you with a knife?
9	P:	once

(Wynn & Wynn, 2006, p. 1390)[6]

Non-verbal behaviours, such as putting a hand on the patient's shoulder, were also identified in this study as a frequently occurring communicative resource that co-occurs with verbal expressions of empathy to strengthen an empathic response. General Practitioners participating in the consultations to be analysed for the current study also deploy these resources in the accomplishment of empathy, necessitating a multi-modal approach to the exploration of this focal theme.

Notably, and in contrast to those instances of interaction that informed the 'model of empathic communication' (Suchman et al., 1997), the interactional sequences examined

[6] Here transcribed interaction is represented line by line rather than turn by turn as in the present study

by Wynn and Wynn encompassed the patient's reception of the therapist's empathic response. Thus the therapist's expression of empathy was confirmed or rejected as having that function by an examination of the patient's next turn. In this way Wynn and Wynn were able to demonstrate how empathy is achieved but also instances of the failure of empathy. They found that a lack of receipt by the patient of the therapist's prior empathic utterance is oriented to by both parties and may result in signs of conversational difficulty such as reformulations, pausing or an abrupt change of topic.

In this cross sectional study empathic sequences were extracted for analysis from the overall context of the psychotherapy session. However interaction is cumulative and as the researchers themselves suggest, the generation of empathy may be reliant on pre sequences and other phenomena that occur well ahead of the overt display of empathy that is the focus of their analysis. Their study cannot provide insight into how this brought along context might be conducive to the patient's offering an empathic opportunity, an issue that is of interest to medical educators participating in the current study (See extract 1 interview 4). Further, as the overall context of the psychotherapy session has been erased, it is not possible to examine the effects of the achievement of or failure to achieve empathy across the trajectory of the consultation.

In another study, within the context of General Practice consultations, Harres (1998) examined empathy as one function of tag questions. Focusing on the use of tag questions in 29 audio-taped consultations between three Australian female general practitioners and their patients, she showed how hearer-oriented 'affective tag questions' (Holmes, 1995) were frequently used in their facilitative function to express empathy and alignment with patients. As the following example from Harres' study illustrates, affective tag questions enable doctors to show concern about a patient's well being and so to present themselves as empathic listeners with the result that the patient may respond by providing more information. In this example, a patient is talking to her doctor about having finally become pregnant.[7]

P: I'm really rapt Carol
D: Yes
H it's good
isn't it H

[7] The symbol 'H' in Harres' transcription refers to intake of breath

P: Uhm
I'm a different person now,
I'll
D: Yeah
P: compared to two years ago
(Harres, 1998, p. 121)

Harres' study usefully identifies the 'affective tag question' as a resource that practitioners deploy to respond empathically to their patients by displaying themselves as empathic and supportive listeners. However, as in the Wynn and Wynn study described above, empathic sequences are extracted from their context, thus narrowing the circumference of analysis by excluding both the brought along context that gives rise to an empathic opportunity and the consequences and effects of empathy beyond the patient's immediate receipt of the doctor's empathic expression.

Ruusuvuori (2005) studied empathy and sympathy in action in Finnish homeopathic and general practice settings. Her approach combines a broad study of troubles telling sequences extracted from 40 consultations with close analysis of protracted sequences of interaction from three consultations. She focuses on professionals' affiliative responses to a patient's telling of a troublesome experience as one way in which empathy is enacted in practice.

Through a detailed conversational analysis of extended interactions, Ruusuvuori was able to demonstrate how professionals succeed in showing affiliation with the patient whilst working to preserve the patient's experience as the focus of interest. For example, a doctor's affiliative response to a patient's trouble might involve offering a more detailed description of the situation mentioned by the patient. In this way, the doctor offers empathic understanding by inferring that she has access to a similar situation whilst refraining from invoking a personal experience that might detract from the central professional activity of patient focussed problem solving.

Ruusuvuori's study makes visible one expert strategy whereby general practitioners meet the professional challenge of displaying detailed understanding of a patient's experience without engaging in a sympathetic sharing of experiences that would detract from the professional task at hand.

3.1.6.2. A case study approach to the study of empathy

Beach and Dixson (2001) and Beach and LeBaron (2002) undertook twin studies of a single health appraisal interview carried out to assess the 'at risk health status' of a member of Kaiser Permanente, a managed care organization in the USA.

Findings from these studies are highly relevant to the current project that seeks to examine the role of empathy in specific crucial sites that include consultations involving patients' unvoiced and hidden concerns. Through detailed conversational analysis of a single encounter, these researchers trace how it is interactionally possible for participants to collaborate in moving from a patient's 'no problem' reporting about her home life to increasingly revealing disclosures about disturbing family and personal problems, including on-going marital difficulties and childhood sexual abuse, that contribute to her health status (Beach & Dixson, 2001, p. 29). 'Formulations' (Heritage & Watson, 1979) that summarise what the patient has been unable to voice, together with the interactional consequences of these formulations are shown to be one set of resources that are deployed collaboratively by patient and interviewer to accomplish this gradual transition from presenting problems that are bio-medical in nature to increasingly delicate life-world matters, including childhood abuse.

By encompassing the whole encounter in their analysis, Beach and Dixson (2001) were able to demonstrate how an environment was interactionally created that allowed for the disclosure of issues and emotions that may not otherwise have surfaced, and hence the creation of new empathic opportunities. This environment was achieved through strategies that included the interviewer's displays of non-judgemental sensitivity to the patient's voiced concerns, repeated displays of encouragement and acknowledgement, and through avoiding moving the interview on prematurely.

Beach and LeBaron (2002) complemented the earlier study of this particular interview by expanding their analytical focus to include not only vocal but also visible forms of interaction made available through video recordings. These non-vocal actions included participants' facial expressions, eye gaze, hand gestures, posture and shifting body orientations, together with the use of objects such as tissues. They demonstrate how delicate moments in the interaction are produced and oriented to by both patient and

interviewer and how attending to such moments is accomplished, not only through wording but through other semiotic means, so as to generate disclosure of a patient's deep, life-world concerns and empathic understanding of these concerns.

Such findings resonate with findings from the current study. A multi-modal analysis of the discourse of PBA Consultation 1, in which the patient's deeper concerns are initially hidden, shows how body orientation and gaze combine with the doctor's verbal expression of empathy to intensify engagement with the patient at critical moments in ways that encourage disclosure (See Chapter 4).

3.1.7 The approach to the study of empathy taken in the current thesis

In an editorial on empathy research for a special issue of 'Patient Education and Counseling', Frankel (2009, p. 2) notes that the vast majority of studies of clinical communication are cross-sectional. He draws attention to the fact that such studies cannot provide insight into the immediate effects of empathy on the trajectory of a consultation nor into the effects of empathy on relationship building and maintenance that is considered to be consequential in shaping the outcomes of care.

In the same issue of the journal, Neuman et al (2009) offer an 'effect model of empathic communication' that demonstrates how an empathically communicating doctor can accomplish improved patient outcomes. In this model, the communication of empathy is represented as achieving various positive effects. For example, patients are likely to talk more about their symptoms and concerns, thereby assisting the doctor to collect more detailed medical and psycho-social information. This leads to more accurate perceptions of the patient's medical and psycho-social state, more specific and responsive therapies, and ultimately to improved outcomes (Neumann et al., 2009, p. 342).

Accordingly, this model goes beyond the empathic sequence taken in isolation to encompass the immediate effects of empathic communication and the impact on clinical outcomes. But how might such a theoretical model play out in interaction? By examining the discourse of whole consultations, the current study seeks to offer a response to this question. To this end, in this study, discourse analytical themes are

brought to bear on the interaction so as to shed light on the collaborative achievement of empathy moment to moment as it unfolds in protracted sequences of talk within the context of entire consultations. This approach allows the researcher to interpret the opportunity for empathy created by the patient in light of what has gone before and to consider the brought along context that enables a detailed understanding of the patient's experience that invests an empathic response with its particular meaning and 'emotional resonance'(Halpern, 1993). It also allows the researcher to examine the effects and consequences of the empathic sequence in shaping the trajectory of the consultation towards its outcomes.

Take the following instance of empathic interaction from a Practice Based Consultation that is analysed in full in Chapter 4 of this study. The brought along context is crucial to interpreting the import of the patient's expression of emotion and the value of the doctor's empathic response. The patient's husband has face cancer and has recently undergone surgery on his nose involving a flap that resulted in considerable disfigurement and a difficult recovery period. Over a number of turns leading up to the moment where the patient initiates an empathic sequence by offering the doctor an opportunity for empathy, patient and doctor have been discussing a further operation that the husband is about to undergo for cancer on his eyelid. Through the doctor's minimal encouragers and acknowledgments an environment conducive to the patient's offering of an empathic opportunity has been created. Depending upon what the surgeons find they may have to do another flap from the top eyelid down. At an earlier turn (61) the patient had alluded to her anxiety about revisiting this experience.

Extract 8. PBA Consultation 2

89	P:	Yeah yeah um (.) and he's becoming a worry:
90	D:	((nods, directing gaze towards patient's face.))
91	P:	The nose was (.) horrendous absolutely horrendous (.) but we got through that (.) I hope they got it all this time they had three goes at it (.) in the end the flap's the way to go but o::hh [((shakes head)) no]
92	D:	[Yeah it's hard] (.) hard work for you cause well who did most of the looking after you or him
93	P:	((laughs)) I did (..) I did (.) but oh he came out of theatre and I just burst into tears when I seen him ((shakes head))
94	D:	But it's looking good now :
95	P:	Oh it's great=
96	D:	=yeah
97	P:	Couldn't believe (.) for what happened there (.) to what he is now (.) It's just (.)fantastic

98 D: Good

At turn 89 the patient discloses that she is worried about her husband. This constitutes an 'empathic opportunity' (Suchman et al., 1997). With an assenting nod the doctor affiliates with the patient in her concern and by simultaneously redirecting his gaze towards her face he increases his engagement with her and so prompts her to elaborate. Encouraged by this 'empathic opportunity continuer' (ibid) the patient is prompted to provide a description of her husband's previous operation (turn 91) that culminates with a further 'empathic opportunity'. The elongated discourse marker 'o::hh' is a 'change-of-state token' (Heritage, 1984a) that displays a shift in the patient's orientation from the more objective description of the operation to an expression of affect that is intensified non vocally by the action of shaking her head. Turn 92 constitutes the doctor's 'empathic response'. In discourse analytical and pragmatic terms this response can be interpreted as the exercise of a 'positive politeness strategy' (Brown & Levinson, [1978] 1987) that fulfils the patient's face want for understanding. But the effectiveness of this politeness strategy as an empathic response lies in its responsiveness to the immediate and brought along context. Specifically it lies in the accuracy with which it reflects understanding of the patient's earlier expressed fears and the life-world issues to which her feelings relate, in this case her anxiety about revisiting the arduous and disturbing convalescent period should her husband's second operation require another flap. It would appear that this response resonates with the patient's emotions and at turn 93, with her laughter and assent, she receipts it as an accurate acknowledgement of her feelings. Empathy has been collaboratively achieved.

As turn 93 continues, the patient offers a further empathic opportunity as she relives her distress at seeing her husband in his post-operative state. Rather than offering an empathic response, the doctor acts strategically to accomplish therapeutic goals. His inquiry about the husband's current appearance (turn 94) prompts the patient to positively reformulate her image of her husband and at turn 96 the doctor's latched acknowledgement constitutes an empathic alignment with the patient in her positive assessment of her husband's current appearance. Thus the doctor motivates the patient to focus on positive outcomes. The trajectory of the consultation shifts as troubles talk is therapeutically reframed as optimism (turn 97).

Mercer and Reynolds (2002) add a further dimension to the conceptualisation of empathy. In their definition, clinical empathy involves the ability to understand the patient's situation, perspective and feelings and to communicate that understanding. But it also involves the ability "to act on that understanding with the patient in a helpful (therapeutic) way" (p. 11). It appears from the above example that therapeutically effective empathy may sometimes involve deflecting immediate emotions so as encourage the patient to reformulate their experience in a more positive way.

Clearly, in interaction the achievement of empathy is complex. The current study will offer a detailed picture of how those practices described in normative models of empathic communication are played out and expanded upon in practice and how they inter-relate with other themes in the context of communicatively challenging consultations.

3.2. Rapport

Rapport, like empathy is a salient focal theme in the discourse associated with clinical communication within the profession of General Practice. The RACGP curriculum that informs education and training and is an essential reference for registrars, supervisors, medical educators and registered training providers, identifies rapport, coupled with empathy, as a 'minimal and essential skill' required for competent practice (2007, p. 9). Under the domain of 'communication and the patient-doctor relationship', development of the capacity to 'establish rapport and be empathic with patients' is specified as a key and common learning objective that is considered to be relevant to every General Practice consultation.

Rapport is also a 'focal theme'(Roberts & Sarangi, 2005) in the assessment of clinical communication. The RACGP Assessment Handbook for Candidates (RACGP, 2009a, p. 5) cites 'establishing rapport', glossed as 'connecting with the patient', as a key aspect in measuring the communicative competence of candidates seeking fellowship. This focus on rapport finds concrete realisation in the Practice Based Assessment Video Rating Form that is designed to guide College examiners as they evaluate a candidate's performance in the video recorded consultations submitted for assessment. In this pro-forma 'communication and rapport' is fore-grounded as the first of five parameters of assessment[8] and given detailed exposition as set out below.

Communication and Rapport
A competent candidate demonstrates genuine respect, rapport and empathy. They [sic] allow the patient to talk freely and to feel at ease in a non-judgemental atmosphere. Communication and rapport includes active listening, appropriate maintenance of eye contact, recognition of verbal and non-verbal cues and body language. It demonstrates the effective use of silence and uses suitable language with an appropriate mix of open and closed questions. It enables the exploration of concerns and expectations and allows recognition of the significance of the patient's words.

N/A	Poor	Insufficient	Doubtful	Sufficient	Good	Excellent
○	○	○	○	○	○	○

Further, examiners frequently invoke the concept of rapport in the written feedback that supplements their global assessment of a candidate's communication along a continuum

[8] Other parameters set down in the RACGP Practice Based Assessment Video Rating Form are history taking, physical examination, problem definition, and management and investigations

from 'Poor' to 'Excellent', with such comments as "obviously caring GP with good communication skills - rapport with patients excellent", "Good-excellent rapport & relationship with patient"; "Patient obviously very comfortable with Dr W - planning to have return visit on way back home"; "Excellent rapport; only second consult for this lady with Dr W but patient obviously very happy seeing her!!!"

Within the profession of General Practice, attention to 'rapport' is not left to chance. Institutionally sanctioned documents, including curriculum frameworks, curriculum statements and evaluation pro-formas, direct educators, examiners and registrars to attend to 'rapport' in the development and assessment of communicative expertise. This focus on 'rapport' can be accounted for by a large body of research from within the clinical world that links rapport empirically with patient satisfaction (Hall, Harrigan, & Rosenthal, 1995; Krupat et al., 2000; Roter & Hall, 2006), as well as with the achievement of positive clinical outcomes including concordance with treatment, reduction of suffering, and a greater disclosure of psycho-social aspects of a patient's illness experience as a pre-requisite of patient-centred care (Crossley & Davies, 2005; Duggan & Parrott, 2001; Epstein & Street, 2007).

But what is rapport and how is it conceptualised within the profession? Despite the established clinical importance of rapport and its central place in curriculum and assessment guidelines, it is not well differentiated from other relational constructs in the discourses about communication that circulate in the profession. To examiners and educators participating in this study it would appear that rapport is tangible and easily recognisable in the discourse of a consultation. Feedback provided to registrars on their performance in training role-plays, and evaluative comments on examination pro-formas attest to this easy recognition. Yet, rapport does not appear to be so easily defined.

3.2.1. A problem of definition

Empathy as a construct in General Practice has evolved from a solid foundation in clinical psychology and psychotherapy and is clearly defined (See Suchman et al section 3.1.4 of this thesis). Rapport however is often used interchangeably with other

constructs. Hall, Roter, Blanch and Frankel (2009) draw attention to the fact that in empirical studies that link rapport with patient satisfaction and clinical outcomes, 'rapport' is usually discussed interchangeably with concepts such as 'trust', 'cooperation' and 'the therapeutic alliance', without any indication as to whether these constructs are synonyms for rapport, conditions for rapport or consequences of rapport. From discussions amongst practitioners participating in the current study it would appear that 'rapport' is frequently conceptualised as synonymous with 'empathy'. In the words of one senior educator, "rapport and empathy often get thrown in together".

Further, whilst the PBA video-rating form foregrounds rapport, it does not differentiate it from communication in general. Rather, under the general heading of 'communication and rapport' examiners are provided with an inventory of features, including active listening, appropriate maintenance of eye contact, recognition of verbal and non-verbal cues and body language, all of which, taken together and severally, are intended to provide clarity and to facilitate objectivity in the assessment process. But these features do not attempt to link rapport to specific descriptors. More significantly, such a list of communication features, abstracted from context, functions to atomise 'rapport'. As Skelton suggests (2008, p. 55) atomisation of a phenomenon results in much less than the sum of its constituent parts. Something goes missing. By attempting to condense the complex interaction wherein rapport is accomplished into an inventory of features, the phenomenon of rapport escapes (Silverman, 1997, p. 24).

In a similar way, examiners' comments as recorded in the PBA rating forms typically condense into a phrase the responses of expert practitioners to the complex moment-to-moment interactional processes wherein rapport between a patient and candidate is achieved. Such comments cannot hope to bring us closer to understanding the nature of rapport as it is accomplished in situ.

3.2.2. Conceptualisations of rapport in medical education- two theoretical models

Recently, within the world of medical education, a new theoretical model has been developed that aims to capture the dynamic process of establishing rapport between doctor and patient (Norfolk, Birdi, & Walsh, 2007). In this model rapport is

conceptualised as a consequence of the achievement of empathy, and is defined by the quality of the doctor's empathic understanding of the patient's situation and perspective. According to this model, the greater the level of understanding of the patient's perspective that is reached by the doctor, the stronger is the rapport between doctor and patient. The process of developing rapport is depicted as iterative in that the achievement of rapport is seen to facilitate the gathering of more in depth information about the patient's feelings and situation and this in turn enhances rapport.

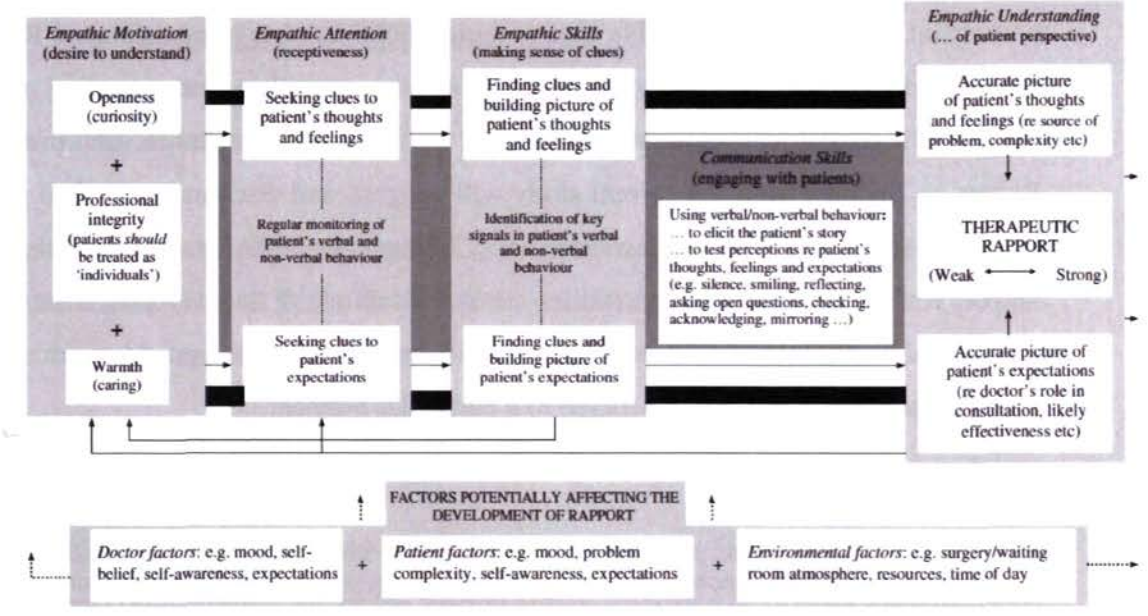


Figure 2: Developing therapeutic rapport in the consultation (Norfolk et al., 2007, p. 695)

Notwithstanding its depiction of rapport as an outcome of interactional processes, this model is not grounded in the analysis of discourse. Unlike the model of empathic communication (Suchman et al., 1997) described in Section 3.1.4 of this thesis, the construct of rapport as set out in this model is not derived empirically from observations of naturally occurring interaction in primary care consultations. Rather, it was developed through a process that involved drawing together skills and aptitudes identified in other studies to create a model that was subsequently refined and validated in consultation with experienced practitioners (Norfolk et al., 2007, p. 690). Whilst the

model of empathic communication, generated from observations of interaction, incorporates moves in an interactional sequence whereby empathy is collaboratively facilitated or inhibited, this model represents an idealised version of rapport, as it should be accomplished, rather than rapport as it occurs in the give and take of interaction. Thus, the fine grained details of how rapport is interactionally achieved remain hidden.

Further, in focussing on rapport as a consequence of empathy, the model narrows the circumference of the lens through which rapport is perceived. Empathy is problem focussed and is occasioned by a particular moment in an interaction when one participant offers some perceptible clue to their emotional state or predicament. Rapport between doctor and patient may result from the empathic understanding that is expressed at such times, as this model holds, but it is not restricted to such moments. Rather, as findings from the current study will suggest, and discourse analytical studies of rapport in other clinical contexts support (Collingridge, 2009; Leahy & Walsh, 2008) rapport is a phenomenon that permeates clinical discourse. It is developed, sustained or diminished in the ebb and flow of interaction between patient and doctor across an entire consultation and is not restricted to a particular moment.

An earlier model that remains influential in clinical education and training conceptualises rapport as a process that is in play across the consultation. Derived from the Calgary-Cambridge guides (Kurtz & Silverman, 1996), an influential set of guidelines for teaching clinical communication, this widely used educational resource (Kurtz et al., 1998; Silverman, 2007; Silverman, Kurtz, & Draper, [1998] 2005) integrates communication skills into the traditional medical history interview. In this model 'developing rapport', conceptualised as an aspect of 'relationship building', is depicted as a continuous thread throughout the medical interview from its initiation to its closing.

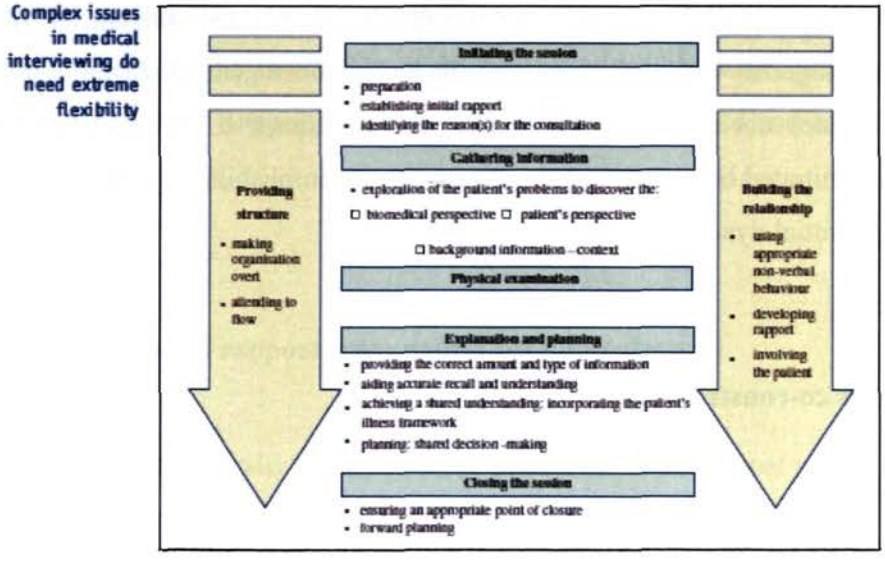


Figure 3: An expanded framework for the medical interview (Silverman, 2007, p. 90)

The guide that accompanies this model provides a comprehensive list of seventy-one itemised communication skills that relate to various aspects of the interview process. Those that relate specifically to rapport have been extracted from the guide and set out below.

Establishing initial rapport

1. Greets patient and obtains patient's name
2. Introduces self, role and nature of interview; obtains consent if necessary
3. Demonstrates respect and interest, attends to patient's physical comfort.

Developing rapport

24. Demonstrates appropriate non-verbal behaviour (e.g. Eye context, posture and position, movement, facial expression, use of voice
25. If reads, writes notes or uses computer, does in a manner that does not interfere with dialogue or rapport
26. Accepts legitimacy of patients' views and feelings; is not judgemental
27. Uses empathy to communicate understanding of the patient's feelings and predicament; overtly acknowledges patient's views and feelings
28. Provides support: expresses concern understanding, willingness to help
29. Deals sensitively with embarrassing and disturbing topics and physical pain including when associated with physical examination

(Silverman et al., [1998] 2005, pp. 8-9)

The model draws attention to rapport as a phenomenon that is to be attended to at all phases of the medical interview and the accompanying lists of skills are intended to provide educators and registrars with a repertoire of strategies that are to be referred to

as needed in teaching and drawn upon as appropriate in practice (Silverman, 2007, p. 91). But the model together with its battery of skills has not been generated from a study of discourse and does not conceptualise rapport as an interactive process. Rather it focuses on doctor-initiated behaviours as the means for accomplishing rapport and in so doing belies its essential dyadic and co-constructed nature.

3.2.3. Rapport as co-construction

> Extract 1. Interview 5
>
> "To me you have rapport when the patient feels comfortable with you and you feel comfortable with the patient. It's a sense of comfort. It's a sense of understanding each other."
> (Medical educator at RTP)
>
> Extract 1. Interview 6
>
> " It's [rapport] a bond.....It's about establishing an emotional bond with the patient"
> (RACGP examiner)

These brief comments from participants in the current study seem to suggest that rapport is fundamentally seen as a mutual accomplishment. For these practitioners rapport is perceived as a sense of ease, comfort and emotional connection that is experienced reciprocally by both doctor and patient. Neither the doctor alone nor the patient alone can realise rapport. It appears that rapport is essentially dyadic and co-constructed.

Empathy too is jointly constructed. As described in section 3.1 of this thesis, the accomplishment of empathy in interaction involves an empathic opportunity initiated by the patient, an empathic response on the part of the doctor and the patient's receipt of this response as an acknowledgement that their feelings and situation have been accurately perceived, and acted upon. Nevertheless, whilst empathy is a collaborative discursive achievement that needs to be studied in the context of interaction, the experience of empathy is of itself internal and personal. It involves one participant, who is usually the doctor, as 'sensor' in the 'mental processes' of 'perception' and 'cognition' (Halliday, 1994, p. 118) . It is conceivable that a doctor who accurately perceives and understands a patient's emotional state may experience empathy without

communicating this to their patient. Rapport however can only be experienced and can only exist in dyadic interaction or in interaction within larger groups such as doctor, patient and carer. Rapport is quintessentially co-constructed and made evident through interaction.

3.2.4. Studies of rapport from within the clinical world

Despite the intrinsically co-constructed nature of rapport, most studies of rapport from within the clinical world focus on the behaviours of clinicians rather than on interaction between doctors and patients. For example, in the context of psychotherapy, a series of studies have examined the verbal and non-verbal behaviours of therapists to identify those that correlate with client-perceived rapport. Clinician behaviours studied include silence (Sharpley, 1997), eye contact (Sharpley & Sagris, 1995), posture (Sharpley, Halat, Rabinowicz, Weiland, & Stafford, 2001) and the use of minimal encouragers, formulations and restatements (Sharpley, Fairnie, Tabary-Collins, Bates, & Lee, 2000). In the context of General Practice, Duggan and Parrott (2001) studied the non-verbal rapport building behaviours of doctors in a continuing care clinic to find that 'facial reinforcers' including smiling and head nodding were positively associated with patients' disclosure about psycho-social concerns.

A recent study published in the influential journal 'Patient Education and Counseling' (Hall et al., 2009) represents a departure from such research in its attempt to capture the behaviours of both participants in the medical interview. This study, which aims to measure rapport between medical students and standardised patients, that is patients or actors trained to present with a standardised history, deploys an explicitly dyadic definition of rapport as "shared positive feeling, mutual involvement or focus of attention, and harmoniousness as reflected in smoothness and coordination"(p. 324) . Further, trained observers charged with the task of rating rapport were directed to attend to the behaviours of both medical student and 'patient'. For example 'shared positive feelings' as an indicator of rapport was to be "correlated with apparent positive feelings in both parties, not just the medical student" (p. 324).

However, despite this commitment to measuring rapport as a dyadic phenomenon, the study continues in the tradition of previous studies through its use of a quantitative research methodology known as 'process analysis' (Roter & Larson, 2002) (See below) which, from the discourse analytical perspective, cannot capture the co-constructed and dynamic accomplishment of rapport.

3.2.4.1. Process analysis as an analytic method

Process analysis involves the use of codes that are applied deductively to behaviours observed in interaction. In clinical communication studies the most widely used and influential coding scheme is that referred to as the Roter Interaction Analysis System (RIAS). This system does not make use of transcriptions of interaction. Rather, trained investigators working directly from direct observations or recordings assign each utterance that is expressed by a participant to one of 37 pre-determined and mutually exclusive categories of communication that purport to distinguish between affective and instrumental behaviours. Utterances are extracted from the interaction and sorted into such behaviours as asking or answering questions about bio medical topics, asking or responding to questions about psycho-social concerns, giving medical information, making emotional statements, showing reassurance or signs of agreement and disagreement, and social talk. In addition to coding discrete communicative behaviours, RIAS coders rate global affect on a number of dimensions including friendliness, warmth, interactivity and hurried/rushed style (Hall et al., 2009, p. 325). In this way a tally sheet of communicative behaviours is produced. Using this data, which expresses behaviours in frequencies, correlations are made between behaviours and outcomes such as compliance with treatment, patient satisfaction, or perceived or observed levels of rapport.

Hall and her colleagues (2009) used this method in their study of medical student/standardised patient dyads to codify the communicative behaviours used by both participants in the medical interview. Once coded and quantified, the behaviours were linked with a rapport rating made on the basis of deduced observations of such phenomena as shared positive feelings and mutual involvement. Amongst the conclusions reached was that high rapport was associated with a high instance of

positive statements, the giving of less medical information, and perceived warmth, interest and interactivity on the part of students, together with a high instance of positive statements, emotional statements, and engagement, warmth and low anger on the part of 'patients'.

Notwithstanding the efforts made in this study to encompass the behaviours of patients as well as doctors, such a methodology cannot bring to light the discursive accomplishment of rapport. On a number of counts, studies carried out through the activity of process analysis are inadequate to capture this collaborative achievement.

Firstly, through the coding process, utterances are extracted from their interactional context and condensed into sets of pre-determined behaviours. The coded material, rather than the actual interaction on which it is based, becomes the data and the context and content of the interaction is washed away (Bassett, 2007; Charon, Greene, & Adelman, 1994; Heritage & Maynard, 2006a). In addition, coding takes place away from the context of the encounter and generally relies on transcripts that have been transcribed verbatim at a level of delicacy that fails to capture the fine grained detail of interaction. Thus "interactivity, the capacity of one party to influence the behaviour of another, or to adjust behaviour in response to another becomes invisible" (Heritage & Maynard, 2006a, p. 358; Stiles, 1989). Yet, it is through such responsive interactivity that rapport is accomplished.

Further, the coding categories used in process analysis are pitched at a general level so that findings can be generalised to other contexts and, as a consequence, lack specificity and detail (Heritage & Maynard, 2006a). They tend to direct attention to features of medical interactions that are common and amenable to statistical analysis and away from the creative and unconventional behaviours that have been found to characterise the achievement of rapport in the current study and which are not amenable to quantitative analysis. As Charon, Greene & Adelman suggest (1994, p. 957), in process analysis "that which is unique about any one interaction is noise" and likely to be discarded.

As an example of my argument, take the following extract from the data base of PBA consultations made available for this thesis. This is a new patient for the doctor and

issues of long-term alcohol use and heavy smoking have emerged as serious risks to the patient's health. Face is at risk and rapport is at a premium in such a context where topics of discussion may have moral implications as they touch upon individual responsibilities to lead life in safe and acceptable ways (Linell & Bredmar, 1996, p. 348). To achieve the on-going therapeutic relationship that is required to manage such lifestyle issues, rapport needs to be established and sustained. At this point in the consultation, the history-taking phase is nearing completion and the doctor is about to take the patient's blood pressure.

Extract 1. PBA Consultation 8 (Supplementary data)

164	D:	Are you allergic to anything that you know of=
165	P:	= no no
166	D:	((adjusts blood pressure cuff))
166	P:	Oh yeah ex wives
167	D:	((laughs)) $$ how many have you got
168	P:	((laughs)) yeah no ex girlfriends (.) that had my daughters ((laughs))
169	D:	((pumps up blood pressure apparatus))
170	P:	Yeah I'm allergic to them

It is difficult to know how such an interaction would be treated through the activity of process analysis. It might be coded as 'social talk' or as a 'psycho-social exchange' that serves an instrumental function by providing insight into the patient's life-world. It might be condensed under the global affect dimension of 'warmth' or 'friendliness'. Or it might be passed over as an interaction that cannot readily be assigned to any mutually exclusive category. Whatever the coding, the collaborative accomplishment of rapport would be lost.

In order to describe and explain how rapport builds at such a moment, close analysis of interaction, as captured by detailed transcription, is required. At turn 166 the patient's revision of his earlier response to the routine question about allergies creatively counters expectations. In so doing it evokes the doctor's laughter and shifts the consultation to a humorous frame. At turn 167, the doctor affiliates with the patient to continue the joke. With smiling voice, he takes a light hearted stance to ask just how many ex-wives the patient has. This in turn invokes the patient's affiliative laughter in response (turn 168). Through this 'affiliative sequence'(Clark et al., 2003) doctor and patient collaborate to sustain a frame of light-hearted banter that enhances rapport.

Interaction is a dynamic and cumulative activity and it is of further concern that the activity of process analysis overlooks this fact (Sarangi, 2009). Whilst moments when rapport is enhanced might be captured in extracts from an encounter, as the above example illustrates, rapport is a phenomenon that shifts, changes and develops across a consultation. Yet, most studies of rapport from within the clinical world restrict analysis to discrete slices of interaction. For example, in the study conducted by Hall and her colleagues (2009) rapport ratings were estimated through a process of observing three separate one-minute extracts from a consultation to arrive at an average rating for each minute of interaction, a process that sets aside the cumulative accomplishment of rapport. Further, in their discussion the authors highlight the finding that interaction variables found to be significant for rapport were present in the opening minute of a consultation. On this basis they conclude that 'rating short extracts of behaviour is a valid and efficient methodology for capturing the concept of rapport' (p. 323). However, whilst openings have a special place in the establishment of rapport and might facilitate conditions for its continuing development across an encounter, rapport is a dynamic phenomenon that is monitored and negotiated moment to moment through co-constructed interaction and can strengthen or weaken across the trajectory of a consultation. Fine-grained analysis of the discourse of an encounter over its extent is needed to capture the trajectory of this dynamic interactive process.

3.2.5. Discourse analytical studies of rapport

Despite the extensive body of literature from within the clinical world that documents quantitative studies of communicative variables associated with rapport, a relatively small number of discourse analytical studies (Clarke, Drew, & Pinch, 2003; Goldberg, 1990) specifically attend to its interactional achievement. Those studies that consider rapport in clinical contexts restrict their focus to small talk (Coupland, Robinson, & Coupland, 1994; Leahy & Walsh, 2008; Ragan, 2000; Walsh, 2007).

Despite their paucity, a review of these discourse analytical studies nevertheless offers the researcher highly relevant 'analytical themes' (Roberts & Sarangi, 2005) that can be drawn upon to shed light on the collaborative and purposeful accomplishment of rapport in PBA consultations.

3.2.5.1. Collaborative interruption as a strategy of alignment

Goldberg (1990) investigated interruptions as displays of rapport. Through examining the relational significance of interruptions for participants in interaction she contested assumptions that interruptions are necessarily indicative of the intent of one party to disrupt the turn space of another or to interfere with the projected form, content or ownership of what is said. Interruptions can be intended and perceived as expressions of solidarity and interest, and function as acts of collaboration and mutual involvement.

Clearly, as Goldberg points out, interruptions are multifunctional. They may be deployed as interactional strategies for exerting power over the discourse and over other participants (Mishler & Waxler, 1968; West, 1979) and in the context of General Practice consultations interruptions can have deleterious effects. Influential studies that are frequently cited in the medical training literature and often referred to by medical educators participating in the current project have found that doctors' early interruptions of patients' stories can function to redirect talk, with the result that a full picture of the patient's concerns does not emerge (Beckman & Frankel, 1984; Marvel, Epstein, Flowers, & Beckman, 1999).

Further, interruptions may arise in an interaction as a consequence of the need to address the immediate communicative needs of the situation (Goldberg, 1990, pp. 887-888). For example, in a consultation a doctor may momentarily interrupt a patient's utterance to pursue an issue that requires immediate attention, such as the clarification of a symptom. At such moments, in keeping with the rights and obligations of participants in such an encounter, the patient will be obligated to momentarily relinquish their turn.

Whilst Goldberg's study is of value to the current project in that it draws attention to the distinctive and various functions of interruptions in interaction, it is also particularly useful in providing a way to describe and to explain how interruptions can enhance rapport between patient and doctor.

Take the following extract from a PBA consultation examined for the current study and introduced in Section 2.2.2. RACGP examiners rated this doctor as 'excellent' on the

parameter 'communication and rapport' for this consultation. The patient is passing through the district and is a new patient to the practice. He presents with ear-ache.

Extract 2. PBA Consultation 7 (Supplementary data)

23 P: I think I might've got a bit of dirt in it at work I'm a carpenter :
24 D: Right
25 P: And the doctor I went to locally at Nelson he gave them a flush out and a clean
26 D: Yeh
27 P: Said they were quite dirty
28 D: Yeh
29 P: And um (.) gave me antibiotics and some ear drops : =
30 D: =and some ear drops as well ok
31 P: Yeah but um (.) he got stuck into the other ear ((inaudible)) I probably should have [done both
32 D: [Maybe done both (.) at the same time
33 P: Yeah
34 D: Yeah so do you wear any protection for your (.) ears
35 P: Just ear muffs [when it's
36 D: [when it's loud but not for dust :
37 P: Not for dust
38 D: I wonder if it's [((inaudible))
39 P: [Yeah I've been thinking about that
40 D: Maybe (.) there may be a case for doing something about ear production er protection when it's dusty
41 P: Yeah
42 D: Um you've got to be careful though to get the right sort of stuff (.) if you're going to do that because um sometimes the plug that you're using can be more of a problem [than a help so
43 P: [Pushing rubbish into the ear
44 D: Yeah well yeah they've actually got to be fitting well especially if you're wearing them a lot of the time

As Goldberg claims, rapport interruptions are oriented towards the interrupted speaker's 'positive face need' (Brown & Levinson, [1978] 1987) to feel that they are listened to and that what they have to say is of interest and of relevance to the other party. Rapport interruptions are therefore moves that stay on topic and exhibit a high degree of 'cohesive fit' (Goldberg, 1990, p. 891) with the interrupted utterance . For example, at turn 32 the doctor's interruption collaboratively completes the patient's turn to align with his perspective that he should have had both ears cleaned. At turn 36 the doctor's interrupting utterance extends the patient's response to her question about ear protection, and the patient's echoing of the doctor's words (turn 37) is evidence that this interruption ties cohesively with what he was about to say. Such collaborative interruptions, together with the agreement tokens that they evoke, display the joint

involvement of doctor and patient with each other and with the interaction. Further, they facilitate collaborative engagement in the development of topics of mutual concern. At turn 43, the patient's interruption of the doctor's utterance elaborates the theme that ear plugs themselves can be a problem and enables her to further develop this topic at turn 44.

In interaction, the pressure towards initiating a turn and completing the previous utterance of the other participant may not be indicative of intent to take over the turn space of another or to disrupt the line of talk. As Goldberg points out (1990), and as the extract above illustrates, interruptions can often be explained as a drive to show camaraderie and involvement and to attend to the positive face needs of the other party to be heard and understood.

Insights such as these may be of particular interest to medical educators and examiners as they draw attention to the range of functions of interruptions in interaction. As noted earlier, findings from influential quantitative studies (Beckman & Frankel, 1984; Marvel et al., 1999) have focussed the attention of the profession on how doctor's interruptions can function detrimentally to direct the consultation away from patient concerns. Interruption in this detrimental sense is a salient theme in communication training. Findings afforded by close analysis of the discourse of PBA consultations may bring into focus other more positive functions of interruptions, including the enhancement of rapport.

3.2.5.2. Affiliation and rapport

Clark, Drew and Pinch (2003) studied rapport in the context of sales encounters. Through detailed examination of audio-recorded interactions between sales people and prospective customers they found verbal expressions of affiliation to be key elements of rapport building in that context. Further, they found that rapport has a 'promissory character' (Goffman, [1959] 1970, p. 14). Once established, rapport has a socially obligating influence on both the ensuing interaction and on the outcomes of an encounter. This insight is of particular value to an understanding of the crucial role of rapport in challenging General Practice consultations to be examined in the current

study, especially those involving patient resistance or dissent. In such contexts, the accomplishment of rapport, in a promissory way obligates more collaborative interaction and a more productive therapeutic relationship.

To achieve rapport, participants in an interaction need to display to each other that they are getting along. As Clark, Drew and Pinch usefully point out, it is not enough for one speaker to affiliate with another through a simple expression of agreement with that speaker's evaluative 'line' (Goffman, 1967). Rather, rapport is accomplished through sequences that involve mutual affiliation. For participants in an interaction to infer that rapport has been achieved, a reciprocal affiliative response is required of the first speaker in a next turn as evidence of mutual alignment.

As an illustration of how such mutual affiliation is accomplished, take the following extract from a training role-play recorded at a consultation skills workshop for registrars and referred to in Section 2.3.1. The fifteen-year-old 'patient' in this role-play had been told to come to the surgery by his mother. He is resentful of 'being treated like a child' and told what to do and from the opening turns of the consultation he is resistant to the registrar's attempts to initiate rapport. Nevertheless, as the encounter unfolds a level of rapport is established that might obligate more cooperative conduct in the ensuing interaction and hold promise for the development of a trusting therapeutic relationship. One way this is achieved is through sequences of affiliative moves, as this extract shows.

Extract 1. Registrar Training Role-play 1

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's great yeah

At turn 105 the registrar's assessment displays appreciation of the instrument that the patient plays and evokes his affiliative second assessment in response (turn 106). Registrar and patient are aligned in their appraisal of the bass. Further, through her assessment, the registrar reveals to the patient a new aspect of her identity and one that is congruent with his own. She too values the bass, and a measure of co-membership appears to be accomplished by way of this mutual appreciation. Yet the patient's agreement token 'yeah (turn 106) may not be sufficiently affiliative to provide evidence of the mutual alignment that constitutes rapport. Forms such as 'yeah', 'yes', 'right' are what Clarke and his colleagues term 'basic' agreements (2003, p. 9) that are open to being perceived as merely nominal agreements. A stronger affiliation is required for rapport to be accomplished.

Across turns 108 to 111 the affiliation between patient and registrar is collaboratively strengthened and developed. The registrar's assessment of the patient's weekend jamming sessions as 'cool' (turn 109) is couched in a term from a young person's lexicon and thus expressive of co-membership and solidarity. It secures a response from the patient in the form of a second assessment that trades off and upgrades the registrar's appraisal: 'Yeah it's really cool' (turn 110). As a final move in this sequence, the registrar proffers a further appraisal (turn 111) that amplifies the patient's previous assessment in a different form. In this way, across the sequence, affiliation is heightened and consolidated as registrar and doctor display to each other that they are indeed getting along. Such a strengthening of rapport holds promise for more cooperative talk in the interaction to follow.

Affiliation sequences appear to be one way through which rapport is accomplished in General Practice consultations. The notion of mutual affiliation sequences will be brought to bear on the analysis of PBA consultations in the current study in order to shed light on the accomplishment of rapport and the failure to accomplish rapport in challenging consultations, including those in which patients resist engagement in interaction.

3.2.5.3. Rapport as purposeful action - discourse analytical studies of rapport in clinical contexts

As indicated earlier, discourse analytical studies of rapport in clinical contexts focus largely on small talk (Coupland et al., 1994; Leahy & Walsh, 2008; Ragan, 2000; Walsh, 2007). Findings from these studies have significantly influenced the current project by drawing attention to the pivotal role of small talk in the accomplishment of clinical tasks. Rapport is purposeful in professional communication and in clinical interaction relational talk and instrumental talk are inextricably intertwined (Candlin, 2000b).

Ragan (2000) focused on humour and reciprocal self disclosure of non–medical matters between female patients and female health care providers in the context of women's health care encounters. By extracting for analysis from the discourse of these encounters those sequences of talk serving seemingly non-task goals, she demonstrated that task and relational goals are enmeshed and interdependent. Specifically, she found that the rapport that was engendered through the joint construction of playful small talk mitigated the face threatening nature of clinical talk around gynaecological topics and facilitated difficult and embarrassing physical examinations by encouraging patients to relax. Similar findings have emerged in the current study where small talk has been found to accompany physical examination as a means to reduce anxiety (See PBA Consultation 1).

Ragan concluded that the rapport that is developed through light hearted relational talk has a direct bearing on clinical outcomes, including the facilitation of uncomfortable procedures, disclosure of relevant information leading to accurate diagnosis, and the likelihood of patient cooperation with management recommendations in the longer term.

Such blending of relational and medical goals is also the theme of an earlier study of small talk in the context of aged care consultations (Coupland et al., 1994). Focussing on consultation openings in which doctor and patient appeared to pursue relational goals, the study found that these phatic sequences typically served as a bridge into more medically oriented troubles telling talk. But the study also found that the distinction

between relational and clinical talk could not be sustained. Attention to the patient's psycho-social world is given explicit priority in the context of aged care medicine where social concerns are medical concerns. As the authors point out, relational talk ".....is close to the *sole* avenue to appreciating patients' socio-environmental circumstances"(1994, p. 119). Similarly, in the patient-centred context of General Practice social concerns are in part medical concerns. In the PBA consultations to be examined in the current study, as in the aged care consultations examined by Coupland and her colleagues, rapport building small talk functions to bring to the surface matters from the patient's life-world that are of clinical significance.

Leahy and Walsh (2008) and Walsh (2007) studied small talk in the context of speech-language pathology interactions to demonstrate that in such contexts relational talk **is** clinical talk. Using the analytical themes of 'frame' and 'framing' (Goffman, [1974] 1986; Tannen, 1993) they were able to show that relational frames co-occur with and overlap with clinical task frames. For example, sequences of small talk in interactions between speech pathologists and patients with aphasia were found to be both relational and transactional at one and the same time. Through engaging in small talk with their therapists, patients were able to display for assessment their capacity to construct and maintain conversational coherence. In this way they revealed evidence of communicative abilities that might not have come to light within a more purely therapeutic frame.

Similarly, in General Practice consultations, relational and transactional frames overlap and the enhancement of rapport may be inextricably intertwined with the attainment of clinical goals. Consider once again the role-played interaction between the registrar and adolescent patient that was described above. Through the process of building rapport, the registrar is at one and the same time conducting part of a mandatory HEADSSS[9] assessment of the patient's psycho-social state. Through exploration of such issues as the patient's sense of belonging, his relationships with teachers and peers and his engagement in activities and interests, she simultaneously invokes a relational frame that puts the interaction onto a conversational footing and accomplishes rapport.

[9] HEADSSS is a mnemonic that represents the domains to cover in carrying out a risk assessment of an adolescent patient's psycho-social and emotional health. See Section 1.4.1 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

At line 93 the registrar's echoing of the patient's term of abuse 'dickhead' is a marker of solidarity. Like her use of the term 'cool' (turn 109) such sharing of lexical items from the dialect of the patient and his peers performs a "social accelerating function bringing speaker and hearer socially closer in the interaction" (Walsh, 2007, p. 27). Through deploying such 'positive politeness strategies'(Brown & Levinson, [1978] 1987) together with strategies of alignment (turns 105-111) the registrar affiliates with the patient to establish rapport. At one and the same time she carries out the clinical task of assessing his emotional and psycho-social state.

3.2.6. The current study – a case study approach

To date, most discourse analytical studies of rapport in clinical settings have been concerned to examine those features of rapport associated with the dual accomplishment of relational and clinical goals. To this end the focus for analysis has been sequences of

interaction extracted from the consultation, such as small talk that might be going on around the accomplishment of the clinical task of physical examination (Ragan, 2000), or consultation openings that function as a bridge into the troubles telling phase of the encounter (Coupland et al., 1994). Further, these studies have concentrated on sequences that constitute the successful accomplishment of relational talk.

But what are the conditions for achieving rapport in challenging consultations including those involving dissent between patient and doctor or withdrawal from engagement on the part of the patient? In such consultations, to be studied in chapters 5 and 6 of this thesis, rapport is both challenged and resisted and its achievement is contingent upon the shifting orientations of participants and the rapport management strategies that they deploy. In order to describe and explain rapport in such situations, a conceptualisation of rapport is needed that will encompass not only its accomplishment but also the dynamic co-constructed processes whereby rapport is thwarted, weakened, strengthened and regained through interaction across the course of the entire encounter.

Spencer-Oatey and Franklin (2009) offer the researcher such a dynamic conceptualisation. They use the term 'rapport' to refer to people's inter subjective experiences of "(dis)harmony, smoothness-turbulence and warmth-antagonism in interpersonal relations" (p. 102). These experiences are subject to change. As people interact with each other they make on-going conscious or unconscious assessments as to whether the rapport between them is being sustained, enhanced, disturbed, or challenged, and respond and react accordingly. 'Rapport management' (Spencer-Oatey, 2005; Spencer-Oatey & Franklin, 2009) refers to the ways in which participants, through discourse, manage or mismanage these changing perceptions of interactional harmony or disharmony. Rapport is discursively constructed and can change dynamically through the give and take of interaction. Further, participants may bring to an encounter differing 'rapport orientations' (Spencer-Oatey, 2005, p. 96) including the desire to protect, enhance, impair or neglect harmonious relations, and these too are subject to change through interaction.

As illustration, consider once more the role-played consultation involving the registrar and adolescent patient. The opening phase of this encounter demonstrates that the initiation of rapport is contingent on the rapport orientations of the participants.

Extract 2. Registrar Training Role-Play 1

1	R:	Hi Graham is it :
2	P:	↓No ↓Bob
3	R:	Bob sorry my name's Linda : um can you tell me what's brought you in to see me today
4	P:	↓My mother said I had to come
5	R:	((nods)) ok can you tell me just to start how old you are
6	P:	(.)Fifteen
7	R:	Ok and why did Mum send you
8	P:	Dunno

The registrar brings to the interaction a 'rapport enhancement orientation'(Spencer-Oatey, 2005). Her desire to establish harmonious relations with the patient is evident from the opening turn. Drawing upon strategies for initiating rapport, she applies them in context sensitive ways by choosing an informal greeting and attempting to put the interaction on to a first name footing (turn 1). In this way she works to establish rapport with this adolescent patient by enacting a symmetrical relationship and reducing role distance.

The patient on the other hand, perhaps because he has been coerced into this appointment and perceives this as a threat to his independence, appears to be dis-interested in the quality of relations with the registrar. His orientation to the interaction is one of 'rapport neglect' (Spencer-Oatey, 2005) and this stance is also evident in the opening turns. At turn 1 the registrar's attempt to initiate rapport is compromised when she gets the patient's name wrong. The momentary loss of face occasioned by this slip disturbs the smoothness of the interaction and requires a response that restores equilibrium if rapport is to be established. But this patient is not concerned to protect rapport. Rather, he responds to the registrar's error with a direct, unmitigated correction, its force augmented prosodically by sharply falling vocal pitch (turn 2).

In response, the registrar deploys what Spencer-Oatey and Franklin (2009) refer to as the rapport management strategy of 'emotion regulation', handling the criticism that is inherent in the patient's bald correction with resilience and restraint. With an eye to reducing the antagonism detectable in the patient's turn, she offers an apology (turn 3) that attends to the offence that the patient appears to have taken because of her mistake over his name. Yet in spite of the doctor's careful monitoring of the patient's face

sensitivities and the responsive rapport management strategies that she deploys, the patient remains disinterested in building rapport. His unelaborated and monosyllabic responses to the registrar's questions (turns 4,6,8) reject engagement. As argued earlier, rapport can only be accomplished collaboratively and is contingent on the orientations of participants. At this point in this encounter it is resisted.

But rapport is subject to change. As Spencer-Oatey (2005) points out, participants constantly monitor interaction and their shifting assessments as to whether rapport has been enhanced or damaged can occasion shifts in rapport orientation as a consultation unfolds. As has been argued, rapport is dynamic and needs to be studied across an interaction.

A few turns later, a shift in the patient's stance can be detected and conditions for the establishment of rapport begin to emerge. Across the turns leading up to the point where the extract begins, the patient has developed the theme that his mother is constantly critical of his behaviours and suspects that he is smoking, using drugs and having sex.

Extract 3. Registrar Training Role-play 1.

21	R:	Ok(.) all right and all the things that you mentioned before that your mum's worried about are you worried about any of them
22	P:	Nope :
23	R:	Nope ok so you're pretty happy with where you are at the moment school and friends and
24	P:	Ah I'm I'm sick of being treated like a child
25	R:	Mm mm
26	P:	Sick of being told what to do and
27	R:	So you think it's more your mum's the problem=
28	P:	=Yeah yeah

At turns 24 and 26 this theme continues as the patient takes the line that he is no longer a child and should not be told what to do. His 'face'(Goffman, 1969) in this encounter involves wanting to be seen as old enough to make his own decisions. At turn 27 the registrar reformulates his utterances with an 'upshot' (Heritage & Watson, 1979) that draws from the patient's account the implication that his mother's failure to recognise his independence is the source of the problem between them. Whilst the registrar maintains professional neutrality and refrains from affiliating with the patient by aligning with his perspective, she nevertheless displays face sensitivity by acknowledging his evaluation of the situation. The patient's latched and marked

agreement tokens at turn 28 underline his assessment that his line has been sustained, and a measure of rapport is tentatively and mutually accomplished.

Some turns later, as has already been discussed, this fragile rapport is strengthened as the registrar affiliates with the patient through her positive appraisal of his musical interests at the same time as she assesses his psycho-social state.

Training role-play scenarios such as this are chosen by medical educators to reflect challenging situations that occur in practice. Indeed, problems of rapport between a doctor and adolescent patient that emerge in this role-play resonate with those experienced by participants in PBA Consultation 4 to be analysed in Chapter 6 of this study, as well as those that arise in an encounter involving conflict and dissent (Chapter 5).

In such contexts how can doctors create conditions for the establishment of rapport? And once established how can rapport be enhanced or protected? If rapport is lost, how can it be regained? These are questions that this study will attempt to answer through examining rapport as it develops in the give and take of co-constructed interaction across whole consultations.

3.2 Finding common ground

> Extract 2. Interview 5
>
> ... if you start to understand 'what does this illness mean to you [the patient]?' 'what do you expect might happen?' If you get that idea from the patient then you can tailor make the management plan ... What you're trying to do is to get your world-view and their world-view to somehow coexist together (Medical educator).

'Finding common ground' is a recurring theme in General Practice where it is a frequently used metaphor that encompasses the processes through which the patient and the doctor are to reach mutual understanding and mutual agreement on the nature of the patient's problems, the goals and priorities of treatment and/or management, and the respective roles that doctor and patient are to play in addressing the problems at hand (Brown, Weston, & Stewart, 2003).

In the medical training literature 'finding common ground' is identified as an integral and interactive component of the 'patient-centred clinical method'(Kurtz et al., 1998; Stewart et al., [1995] 2003) that was described in Section 1.2.2. In accordance with this method that is highly influential in the teaching of clinical communication for General Practice, ill-health is conceptualised as both disease and illness. Disease refers to the bio-medical aspects of a patient's condition as revealed through signs and symptoms of biological dysfunction, whilst illness refers to the patient's unique personal experience of illness including its emotional and psychological impact and effect on functioning in the patient's everyday work, family and social life. Through 'weaving back and forth' (Stewart et al, 2003) between physical aspects of the patient's condition as they emerge through the medical history and physical examination, and those emotional, psychological and social aspects that emerge through the patient's unique illness narrative, doctor and patient are to arrive at an integrated understanding of the nature and scope of the patient's problems so as to make mutually acceptable decisions about what needs to be done.

Thus, 'finding common ground' is conceptualised within the profession as an essentially interactive and collaborative accomplishment. As Kurtz notes "... people reach a conscious mutual understanding of the common ground they share primarily by talking to each other about it" (Kurtz, 2002, p. 27).

But in clinical practice achieving common ground appears to involve more than the sharing of information through interaction. By bringing the patient's unique illness narrative into the discourse of the consultation new clinical objects relating to the patient's illness experience are created for the doctor and patient to reason about. As the following data from ethnographic observations of registrar training will suggest, and analysis of the discourse of PBA consultations will later confirm, the accomplishment of common ground is likely to involve not only the sharing of information from the bio-medical world of the doctor and the life-world of the patient but also the interplay and melding of different forms of reasoning.

3.3.1. Reasoning in General Practice.

Training vignette 5 – registrar training

It is early morning as registrars begin to gather in a RTP training room on the outskirts of Sydney for a workshop on elderly patient care and dementia. As the young registrars take their seats, a CD plays the Beatle's song "When I'm sixty four". An image of an elderly woman is on a large screen at the front of the training room. She sits alone and stares vacantly. Then, as the music continues a slide show unfolds; the woman as a mother with her children, as a bride, as a young woman out dancing, as a child, a baby and back again to the image of an aged person sitting vacantly in a chair, in a nursing home.

Nothing is said. But against this backdrop the training session on dementia begins. A formal presentation on the various types of dementia and their diagnoses ensues. Then, a little later, as the topic shifts to management, the educator presents the registrars with a series of narratives from the work of a General Practitioner at a nursing home.

The first story is about Maeve. Maeve's behaviour is causing considerable distress to other patients. The nursing staff is at a loss to know what to do. She is constantly taking fluffy slippers that belong to other patients. She grasps them close to her and won't give them back. She becomes distraught if anyone tries to take the slippers away.

Leo is Dutch and ex-navy. A myocardial infarction has left him with loss of cognitive function. Leo refuses to allow the staff to shower him in the morning. This is becoming a hygiene problem.

"What's going on? What can be done?" These are questions that the medical educator puts to the registrars. Suggestions of pharmacological intervention are set aside. "Don't go straight for the pharmacological gun", advises the educator. "Keep it holstered. We've got other guns". The registrars are encouraged to apply the mnemonic ABC; Antecedent, Behaviour, Consequences to the narratives as they seek to understand the patients' 'life-world'(Mishler, 1984) and to explore practical non-pharmacological solutions to the management problems that the patients' behaviours present. Maeve, it emerges, craves physical contact. Therapeutic massage may provide an answer and her family will be encouraged to bring her grandnieces to visit more often. Leo they

discover has lived a life governed by strict routine, including evening showers. Once the showering timetable is adjusted, he takes his shower without complaint.

Reasoning in General Practice does not appear to be restricted to scientific modes of thought. In this workshop, the registrars, whilst applying bio-medical reasoning to explore medical explanations for the patients' problems, were encouraged to simultaneously apply a version of 'narrative reasoning' (Greenhalgh & Hurwitz, 1998; Mattingly, 1998) that incorporated the patients' unique life-world experiences into the diagnostic and decision making processes. Using this form of practical, interpretive reasoning, the registrars sought to connect each elderly patient's behaviour to their specific biography so as to arrive at the right action to achieve the best good for each situation.

As the medical anthropologists Hunt and Mattingly assert (1998, p. 270), 'bio medical reasoning may be sufficient to explain the bounded realm of microscopic events and abstract principles, but other kinds of reasoning are necessary when those principles are applied to the unbounded universe of the real world of physical, phenomenological, and social lives" . Through applying scientific bio-medical reasoning, doctors are to arrive at an understanding of the disease process and likely diagnosis. Through engaging with the patient's life-world and interpreting the reasoning of patients, doctors are to access the patient's unique experience of illness.

The purpose of this interplay of bio-medical and lay reasoning is to assist with a wider diagnosis that takes the patient's circumstances and experience of illness into account. It is this interplay that is at the heart of shared decision-making in General Practice, enabling doctor and patient to arrive at common ground about the problem to be addressed and to make mutually acceptable decisions about treatment and management that connect with the complex social world in which the patient lives.

But how is this achieved in interaction? How do doctor and patient realise the complex task of merging different agendas, different meanings and disparate rationalities to arrive at the basis for shared decisions about appropriate care? These are questions that will be explored through analysis and discussion of the discourse of a range of challenging consultations in later chapters of this thesis.

In this section of my thesis the construct of 'finding common ground' that involves a melding of lay and professional reasoning, will be examined from the perspective of the profession. Why is it considered to be important within the institution of General Practice? Is it a contested construct and what are the circumstances that might constrain its realisation in practice? How is it represented and reinforced through training and evaluation? How has it been approached in terms of discourse analysis? In addition, through a review of relevant discourse analytical literature, analytical themes will be identified that will be drawn upon in later chapters to shed light on how 'finding common ground' is accomplished, or challenged, or transformed through the interaction between doctor and patient.

3.3.2. The clinical importance of 'finding common ground'

Within the clinical world, 'finding common ground', including patient involvement in decision-making about treatment, is considered to be of both instrumental and intrinsic value (Wirtz, Cribb, & Barber, 2006). From the instrumental perspective, systematic reviews of the literature of doctor-patient communication (Stewart, 1995; Stewart et al., 2000) indicate that patients' perceptions that their illness experience has been fully explored and that they have played an active role in decision-making about the treatment of their condition, is associated with good clinical outcomes. These outcomes include patient recovery from discomfort, better emotional health, and reduction in diagnostic tests and referrals, as well as improved adherence to medication regimes and treatment plans (Dowell, Jones, & Snadden, 2002; Epstein, Alper, & Quill, 2004).

Other studies provide empirical evidence of the value that patients place on finding common ground. For example, in a study that involved compilation and further analysis of a range of studies of women's experiences regarding diverse and distinct health care issues, including pre-natal genetic screening, hormone replacement therapy, and the use of complementary and alternative therapies in breast cancer treatment, Brown, Carroll, Boon and Marmoreo (2002) reported a consistent desire amongst participating patients for the free flowing exchange of information, for an active role in the decision making

process, and ultimately for arriving at common ground with their doctors about how to proceed.

Finding common ground, and specifically the involvement of patient and doctor in shared decision-making, is also advocated by medical theorists because of its intrinsic moral and ethical value, irrespective of the practical outcomes that are achieved. Within a social and institutional context that values principles of patient autonomy, rights to information, and patient control over decisions that affect their well being, finding common ground is considered to be a corrective to purely paternalistic consultation models (Emanuel & Emanuel, 1992), also called 'parental' or 'priestly' models (Pearce, 2007), that position the patient in a passive and dependent role in relation to the doctor as expert and leave the patient outside the decision making process.

Yet, in practice, as participants in the current study point out, doctors adapt concepts such as 'finding common ground' and 'shared decision-making' to the realities of the particular situation at hand. The realisation of such constructs is locally managed at the level of interaction, and the extent to which doctor and patient will explore the patient's life-world and engage in the process of shared decision-making will be constrained by many factors including the clinical circumstances, the nature of the patient's condition, and the patient's preferences.

> Extract 3. Interview 4
>
> There are some patients who want the doctor to just to lay it on the line ... they don't want to be asked for their opinion: 'For heaven's sake. You're the doctor. Tell me'. There are those people who want to be informed. You know 'just give me the points'.
>
> We hope to expose registrars to the multiplicity of ways and essentially that is patient focussed because if you assess that your patient needs the quick bullet point approach, then it is patient focussed because that's what they appear to need, and if the patient wants to talk about things and wants to have an opinion and be given credence and wants to be involved in the decision, well then that's what they need.
>
> So I guess it's selecting, negotiating what kind of relationship each individual patient wants and learning to be a chameleon...and therefore you need a palette of skills that you can adapt to the individual needs of your patient, be that scientific matter of fact, be that interactive and negotiating or be that 'here are the facts and you choose'.
>
> So there are multiple roles and the doctor is the chameleon who can respond to this patient this way and that patient that way (Medical educator).

These observations from practice resonate with findings reported in the medical research literature. Whilst patients consistently want information about the nature of their condition and the treatment options available to them (Beisecker & Beisecker, 1990), the patient, thus informed, may wish to be given the facts and to make the decision for him or herself, or to share in decision making through a process of interactive negotiation, or to delegate responsibility for decision making to the doctor (Charles, Gafni, & Whelan, 1997) . The extent to which patients wish to be involved in decision-making is thus highly variable.

Within the profession, a range of theoretical models have been conceptualised that aim to capture the different types of partnerships that develop between doctor and patient in relation to decision making about treatment and management. These models, that will be explored below from a discourse analytical perspective, include 'the paternalistic model'; 'the informed decision making model'; and 'the shared decision-making model' (Charles et al., 1997; Charles, Whelan, & Gafni, 1999; Murray, Charles, & Gafni, 2006).

In drawing upon these models, doctors are constrained not only by the preferences of the patient but by institutionally sanctioned values and institutionally recognisable norms that regulate what is considered to be appropriate in particular clinical circumstances.

3.3.3. Decision-making models

3.3.3.1 The paternalistic model

At one end of the spectrum of decision-making models might be placed the paternalistic or parental or priestly model referred to above. This model traces its origins to Parsons' conceptualisation of 'the sick role' (Parsons, 1951) that carries with it certain rights and obligations. Granted the sick role, the patient has the right to abstain from other roles such as those associated with work and family responsibilities, but also has the obligation to seek expert medical help, to try to get well, and to comply with treatment directives. More recently, Emanuel and Emanuel (1992) have depicted the paternalistic

model as one involving the doctor in the role of guardian of the patient's best interests. In enacting such a role, the doctor provides the patient with selected information, articulates a treatment plan that the doctor considers to be appropriate, without eliciting the patient's preferences, and encourages the patient to consent to what the doctor believes to be the best course of action. The purpose of interaction around treatment is to provide advice and to reinforce instructions. The goal is compliance with the doctor's advice that can be measured in the patient's behaviour in following instructions such as taking a prescribed medication. Compliance, arrived at through doctor-directed interaction, contrasts with 'concordance' (Royal Pharmaceutical Society & Merck, 1997), an interactional process whereby patient and doctor arrive at a negotiated agreement about a course of action based on mutual understanding of each other's perspectives.

In emergency situations, the paternalistic model may be the only feasible model (Emanuel & Emanuel, 1992; Wirtz et al., 2006) as time taken to negotiate treatment decisions could put the patient at increased risk. Further, in General Practice consultations involving acute physical problems, research suggests that patient satisfaction is enhanced when the doctor's consultation style is directive rather than sharing (Savage & Armstrong, 1990). In addition, as the experience of medical educators participating in the current study suggests, and research findings referred to above support, some patients may prefer to abdicate their decision- making role in favour of the doctor.

Yet, the paternalistic decision-making model does not sit comfortably with a bio-psycho-social clinical approach and the principles of patient-centredness that imbue 'the institutional order' (Berger & Luckmann, 1967; Candlin, 2000a; Sarangi & Roberts, 1999b) of General Practice. The paternalistic model is doctor-centred and likely to be bio-medically focused, thus tending to marginalise a patient's emotional and social concerns from the consultation. As practitioners interviewed for this study point out, even a simple bio-mechanical problem such as a fractured finger, that seems to require a simple technical solution and as such casts the doctor in the role of technician, may offer the General Practitioner a pretext for engaging with underlying psycho-social issues from the patient's life-world that are of crucial concern to the patient's well-

being. In such contexts, as doctor's take up different roles, life-world and clinical discourses are likely to intertwine.

> Extract 1. Interview 7
>
> Sometimes patients come in thinking they have some problem and it will have a bio - mechanical focus but straight away I'll think well I know this person. I know we're they're coming from and I know the illness they're coming with will pass very quickly. But I'll have 15 minutes to maybe sensitively broach another topic that I know will become the biggest thing in their life, and so they'll be talking about their fractured finger but I will have known this person for many years and I may secretly in my mind think I know that this person's real big problem is their attraction to a dangerous life style. Or some other trait that I know from my own life experience, long term will pose a bigger problem. So if I can't say it directly I'll try and model the advantages of the alternative view of the world to them and they will have derived from the consultation something far better than fixing the fractured finger (Registrar trainer).

Usherwood (1999, p. 38) draws attention to the need for General Practitioners to be sensitive to the patient's wishes in talking about life-world concerns that may be of no relevance to the problem that the patient wishes to address. Referring to Zigmond (1978), he points out that given the power asymmetry in the patient-doctor relationship, patients are vulnerable to 'psychic intrusion' by the doctor, and cautions practitioners against such unwanted intrusion. Nevertheless, it appears from the interview cited above, and from consultations examined for this study, that even those consultations where the presenting problem is of a simple bio-physical nature may potentially involve broader psycho-social concerns.

Further, General Practitioners are increasingly engaged in caring for patients with chronic conditions, such as diabetes and hypertension, and long-term psychological conditions such as depression or anxiety, and in such clinical contexts, doctor-directed paternalistic consultation models that aim for compliance with directives are widely considered to be ineffective (Charles et al., 1997). In these clinical situations, the achievement of optimal benefit from treatment and intervention is likely to depend on the achievement of concordance through a collaborative patient-doctor relationship and an on-going process of consultation, monitoring and adjustment that takes into account the patient's values, preferences and life-world context.

Consider the following extracts from a PBA consultation examined in light of examiner feedback. It is to be noted that examiners differed in their evaluation of the candidate's

performance and that this discrepancy suggests some inconsistency in attitudes to paternalistic models within the profession. Nevertheless, the strongly worded reservations expressed by one examiner are indicative of an institutional order that deems a directive, doctor-centred communication style that functions to marginalise life-world concerns to be unacceptable in clinical contexts involving chronic and psychological conditions

The patient in this consultation is a 45 year-old man who has returned to see the doctor after a lapse of some time. He had previously been diagnosed with depression and the doctor had prescribed anti-depressant medication that the patient has since stopped taking following a consultation with another doctor. One examiner rated the candidate as 'good' on the global parameter of 'communication and rapport' and commented briefly, 'good management of depression'. The other however, gave a rating of 'sufficient' supporting this assessment with detailed comments highlighting considerable professional concern about the candidate's paternalistic approach. These comments include:

- Why did he[the patient] come to the doctor? Very doctor-centred consultation. Doctor talks +++ [a great deal]. But it wasn't an easy consult – he [the patient] was rather passive, blunted
- No real exploration of his [the patient's] understandings/beliefs
- No real negotiation. Quite directive. Somewhat unrealistic
- The doctor has a gentle, mature and effective interviewing style limited by...a rather too doctor-centred and directive approach.
- ... tends to under-define the problem both through too little history and too little exploration of the patient's beliefs, concerns, preferences, etc.

(RACGP Practice Based Assessment video rating form – examiner's comments)

Clearly, for this experienced examiner/practitioner, behaviours such as being doctor-centred and directive and failing to explore a patient's beliefs, concerns and preferences fall outside what counts as appropriate clinical Discourse in this context. Yet these comments are not linked to specific utterances in the encounter, and so cannot of themselves provide evidence for the examiner's judgements, or explanation of how a paternalistic doctor-patient relationship is discursively co-constructed through interaction.

It is an objective of this discourse analytically focused study to uncover some of the grounds for the judgements of expert examiners and to make these findings available to the profession. To this end, in later chapters, consultations will be analysed in their entirety in light of examiner feedback. At this point in the thesis however, analysis of the discourse of two short extracts from this consultation will be briefly discussed in order to consider the basis for this examiner's concerns and to understand reservations about using such a paternalistic approach in such a context within the institutional order of General Practice.

At the point in the consultation where the first extract begins, it has already emerged that the patient has ceased taking medication and that he is again experiencing symptoms of depression. The doctor acts to encourage the patient to again take anti-depressants, action that she considers to be in his best interests.

Extract 1. PBA Consultation 9 (Supplementary data)

75	D:	But with your history that you have given me it has happened in the past that you have been on anti depressants (..) you do well everything is fine
76	P:	((nodding))
77	D:	Even when I saw you you were re (.) you said I'm fine I can go to work and I feel happy and all that (.) and then again when you stop the medications you (.) take a while but then again you go down =
78	P:	= down yeah that seems to be a pattern
79	D:	So what is happening is you keep relapsing =
80	P:	mm
81	D:	=And in that case you should not really stop the anti depressants at least at least for one and a half years or two
82	P:	((nodding)) mm mm
83	D:	If at all
84	P:	((nods))
85	D:	It's not something that you should (.) say that well you are coping (.) yes because you are on the medication (inaudible) but what is happening is getting a relapse because (..) of that reality you have to be on the medications again

As noted by the examiner, the doctor does most of the talking. She has the floor, and thus topic control, for most of the time for most of the consultation, and through her linguistic choices, positions the patient as a 'passive' and 'blunted' respondent rather than as an active participant in treatment decisions pertaining to his own health care.

Rather than asking open-ended questions that would hand the speaker role to the patient and enable him to elaborate on his concerns about taking anti-depressant medication, the doctor initiates a series of exchanges that constrain his responses both in length and content. Each of her initiating moves (turns 75, 77, 79) is a declarative statement that draws upon the patient's own history to construct evidence that the patient does well when taking medication and relapses into depression when he stops. As declarative statements, each utterance constrains the patient to a responding role in the exchange, thus eliciting verbal and non-verbal acknowledgements and agreements with the doctor's bio-medically reasoned argument of a causal relationship between ceasing medication and his depression.

At turn 81 and again at turn 85, the doctor incorporates meanings of obligation into further declarative clauses through her choice of 'modulated finites' (Halliday, 1985, pp. 86-88) 'should' and 'have to'. Thus, whilst grammatically structured as statements, her utterances can be seen to function as commands, first of median obligation through her choice of 'should' (turn 81) and then intensified to a high degree of obligation: "... you have to be on the medications again" (turn 85). As commands, these utterances elicit minimal verbal and non-verbal expressions of compliance from the patient to the doctor's view that continuing with medication in the long term and perhaps indefinitely is in his best interests.

Some turns later, as the next extract begins, the patient acts to reintroduce the topic of life-long use of anti-depressants that the doctor had introduced at turn 83.

Extract 2. PBA Consultation 9

106	P:	Yeah is there any (2) um you sort of said that I uh it could be a rest of the life thing
107	D:	Sometimes yes ((rise fall tone))
108	P:	Ah how would you know (.) how do you know [inaudible
109	D:	[you have tried it twice or thrice [going off it
110	P:	[yeah yeah ok yes ((looking down and nodding with a wry grimace))
111	D:	And then you go backwards so for you it means you have to give it <u>more</u> time rather than stopping it after eight months after six months give it <u>more</u> time if you want to still try (.)
112	P:	((nodding))
113	D:	Give it some time rather than stopping it as soon as you say well I'm fine now (.) you are fine because you're ↓ taking the medications
114	P:	Ok yeah I sort of understand that now

115 D: You see ;
116 P: Yeah
117 D: For that reason you really have to be (.) a bit more strict with yourself rather than saying I'll be dependent (.) it's a drug (.) things like that.
119 P: mm
120 D: It's not (.) it's a medication just for you to really feel comfortable and get going with your life ;
121 P: ((nods)) mm mm
123 D: You don't want to feel all the time the way you are feeling
124 P: No m:ost definitely not no
125 D: Ok ;

Rephrasing, hesitations and hedging (turn 106) mark the patient's utterance as troubles talk and are suggestive of life-world fears and concerns about side effects and dependency that might be associated with on-going use of the medication. This utterance serves as a 'contextualisation cue' (Gumperz, 1982), designed, perhaps unconsciously, to nudge the doctor to pick up and respond to the inference that the patient is fearful of long term use of medication. The doctor's response however (turn 107) acknowledges and agrees with the propositional content of the patient's utterance. He may indeed be on anti-depressants for life. The patient's fears and concerns remain sidelined from the discourse of the consultation as the doctor again invokes a recurring history of relapse into depression to mount evidence for the bio-medically reasoned argument that the patient needs to continue to take medication (turns 109, 111). Again, through a series of declarative statements that are expressive of obligation and necessity (turns 111, 117), and commands realised directly through imperatives (111, 113), the doctor constructs a series of exchanges that position the patient to respond with agreements and acknowledgments and consign him to a passive role of compliance with the treatment decisions that the doctor thinks best.

As medical theorists point out (Wirtz et al., 2006, p. 121), there are uncertainties inherent in clinical reasoning and uncertainties involved in any treatment choice. In many clinical contexts, and in particular in those situations involving long term chronic and psychological conditions, choice of treatment cannot be reduced to a technical task based on purely scientific reasoning. Rather, decisions need to take into account the reasoning of patients and their experience, values, concerns, lifestyle and preferences. Paternal models of decision making, as examiners' comments suggest and the above analysis illustrates, do not allow for the interplay between the bio-medical world and the

patient's life-world that is required if doctor and patient are to arrive at common ground about the nature of the patient's condition and the best course of action.

3.3.3.2. The informed decision making model

At the other end of the spectrum of decision-making models that are available to practitioners lies 'the informed decision making model' (Charles et al., 1997; Emanuel & Emanuel, 1992). Whereas in the paternalistic model the locus of decision-making lies with the doctor, in this model it shifts to the patient. The doctor, in the role of competent technical expert, provides the patient with relevant factual information about alternative treatment options and interventions and their benefits and risks. The patient, thus informed, is empowered to become an autonomous decision maker about his or her own treatment in accordance with his or her own preferences, values and life-world concerns. Decisions about management lie with the patient and the doctor's role is to implement the intervention that the patient selects.

In practice, such a model might be called upon in a situation of 'equipoise' (Wirtz et al., 2006, p. 121), that is, where a number of options exist, including the no treatment option, without particular professional preferences for any one option. Doctors perceive situations of equipoise to be those in which legitimate choices are available precisely because clear pros and cons exist for each option (Elwyn et al., 2001). Ethnographically grounded observation carried out for this study, and in particular observation of examiner training, suggests that within the institutional order of General Practice, the informed decision-making model is the preferred model in those situations of equipoise where a patient's value system and individual circumstances constitute crucial factors in the decision making process, as for example, in the context of an unexpected pregnancy.

Such a clinical scenario provides the context for a video-recorded re-enactment of an OSCE[10] Fellowship examination role-play that is frequently used in training workshops

[10] The objective structured clinical examination (OSCE) constitutes the clinical component of the RACGP College examination. As discussed in the introduction to this thesis, it is made up of a series of stations that engage the Fellowship candidate in simulated consultations that reflect practice. Practice Based Assessment (PBA), involving video recordings of naturally occurring consultations, represents an alternative examination pathway to the OSCE.

for new and experienced RACGP examiners. At these workshops, observed by the researcher, examiners engage in moderation activities aimed at standardising their evaluation of a candidate's performance in line with institutionalised perceptions of what constitutes acceptable practice. Examiners are required to view recorded simulations, rate the performance of each candidate individually on a range of parameters including 'communication and rapport', and engage in small group discussions about the basis for their judgements so as to approximate consensus.

The role-play in question involves a married woman who has come to see the doctor with symptoms of nausea and fatigue. During the consultation it emerges that she is pregnant. Her husband has had a vasectomy and the pregnancy is a result of a brief affair with a family friend. As indicated by criteria provided to examiners so as to guide their assessment on the parameter 'communication', as well as by themes that emerged in the moderation process, a good candidate in this particular context is expected to be 'non judgemental' and 'sensitive to the difficulty the patient has in disclosing her sexual history'. In keeping with the principles of the informed decision–making model, the good candidate is also expected to be appreciative of the patient's need for time in considering her options and coming to a decision about how to proceed.

Analysis of the discourse of a short extract from a performance that was recognisable to examiners as appropriate action for this situation, offers some insight into how institutionally sanctioned principles of informed decision making might play out in institutionally acceptable ways in such a clinical context.

In the turns leading up to the point where this extract begins, the doctor has responded empathically to the patient's shock at receiving the news that she is pregnant, established her impartial support for the patient's choice of action, "...and also you know supporting you with whatever you choose to do" (turn 73), and suggested a further consultation in the very near future when the patient has had time to think.

Extract 1. Training role-play 2 (examiner training)

96 D: Mm yeah I mean as I said you will need support over this time and this is a safe place that you can come to talk about (..) you know anything that you need to but um (.) and obviously you know (.) I know Craig but I will keep this confidential as long as you would like me to

97 P: ( ) thanks hh yeah I can talk to my sister she's [like a rock
98 D: [yep yep (..) I mean obviously depending upon what you decide to do there are lots of other things to talk about (..) and there are different options for you and um (.) would you like me to talk about those a little bit now or
99 P: ((hand gesture of agreement)) yeah I mean I don't know how much will stay in =
100 D: = Yeah yeah I mean =
101 P: = I've never had to think about something like this ever before
102 D: Yeah yeah (.) some people in your situation would choose to continue (.) the pregnancy and that's an option for you and if you choose to go down that path we can talk a lot about early pregnancy tests ((looks at patient notes)) it's been a little while since you've had a child=
103 P: =mm
104 D: =so we might need to remind ourselves about that and the most important things in that regard would be starting folate as soon as possible in order to you know protect the baby (.) umm some other people would choose not to go forward with the pregnancy and then you know I could talk to you about options in terms of abortion
105 P: mm
106 D: And we could talk about what's involved with that and how we would go about organising that for you (.) I suppose I suppose the third option I always mention is the option of continuing the pregnancy but adopting the baby out if that's what you chose to do
107 P: mm
108 D: yeah
109 P: mm
110 D: It's a lot to take in (..) yeah
111 P: OK I'll um (.) yeah so I mean hh so if I come back and see you in say (.) maybe two or three days
112 D: Yeah yeah yeah .....

Notably in this situation of equipoise, where no one course of action is medically preferable, and where the patient's values and personal circumstances are central to decision-making, the doctor refrains from offering advice. Rather she draws upon discursive practices more typically associated with the Discourse of 'non-directive counselling' (Feltham, 1995; Silverman, 1997). Non-directive counselling is a way of attempting to ensure that the client arrives at their own decision about the course of action that is best for them. Thus it aligns with the informed decision making ideal in that the counsellor is to take the role of information provider, rather than advisor, setting out various courses of action in a neutral and non-judgemental manner so as to leave decision-making to the client.

In the extract above, the doctor generates options for the patient to consider, but strategically these options are presented impersonally as generalised reflections on what other patients in similar circumstances choose to do (turns 102. 104) or as an option

routinely available (turn 106), rather than as the suggestions of a doctor. Thus, whilst creating an environment of choice, the doctor carefully removes herself from involvement in any deliberations about what the patient should do. In accordance with the informed decision making model, the doctor's role is to provide all relevant information to the patient. But deliberation and decision making is the prerogative of the patient and in this case is likely to take place outside the clinical context in the patient's life-world.

The above extract from a simulated examination role-play involving a situation that is clearly characterised by equipoise, offers a simple clear-cut realisation of non-directiveness. However studies of interaction in a range of counselling sites, including HIV test counselling (Silverman, 1997), genetic counselling (Sarangi, 2000), ante-natal screening (Pilnick, 2004), and family planning counselling (Candlin & Lucas, 1986) indicate that in practice the accomplishment of non-directive counselling may be far more complex. Further, it may not always be desirable as professionals act to manage the tension between respect for the client's autonomy as a decision maker and their own role as advocate of the patient's best interests.

In their study of the discourse of family planning counselling, Candlin and Lucas (1986) found that because counsellors had to offer education as well as information, they produced discourse that fluctuated along a continuum between information giving and seeking on the one hand and the specifying of contra-indicating behaviours on the other (p. 14). Whilst counsellors refrained from explicitly advising a course of action, contra-indicative statements that drew attention to the potentially negative outcomes of a particular course of action, carried 'advice potential'(Sarangi & Clarke, 2002). Such statements were likely to be heard by clients as advice rather than as information and potentially as directives. In a similar way, in the context of General Practice consultations, information voiced by the doctor may be interpreted by the patient as advisory or directive.

3.3.3.3. The shared decision-making model

Shared decision-making aligns closely with the patient-centred clinical model and is integral to the construct of finding common ground. It is based on the assumption that the patient's life-world experience of illness, together with their fears, concerns and preferences about treatment, needs to be incorporated into patient care. At its core is the concept of doctor and patient coming to a shared understanding of each other's perspective so as to arrive at common ground about the nature of the patient's problem. On this foundation, mutually acceptable decisions about treatment can be negotiated.

Within the medical literature, shared decision making is conceptualised as a phased and interactional activity in which doctor and patient share all stages of the decision-making process (Charles, Whelan et al., 1999). During the information exchange phase, doctor and patient exchange information from the medical and life-world. During the deliberation phase, doctor and patient discuss and evaluate treatment options and treatment preferences, including the doctor's preferences, to try to build a consensus on the appropriate treatment to implement. These discussions may include family members and carers. In the final stage doctor and patient together decide upon a mutually acceptable treatment plan that incorporates the patient's preferences and is congruent with the best available clinical evidence.

Whilst such a model is designed to conceptualise good practice, it is, like all theoretical models, necessarily an idealisation. It is in the nature of theoretical models to abstract from and simplify the complex reality that they represent (Peräkylä & Vehviläinen, 2003; Wirtz et al., 2006). In the real world of every-day practice, clinical decision making interactions are unlikely to unfold according to the patterns of an ideal model, as Charles, Whelan and Gafni acknowledge (1999, p. 781) and as is evident from the PBA consultations to be analysed and discussed in the current study.

Further, theoretical models cannot offer description of how the complex interactive processes involved in shared decision-making are brought about. How are the patient's values, concerns and preferences brought into the discourse of the consultation? How is the patient's reasoning made available to the doctor? How is the doctor's clinical reasoning made available to the patient? How might different appraisals of a condition

and its treatment be reconciled? These are questions that will be considered through close analysis of the unfolding discourse of a range of challenging consultations in later chapters of this study.

3.3.4. Between model and practice: Teaching registrars to engage in the process of finding common ground

Extract 3. Interview 5

.....We're looking at what will make the patient better not only in the physical sense but the mental, social and spiritual sense. ...I teach them [registrars] to use the device 'FIFE'. You've got to ask the patient what are their fears, ideas and expectations of the illness. So if you start understanding 'what does this illness mean to you?' 'What do you expect might happen?' If you get that idea from the patient then you can tailor make the management plan...What you're trying to do is to get your world view and their world view to somehow coexist together (Medical educator).

Extract 4. Interview 2

... they've [the registrars] got to 'BATHE' twenty patients for me and we tape a few of them as well just to make sure they're doing it. And there's so many great questions that people don't use; stuff like 'What do you think it is?' 'What's worrying you the most about this?' (Medical educator and PBA examiner).

In training workshops and during feedback discussions on practice, educators and trainers frequently draw upon the mnemonic 'FIFE' and its variations 'ICE' and 'BATHE'[11] to assist registrars to bring the patient's life-world experience of illness into the discourse of the consultation and to incorporate the patient's perspective into their own reasoning process. To illustrate the application of these mnemonics, educators and trainers also offer exemplar phrases drawn from professional training texts (Kurtz et al., 1998; Stewart et al., [1995] 2003) or from their own repertoire built up through experience in everyday practice.

At the same time, educators and registrar trainers are conscious that mnemonics and exemplar questions, designed to assist practitioners to elicit the patient's perspective are of themselves abstractions, distilled from context. In practice, in a particular encounter,

[11] FIFE: **F**eelings **I**deas impact on **F**unction **E**xpectations (Kurtz et al., 1998; Stewart et al., [1995] 2003). ICE:(Neighbour, 2005) **I**deas **C**oncerns **E**xpectations. BATHE:(Stuart & Lieberman, 1993) **B**ackground 'Tell me about it' **A**ffect 'How does it make you feel?' **T**roubling 'What troubles you the most?' **H**andling 'How do you feel you're handling it?' **E**mpathy 'That sounds like a difficult situation'.

their effectiveness lies in the doctor's ability to integrate questions responsively into the flow of the interaction so as to apply communicative models in a contextualised and 'veiled fashion' (Sarangi, 2007b, p. 46).

Extract 4. Interview 4

> I often hear ... people [registrars] say 'How do you feel about that?' It's almost like an out of context, parroted phrase that doesn't fit in with the rest of the way they speak. They go on an on about stuff then 'and how do you feel about that?' It's as if they've been programmed to say that but because it doesn't fit with the voice of the rest of the conversation you get this jolt when you listen to it or when you observe it. I don't know how the patient feels about it ...(Medical educator).

As this educator's comment implies, learned phrases that are not responsive to the exigencies of a particular moment in the interaction, may be perceived by the patient to lack authenticity and genuineness. At worst, they may be perceived as 'pseudo-interaction', a term used by Ritzer (1996) to describe the proscribed, trained, interactive routines that are associated with formulaic customer service encounters. Patients are likely to be resistant to what they perceive as a trained utterance and, as a consequence, less likely to disclose feelings and ideas that might lead to mutual understanding about their life-world concerns.

Professional concern about the unveiled use of trained routines has been similarly noted in a discourse analytical study of the performance of medical students in OSCE examination role-plays (Roberts et al., 2003). In that study it was reported that examiners are wary when presented with too formulaic a response by a candidate, and may downgrade them accordingly. Examiners participating in the current project echo this position. As the following comment suggests, the high performing candidate is perceived to be one who is able to seamlessly integrate communication models into the interaction.

Extract 1. Interview 8

> I mean they learn these things [mnemonics and models] in practice workshops ... you might see someone who's trained and they might get the information well but then you see someone who's the really good candidate whose able to do it without it looking like a sort of rehearsed piece. The person who does the really rehearsed thing will probably do ok [in the OSCE examination] but it still looks a little bit different to that person, the really high performing person (RACGP examiner).

Mnemonics such as 'FIFE' and 'BATHE' have been conceptualised by professional educators who themselves are practitioners. Their purpose is to provide educators, registrars and practitioners with an aide memoire to standardised formulae that might be drawn upon to accomplish the task of eliciting a patient's illness experience in diverse clinical situations. But these models, together with exemplar phrases, are not derived empirically from the analysis of transcribed interaction and are inevitably reductionist. They represent only the doctor's role in idealised interaction, setting aside the complex interactional reality whereby the patient and doctor jointly accomplish mutual understanding and common ground.

Similarly, models of shared decision making that are to be found in professional training texts represent an idealised version of what should be that may not transfer easily to practice. Consider for example the following list of skills and exemplar phrases for engaging patients in deliberations about treatment options. The list is drawn from a widely used text book (Silverman et al., [1998] 2005) that originated with the influential Calgary-Cambridge guides (Kurtz & Silverman, 1996)[12] referred to in Section 3.2.2. These guides incorporate 71 itemised components that delineate the communication process in the medical interview. This extract represents the shared decision making phase of that guide.

- **Share own thoughts:** ideas, thought processes and dilemmas. *'There are two possibilities here which might explain your symptoms, either an ulcer or gallstones. It's not clear from just examining you which it is. I'm trying to decide between two ways forward – we can either just treat it as if it is an ulcer or we could do some tests first to get a more definite diagnosis.'*
- **Involve patient by making suggestions rather than directives:** *'My suggestion for tackling this would be ... What do you think?'*
- **Encourage patient to contribute their thoughts, ideas, suggestions:** *'I'd be interested to hear your thoughts about ways that I could help you to stop smoking.'*
- **Negotiate:** negotiates a mutually acceptable plan. *'What I've suggested makes sense to me ... but if it isn't right for you, we'll need to think again. Tell me what you feel about it.'*
- **Offer choices:** encourage patient where possible to make choices and decisions. *'There are several things we might try here, each as I've said with their own advantages and disadvantages ... Do you have any clear preference?'*

[12] The Calgary-Cambridge guides, an outcome of a long term collaboration between Cambridge and Calgary schools of clinical medicine, is a model for teaching medical interviews that integrates communication process skills with the content skills of the traditional medical history. They are used throughout the world at all levels of medical education as a primary teaching resource and assessment tool.

- **Check with patient:** if accepts plans, if concerns have been addressed. *'Now, can I just check that you are happy with the plan?*

(Silverman et al., [1998] 2005, p. 121)

The authors of this model are cognisant of the intrinsically interactive nature of shared decision making (Kurtz, 2002, p. 27). Further, in offering such a model they do not intend to represent shared decision making as a step through process of prescribed skills. As one author of the model asserts (Silverman, 2007, p. 88), flexibility and responsiveness is the key skill associated with medical interviewing and communication cannot be done 'by the book'. Nevertheless, in presenting only the doctor's contribution to interaction in isolation from that of the patient, such models represent spoken interaction as a one-way transfer of information that has a fixed and static meaning, regardless of context and regardless of participants' roles, rather than as a dynamic and co-constructed process. Take for example the utterance that is offered as an exemplar for the strategy of making suggestions rather than directives:

'My suggestion for tackling this would be ... What do you think?'

Seen from a discourse analytical perspective, this utterance, whilst framed as a suggestion that the patient is invited to consider, carries 'advice potential' (Sarangi & Clarke, 2002). Coming from the doctor, it might be taken up by the patient as advice to be followed rather than as a suggestion to be considered. Form and function are not locked together and "...almost any utterance can have almost any function in some context and situation" (Corder, 1973, p. 42). In practice and in context what counts as advice and what counts as a suggestion depends upon who says what and when, and how what is said is taken, and not just on how the message is linguistically framed.

Theoretical models, such as these shared decision-making models that are set out in training texts, and mnemonics such as FIFE and BATHE that are drawn upon in training sessions, are designed to teach doctors what to say. But spoken discourse is locally managed and exhibits a high degree of contextually conditioned variation (Cameron, 2000, p. 71). Such models cannot generally be applied in a deductive top-down manner. As Eraut states (1985, p. 120) "...theoretical ideas cannot usually be applied 'off- the-shelf': their implications have to be worked out and thought through...".

Empirically based studies are required that display for the consideration of educators and registrars how doctor and patient actually talk and what they do as they interact to accomplish common ground as a basis for engaging in shared decision-making in real situations.

3.3.5. An empirical study of the process of shared decision-making

Elwyn at al, (2001) carried out such a study of the communication strategies used by experienced General Practitioners who were motivated to involve patients in management decisions. Cognisant of local constraints on the achievement of patient involvement, including time limitations, power and information imbalance, and the variable motivations and attitudes of patients towards engagement, these researchers set out to test theoretically conceptualised models of shared decision-making (Charles et al., 1997; Charles, Gafni, & Whelan, 1999; Kurtz & Silverman, 1996; Kurtz et al., 1998; Towle & Godolphin, 1999) against the realities of practice. Ten consultations in which doctors expected to involve the patient in management decisions were audio-recorded and transcribed using conventions from conversational analysis. Transcript sections were then coded as discrete categories by determining the doctor's main strategy during that section of the consultation. These empirically derived categories were then represented as visual displays of the sequential phases of particular consultations that could be compared to those phases set out in the idealised models.

Elwyn and his colleagues found that the empirical data did not match behaviours advocated in theoretical frameworks. For example, in practice, doctors in their study did not explicitly invite patient's views and ideas about treatment options or their preferred role in the decision making process. Rather, practitioners presented options and information, allowing the patients to determine their own level of involvement. The desirability of such involvement was found to be implicit in the discourse of a consistently occurring phase, categorised as 'equipoise', in which the doctor conveyed that the problem could be managed in more than one way and that legitimate choices existed for the patient. This broad strategy was frequently found to function as a catalyst to an equitable exchange of views and information about options.

In addition, it was found that theoretical models did not capture the level of interactivity involved in the decision making process. In the consultations examined, a significant proportion of consultation time was given to information exchange and responsive interaction with the patient. The data displayed numerous iterative switches between phases involving talk about options and risks and enabling phases that allowed patients opportunities to ask questions and to reflect.

However, whilst highlighting the interactivity of shared decision-making and challenging assumptions that inform theoretical models, the study by Elwyn and his colleagues still focuses on the doctors' moves rather than on how shared decisions are jointly produced. These researchers were concerned to identify and categorise the broad strategies used by doctors so as to compare these with theoretical models that of themselves, as noted earlier, represent only the doctor's contribution to interaction. To this end, doctor strategies were deduced from the interaction and coded and categorised to become the data for comparison. The fine-grained detail of how shared decision-making is interactively, collaboratively and cumulatively accomplished was not an object of inquiry and the question remained as to how shared decision-making was actually achieved.

I will now turn to discourse analytical studies of clinical interaction that have considered this latter question to examine how the study of shared decision-making has been approached and the discourse analytical themes that have emerged.

3.2.7. Previous discourse analytical studies of finding common ground

A range of discourse analytical studies have examined shared decision-making in a variety of clinical contexts, including paediatrics (Stivers, 2005, 2006) , general practice (Collins, Drew, Watt, & Entwistle, 2005; Gwyn & Elwyn, 1999; Stivers, 2006), and oncology (Bassett, 2007; Collins et al., 2005). These studies focus largely on decision-making rather than on the broader focal theme of 'finding common ground'. Most examine decision-making sequences extracted from a large number of consultations. Two studies (Bassett, 2007; Gwyn & Elwyn, 1999) take a case study approach to examine shared decision-making in the context of whole consultations.

3.3.6.1. Patient resistance as a resource for engagement in decision-making

Stivers (2005) examined parent participation in treatment decisions in acute primary care paediatric consultations. Her focus was decision-making sequences within consultations involving children with upper respiratory infections where a viral infection would render antibiotic treatment inappropriate. In line with the observations of Elwyn and his colleagues (2001) as described above, Stivers found that parent involvement in decisions about their children's treatment was not dependent on a doctor's explicit invitation to participate. Rather, in Stivers' study, both doctors and parents were found to orient to treatment recommendations as proposals that normatively require acceptance by the parent before the doctor is able to complete the decision-making activity and move towards closure of the consultation. Thus, through communicative behaviours that displayed their acceptance of or resistance to a doctor's recommendations, parents were able to influence treatment decisions. Further, in so far as acceptance is required before the doctor can move on, a parent's resistance was found to have clinical as well as interactional consequences, including concessions and modifications of the doctor's treatment recommendations (Stivers, 2005, p. 43). In this way resistance functioned as a resource for the negotiation of treatment decisions.

In a subsequent paper, Stivers (2006) draws upon a broader range of data, including adult acute care consultations, to document that treatment recommendations are similarly oriented to as proposals to be accepted or negotiated across primary care contexts.

As an illustration of Stivers' findings, consider the following extract from a PBA consultation that forms part of the database for the current study. This extract demonstrates the strength of the normative requirement to gain patient acceptance in arriving at decisions about treatment. The patient is an adolescent who presents with an eye infection in the company of her mother. As the consultation is drawing to a close the mother raises her daughter's concern about acne. In the turns leading up to this extract, as the doctor is explaining the causes of acne and setting out a number of treatment options, the patient displays what Heath (1988, p. 138) describes as "characteristic signs of embarrassment, in particular loss of composure and an inability to participate, if only momentarily, within the encounter". She becomes tearful and

focuses her gaze on the middle distance to enact 'a private place' within the 'interactional space' of the consultation (Beach & LeBaron, 2002, p. 627). She inhabits this space, where the doctor's gaze is avoided and his attempts to engage her are averted, across the following sequence. To use Goffman's term, she withdraws from 'involvement obligations' that are inherent in interaction (Goffman, 1967, p. 114).

Extract 2. PBA Consultation 6 (Supplementary data)

327		....and one other alternative is to use the pill ((directs gaze towards mother))that is why I asked you know
328	M:	Oh ok yep =
329	D:	= So because this is brought by hormonal [changes in the body =
330	M:	[mm
331	D:	=so ((inaudible)) actually the pill would be the best option you know :
332	M:	Ok
333	D:	((directs gaze to patient who continues to gaze into the middle distance)) ahh regulate your periods(.) regulate your hormones and some are very very good for the skin you know :
334	P:	((sustains focus on middle distance))
335	D:	so:o those are the options that are available=
336	M:	mm
337	D:	=I would personally recommend you go on the pill you know :
338	P:	((sustains focus on middle distance))
339	D:	((directs gaze to mother))not any type of pill but we have this you know =
340	M:	yeah
341	D:	=a few ones are good for the skin I would want to write that for her =
342	M:	Yeah yep good
343	D:	=if you don't mind ok because with the pill and those creams that I talked about initially all right : ((directs gaze to patient who continues to gaze into the middle distance))and well u::m you wake up very early in the morning because the early morning sun is very good for acne as well you know: (.)
344	P:	((continues to gaze into middle distance))
345	D:	s:o that is all my [recommendations
346	M:	[Yeah yep

At turn 332 the mother's acknowledgement functions as acceptance of the doctor's proposal to treat her daughter's acne with the oral contraceptive pill. But in keeping with institutionalised principles of adolescent health care (Chown et al., 2008) that inform and constrain what counts as appropriate communication in such contexts, the doctor appears to require the patient's acceptance as well. In accordance with these principles, General Practitioners, in light of a young person's cognitive development towards independence, are to foster adolescent participation in the consultation process and to involve them in decisions about their own health.

From this extract it can be seen that the doctor orients to the patient's silence and to her retreat into a private interactional space as a noticeable absence of acceptance that requires him to act to pursue her acceptance of his proposals in various ways. At turn 333, as he attempts to engage the patient by directing his gaze towards her face, he pursues her response with a three-part list of benefits associated with taking the pill. Such a three part list format is strongly conducive of recipient uptake (Jefferson, 1990). Combined with 'you know' and rising intonation at the end of the turn construction unit, this utterance directly invites the patient's response. But again she withholds acceptance with sustained gaze into the middle distance. In response, at turn 337 the doctor upgrades his proposal to a personal and not just a professional recommendation. Yet this re-doing also fails to invoke the acceptance required to allow him to move to closure of the treatment decision sequence.

Ultimately, in face of the patient's continuing 'misinvolvement' in the interaction (Goffman, 1967, p. 117), the doctor pursues confirmation of the mother's acceptance. At turns 339 and 341 his utterances constitute a re-specification of his initial recommendation. These re-specifications function to obtain a response from the mother through which she reinforces her earlier acceptance of the doctor's treatment proposal with reiterated acknowledgements and a positive assessment (turns 342, 346).

The doctor's persistence in pursuing a response from the patient, and, in its absence from her mother, resonates with Stivers' finding that a doctor's treatment recommendations are normatively oriented to as proposals requiring acceptance, and that acceptance or resistance constitutes one way that patient's impact the decision-making process. In later chapters of this thesis, this discourse analytical insight will be brought to bear on the analysis of decision-making in challenging PBA consultations, particularly those involving patient resistance to the doctor's appraisal of their condition and to treatment recommendations (Chapter 5).

3.3.6.2. 'Bilateral' and 'unilateral' approaches to decision-making

Collins, Drew, Watt and Entwistle (2005) examined decision-making sequences drawn from video-recordings of 80 consultations with a particular focus on primary care

consultations about diabetes management and those involving the treatment of ear nose and throat cancer in oncology settings. Using techniques from conversation analysis, their aim was to describe the various approaches to decision making used by practitioners and to consider their implications for patient involvement.

Through repeated viewing of the data, these researchers identified and characterised a typical decision-making trajectory that extended from a doctor initiated transition to a decision-making phase, through a sequence of stages including presentation of diagnosis or results, consideration of options, and arrival at a decision or conclusion about a course of action. Through close analysis of the discourse, contrasts and variations in how practitioners managed these decision-making sequences were documented so as uncover a spectrum of approaches ranging from the more 'bilateral' to the more 'unilateral'. Their findings suggest that these different approaches may tend to encourage or inhibit patient participation in decision-making.

In summary, and across different clinical settings, a more 'bilateral' approach was characterised by practitioner talk that actively pursues patient contributions by providing places for the patient to join in and building on contributions that the patient makes. For example, from the outset of the decision-making phase, doctors using this approach presented decisions as 'yet to be made' and therefore open to discussion. In addition, discursive signposts signalled in advance that options were about to be presented thus alerting patients to opportunities for engagement. In contrast, in a 'unilateral approach', practitioners' talk was found to be less conducive to patient participation. Decisions were presented as 'made' leaving little room for negotiation or for the patient's perspective to enter the discourse. Options were presented as medical matters for the doctor to decide and handled somewhat independently of the interaction (p. 2625), findings that resonate with the paternalistic decision-making model described and illustrated in Section 3.3.3.1 of this thesis.

But as Collins and her colleagues point out, the predominant focus of their analysis was practitioner talk. They suggest therefore that the observations they offer about the impact of the practitioner's approach on patient participation in decision-making are preliminary and warrant further investigation. Overall, they found that patient participation in decisions about treatment is limited and that the adoption of a bilateral

approach on the part of the doctor does not always lead to a significantly greater contribution from the patient. Nevertheless, their data suggests that characteristic features of a 'bilateral' approach, such as use of discourse markers that signal transition to the decision making sequence, or signposting an option before engaging in discussion about it, seem to be conducive to patient input. They call for further studies that might refine their characterisation of the approaches identified and investigate the extent to which these approaches facilitate greater patient participation in decision-making about treatment.

One such study (Bassett, 2007) has examined decision-making in the context of oncology consultations to identify 'voicing' as an expert involvement strategy deployed by practitioners.

3.3.6.3. Voicing as an analytical theme

Bassett defines 'voicing' as it emerged from her analysis of the discourse of five oncology consultations, as "the construction of a dialogue in which the oncologist introduces an alternative perspective to that already proposed or discussed by projecting into the interaction the direct speech of another person, who is usually the patient" (2007, p. 10).

Through this projection the doctor makes salient something that he or she perceives the patient may want to say but be constrained from saying. In this way, the practitioner validates a perspective that may be at odds with the medical viewpoint so as to create a safe environment in which the patient feels able to express their point of view.

Bassett was concerned to describe, interpret and explain instances of voicing and their impact on decision-making within the broader context of the entire consultation in which they are embedded. Thus, the brought about context, generated by what doctor and patient had talked about and understood earlier in the consultation, as well as what was said later, was encompassed by her analysis.

As illustration of voicing as an expert resource for bringing patient preferences into the discourse of the consultation, consider the following contextualised instance from Bassett's study. The patient has early stage breast cancer and has already had a lumpectomy. Her surgeon has referred her to the doctor, who is a radiation oncologist, with the expectation that further treatment with radiotherapy will be arranged. However, after looking at the pathology report the doctor concludes that mastectomy will offer the patient the best chance of cure. Her objective in this consultation is to communicate her perspective on the risk of the cancer recurring and to recommend mastectomy as a more effective treatment. But this is their first meeting and the doctor doesn't know what the patient's feelings might be around the emotive and highly charged issue of losing her breast. Nor does she know if such feelings may have influenced previous decision-making with her surgeon to opt for a lumpectomy. At the point in the consultation where this extract begins, doctor and patient have already discussed the clinical evidence around treatment options and the doctor has explained that the risk of cancer recurring in the conserved breast over the next five to ten years is about 50%. She proceeds as follows:

167	Dr	(2) but fifty percent in not a hundred percent
168	Pt	no
169	Dr	and .. it's not uncommon for [women]
170	Pt	[mmmm]=
171	Dr	=to sit where you're sitting and say **I don't (1) you know .. I'm prepared to take a fifty percent chance .. I desperately want to keep my breast**
172	Pt	I'm not that desperate
173	Dr	that's .. what I need to get a sense of

(Bassett, 2007, p. 21)

At this critical moment, as she attempts to elicit the patient's perspective on the emotive issue of a possible mastectomy, this doctor might have drawn from idealised strategies as set out in the professional communication texts illustrated in section 3.3.4 above. Following Silverman and colleagues ([1998] 2005, p. 121) she might have offered her own suggestion and asked for the patient's opinion directly using the exemplar format "My suggestion would be to opt for a mastectomy. What do you think?"As suggested by the discussion above, such an utterance, coming from the oncologist, would probably have been received by the patient as advice to be followed rather than as an invitation to present her own point of view. The patient's feelings about the matter of mastectomy may not have entered the discourse.

But this doctor does not explicitly invite the patient's involvement. Rather she chooses to take an indirect approach. At turn 167, as highlighted by Bassett in her analysis, the doctor signals to the patient that she is about to counter the expectation generated through their discussion of risk across previous turns that mastectomy is the only feasible path to take. At turn 171, deploying the strategy of 'voicing', she projects into the discourse of the consultation a quotation from other women who, in the same situation, confronted by similar medical evidence and a similar choice, have opted to keep their breast. In this way the doctor acknowledges this as a valid option, creating a safe interactional environment in which the patient might voice such a preference in spite of the medical evidence already explored. Thus, voicing, in the form of the tactical inclusion of quoted speech, functions indirectly as a question about this patient's perspective. It is taken as such by the patient who responds at turn 172 with her point of view.

Bassett's discourse analytical study has uncovered 'voicing' as one expert strategy that oncologists actually use at critical moments to involve patients in decision-making. Whilst instances of 'voicing', as defined by Bassett, have not emerged from the primary care data examined for the current study, voicing remains as an 'analytic theme' (Roberts & Sarangi, 2005) that is of relevance to the study of decision making in General Practice contexts. Instances of voicing occur in the primary care data that Collins and colleagues (2005) draw upon to illustrate a 'bilateral' approach to decision-making. Although these researchers did not identify voicing as a feature of decision-making talk, the following extract from their database illustrates its deployment in the 'discussing options phase' of a primary care consultation around diabetes management.[13] Note how within turns 47 and 48, the doctor projects the patient's voice into the interaction with a hypothetical quotation that acknowledges 'doing nothing' as a perspective that the patient might validly hold, even though it is at odds with his own view about how to proceed. Arguably, this contributes to a safe environment in which the patient could, if he so wished, express a preference for this option.

[13] The notation system used by Collins, Drew, Watt and Entwistle differs from that used in the current study in that participant's turns are chunked into smaller segments for the purposes of description and analysis.

43 D: so we've got (2.0) we've got a
44 couple of choices about that
45 really (1.8) either we say (1.2)
46 well (.) we leave it (0.2) and don't
47 try and do anything **I'm not**
48 **interested in doing anything .hh** and
49 take the risk with the complications
50 (0.2) it wouldn't be a (0.0) it
51 wouldn't be a route I'd (0.2) suggest
52 but it's –it's an option (0.7) then
53 the other option we've got is
54 looking at your diet (0.5) even more
55 closely (0.5) but it sounds like
56 you've (1.8) you feel that that's
57 fairly much honed down now
58 P: pk - .hh I hope so

(Collins et al., 2005, p. 2616) (bold type added by thesis author)

Additional indications of the relevance of 'voicing' as an involvement strategy in General Practice contexts have emerged from ethnographic and consultative research carried out for the current study. At a series of collaborative workshops, described in Section 2.3.4.5 of this thesis, medical educators from a RTP were invited to consider the application of discourse analytical concepts to training. Educators enthusiastically received the concept of 'voicing', illustrated with data from Bassett's study, as a strategy that they could usefully draw upon to involve patients in decision-making in their own practice and introduce to registrars in training sessions.

3.3.6.4. A case study approach to the examination of shared decision making in the General Practice context

Gwyn and Elwyn (1999) examined shared decision-making in the context of a single, multi-party General Practice consultation involving an infant with a viral infection and his parents. Their study is relevant to the current project in a number of ways. Firstly, unlike most studies of decision–making in primary care that take decision-making sequences as their unit of analysis, it illustrates the value of a case study approach to the study of interaction that analyses decision-making within the context of a whole consultation. Such an approach allows for what Sarangi (2006, p. 212) terms the 'part-whole dynamics of interpretation' that explains interaction in the context of what has gone before and what is to come. Secondly, their study draws attention to how

constraints such as the power asymmetry embedded in the doctor-patient relationship, and conflict between the doctor's treatment preferences and those of the patient, can function interactionally to disrupt a doctor's efforts to arrive at shared decisions.

Shared decision-making is a cumulative activity that is not restricted to a particular moment when a decision gets made. As Gwyn and Elwyn's study shows, at any particular moment in the interaction the 'brought along context' that incorporates what doctor and patient (or in this case doctor and parent) have already said and understood can inhibit or enhance the process of patient involvement. Consider for example, in light of what has gone before, the following sequence from their case study in which the doctor explicitly invites the father's ideas about treatment of his son's tonsillitis[14]

075	D:	now (2.0)
076		did you have any ideas as to how we should
077		deal with this (.) problem?
078	F:	actually I have a (.) other *son* [D: mmm] (.)
079		six and a half years old [D: mmm] (.) he had
080		lots of problem about his *ton*sils (.)
081		the *same* problem (.) actually he [all come?] now
082		he finished this problem (1.0) he's coming to age seven
083		(.) so (.) I think it is better to keep the child from *cold*
084		(.) no cold drinks? something like that (.)
085		I don't know any more

(Gwyn & Elwyn, 1999, p. 443)

In response to the doctor's invitation (lines 076,077) the father draws upon the strategy of 'category entitlement'(Potter, 1996) . His experience as the father of an older child who has had a history of the same problem entitles him to special knowledge about how his infant son should be treated. Yet despite his claim to such knowledge, his suggestion about what should be done is restricted to refraining from cold drinks and qualified by disclaimers (turns 084. 085). As Gwyn and Elwyn suggest (p. 442), the father appears to treat the doctor's invitation to contribute as rhetorical. With his final disclaimer, 'I don't know any more' (085) he implies that no matter what his contribution only the doctor's knowledge is valid in the context of the consultation.

[14] Gwyn and Elwyn's transcription conventions differ from those used in the current study. In this extract ? indicates rising intonation and italics indicates stress or emphasis

Such 'interactional submission' (ten Have, 1991) in spite of the doctor's explicit invitation to participate in treatment discussions, can only be fully understood and fully explained against the backdrop of the 'brought about' context of the interaction that is encompassed by a case study approach. The father is a non-native speaker of English. In the interaction leading up to the treatment discussion phase (not shown here), the doctor has drawn attention to this fact in a number of ways. For example, during the history-taking phase, by simulating a coughing sound rather than relying on wording he signals lack of confidence in the father's ability to understand his diagnostic question. A moment later he appears to correct the grammar of the father's response, prompting the father to correct himself. Then, some turns later, following physical examination of the child, the doctor reformulates his lay description of the patient's condition in technical terms: " in medical terms we call it tonsillitis". Whilst such action could be seen as a sharing of professional knowledge, it can also be understood as an unnecessary intrusion of professional discourse into the interaction that reinforces professional dominance (Gwyn & Elwyn, p. 442). In this instance it appears to be taken as such and contributes to the cumulative interactional accomplishment of an asymmetrical doctor-patient relationship in which the father takes a submissive role despite his life-world experience and the doctor's attempts to engage him in decision-making.

3.3.7. The approach taken in the current study

Following Gwyn and Elwy (1999) and Bassett (2007), the current study takes a case-study approach that considers decision-making in General Practice in the context of whole consultations. However, in this study, decision-making is conceptualised and examined as part of the broader professional construct of 'finding common ground'. As will be seen from analysis of communicatively challenging PBA consultations to be presented in this thesis, doctor and patient may bring to their interaction different meanings about a condition, shaped by different ways of reasoning and different experiences, and realised through different discourses. In the context of HIV AIDS medicine, Moore, Candlin and Plum (2001) found that doctor and patient brought different meanings to the concept of 'viral load'. Similarly, in the current study doctor and patient bring different ways of reasoning to their interpretation of events. For example, to the doctor in a consultation involving management of diabetes type two

(See Chapter 5), a worsening blood sugar result, in light of bio-medical reasoning means worsening health. To the patient however the meaning of his test results is informed by a subjective sense of being well that constitutes a challenge to what any test results might objectively indicate.

In such situations, how do doctor and patient accomplish the task of melding different meanings and different rationalities so as to arrive at common ground about the nature and scope of a patient's problem? How do they arrive at a basis from which progress can be made towards jointly agreed decisions about what needs to be done? These are questions that will be considered through analysis of the discourse of PBA consultations in the chapters to follow.

3.4. Summary of chapter

This chapter has examined three 'focal themes'(Roberts & Sarangi, 2005) that have emerged as salient in the discourses of communication that circulate in the profession of General Practice. Drawing upon ethnographic findings as well as a review of the communication and training literature from within the medical world, the themes of empathy, rapport, and finding common ground as a basis for shared decision-making have been described from the perspective of the profession. Through this discussion, a place has emerged for a discourse analytical study that might contribute to professional understanding of how these themes play out in practice. Drawing upon a review of previous discourse analytical studies, 'analytic themes' (Roberts & Sarangi, 2005) have been identified that will be drawn upon to shed light on how these focal themes are interactionally, collaboratively, and cumulatively accomplished in specific General Practice contexts.

The three chapters to follow will examine how these themes inter-relate in purposeful ways in the discourse of four consultations representing clinical situations considered by examiners and educators participating in this study to be particularly significant in teaching and evaluating clinical communication and particularly telling of communicative expertise. To briefly reiterate, Chapter 4 will present analysis of the discourse of two consultations where the patient's initial reason for presentation masks

hidden concerns. Chapter 5 will examine a situation involving dissent and conflict between doctor and patient about the patient's condition and its management. Chapter 6 will focus on a multi-party consultation involving a parent and adolescent patient.

Chapter 4 (Part A)

"Hidden agendas, they're the difficult ones"

Extract 2. Interview 8

The difficult ones [consultations] are ones that have some sort of psychological problems going on. I mean the patient may not straight away come out with that, so you've got to try to elicit some of those things... ... things to do with kind of depression or more serious kinds of psychological problems, or social problems...there might be family issues that again might be the underlying problem with the patient but they may not give you this information straight away. I think those ones are always more difficult (RACGP examiner).

Extract 2. Interview 6

....when people have that hidden agenda where you're not actually sure what they really want. When they come to you with abdominal pain and they actually want some antidepressants. That's a difficult consultation and a difficult communication (RACGP examiner).

Extract 5. Interview 4

Dealing with emotions is always difficult; anger, fear...they're difficult situations. Or they're [the patients] going off on a tangent and you've no idea what they want.....getting the patient to let you know exactly what they want or what the problem is; structuring a consultation to find out what the patient wants in the first place. Hidden agendas, they're the difficult ones (Medical educator).

These quotations from participants in the current study are responses to the researcher's question about consultation types considered to be particularly communicatively challenging in practice and particularly significant in teaching and evaluating clinical communication. The voices of these practitioners resonate with that of Middleton (1989), an influential medical educator, who suggests that in General Practice the problem that the patient raises initially may be 'the tip of an iceberg' and merely a 'ticket of admission' that represents what the patient finds easiest to say or least threatening to express. The experiences of these doctors also align with findings from empirical research that highlight the issue of unvoiced concerns in primary care consultations. Barry et al (2000), using complex data sets, including pre and post-consultation interviews with patients, interviews with doctors and transcriptions of consultations, examined the extent to which the concerns patients intended to raise with their General Practitioners actually emerged in the discourse of the consultation.

Patients voiced all of their agenda items in only four of the thirty five cases studied. Whilst voiced concerns tended to be bio-medical matters such as physical symptoms and requests for a prescription, those concerns that were unvoiced tended to be psycho-social and emotional in nature.

It appears that in General Practice consultations the patient's presenting problem and their underlying agenda may not be the same. The challenge for participants in encounters where the patient's expressed reason for presentation masks underlying emotional, psychological or social concerns is to create and sustain an interactional climate wherein life-world issues that are of clinical significance can emerge to be addressed. How this is interactionally accomplished and how it fails in specific PBA consultations is the focus of this chapter. Before turning to analysis of the discourse of these consultations, influential studies associated with the theme of hidden agendas will be discussed.

4.1. Hidden agendas in the research literature

The issue of patients' unvoiced and unmet concerns has been a recurring theme of medical communication research for a number of decades. Beginning with Mishler's seminal study of the discourse of medical interviews (1984), (see below) the focus of much of this research has been on the behaviours of doctors and, in particular, how doctors control the interaction so as to pursue a bio-medical agenda in ways that sideline the patient's individual illness experience and life-world problems. The question of how patients indicate what may be on their minds and how the communicative choices made by both doctors and patients might jointly accomplish the emergence of underlying concerns or, conversely, realise their suppression, appears to have been less fully explored.

4.1.1. Studies that focus on the behaviours of doctors

Mishler's now classic study (1984) examined patterns of communication between doctors and patients in 25 encounters recorded in the mid 1970's in both hospital out-

patient and private practice settings. Drawing upon concepts from Habermas' 'theory of communicative action' (Habermas, 1984), Mishler explained the medical interview in terms of a struggle between the 'voice of medicine', representing the abstract norms, scientific attitude and technical interests of bio-medicine, and the 'voice of the life-world' representing the patient's grounded, contextualised, everyday experience of illness. Doctor control over the interaction and the resulting dominance of the voice of medicine was seen to account for the marginalisation of patient's life-world concerns from the discourse of the medical interview. Mishler suggested that there is a typical 'unremarkable interview' structure through which doctor control is exerted. This interview structure involves the recurring sequence of doctor initiated request, patient response and doctor assessment of that response followed by a new doctor initiated request. The doctor is both first and final speaker in each exchange and as a consequence, only the doctor is involved in topic initiation, development and change. Whilst Mishler found that patients occasionally extended their responses to offer glimpses from their life-world, he also found that this voice of the life-world was silenced in all but one interview as the doctor redirected talk to pursue bio-medical matters. Thus the voice of medicine was found to dominate the interaction, as doctors listened selectively to a patient's story to extract information that might support an emerging bio-medical diagnosis whilst discarding the patient's individualised life-world accounts. Through this process, Mishler argued, the social and emotional context of illness on which a full understanding of the patient's illness experience depends was stripped away. On the basis of his findings, Mishler called for a different approach to the medical interview that would attend to 'patients' life-world contexts of meaning as the basis for understanding, diagnosing and treating their problems' (Mishler, 1984, p. 192).

Since Mishler's study, discourse analysts have observed that such a bald dichotomy between the voice of medicine and the voice of the life-world cannot be sustained (Atkinson & Paul, 1995; Roberts & Sarangi, 1999a). Indeed, several voices may be associated with the world of bio-medicine and the life-world of the patient. As analysis of PBA consultations carried out for this study will show, doctors may adopt the discourse of the life-world for strategic purposes. Further, patients may take on the voice of medicine. In fact, professional talk is increasingly characterised by an intermingling of discourses and voices as doctors seek to voice an association with the

life-world of the patient and patients, in turn, may articulate their condition drawing on the discourse of medicine.

Nevertheless, as a response to Mishler's seminal research, a series of related studies from within the medical world identified particular behaviours of doctors that function to attenuate the patient's expression of concerns. Beckman and Frankel (1984) examined the discourse of 53 consultations conducted by internal medical residents to find that these novice doctors commonly disrupted patients' statements of concern by redirecting and refocussing the interview to pursue a diagnosis as soon as an initial problem had been raised. Once redirected, patients with additional concerns were faced with the 'practical problem' of finding an appropriate place in the interview format where these concerns could be broached (Beckman & Frankel, 1984, p. 694) . With a single exception, patients did not return to the problem presentation phase to complete their problem agenda.

In a follow up study, Beckman, Frankel and Darnley (1985) were able to show a significant relationship between interrupted problem statements and hidden agendas that emerged at the very end of the consultation. From this they concluded that interruptions by the doctor early in an interview inhibited patients from supplying information that was in some cases critical for decision-making.

Fourteen years later, in a further follow up study, this time investigating the behaviours of experienced primary care physicians, Marvel, Epstein, Flowers and Beckman (1999) found that a similar pattern persisted to that identified by Beckman and Frankel (1984). Whilst the time lapse from initiation of the patient's problem statement to redirection had increased from a mean of 18 seconds in the initial study to a mean of 23 seconds, and patients' statements were completed in 28% of cases, a pattern prevailed involving doctor initiated interruption of the patient's problem presentation and premature progression to the information gathering phase of the medical interview. When interruption occurred, the narrative thread of a patient's illness experience was fragmented and concerns that may have arisen from this narrative were lost.

4.1.1.1. The impact on training and practice

The impact of these doctor-focussed studies on General Practice has been far-reaching. Mishler's compelling study (1984) together with his call for a new approach to the medical interview that attends to the patient's life-world was influential in the development of 'the patient-centred clinical model' (Stewart et al., [1995] 2003) that has evolved to become the prevailing paradigm informing clinical practice and training. Introduced in the opening chapter of this thesis and further described in Section 3.3, this institutionally ratified model aims to provide practitioners with a framework for eliciting the patient's life-world concerns and illness experience so as to incorporate this broader perspective into diagnostic reasoning and treatment processes.

Further, early studies of doctor behaviours and doctor control have informed the development of an array of strategies designed to assist practitioners to bring the patient's hidden concerns into the discourse of the consultation. Mnemonics such as FIFE and BATHE, (see section 3.3.4) have been devised as memory aids to sets of doctor initiated questions for eliciting the patient's agenda. Behaviours to counter doctor interruption of the patient's problem presentation, such as "encouraging patients to tell their story in their own words, attentive listening, and leaving space for patients to think" are set out in influential interview guidelines and widely used professional training texts (Kurtz & Silverman, 1996; Silverman et al., [1998] 2005), and invoked by medical educators during training. In RTP training workshops observed by the researcher, registrars were constantly enjoined to listen without interrupting to the patient's problem presentation, and attentive silence was advocated as a means of eliciting unvoiced concerns, as captured in this advice given to registrars as they reflected on their performance in role-plays involving 'hidden agendas':

> Training vignette 6
>
> What the patient volunteers without prompting, is important for the patient...
> If you keep silent I guarantee that the next thing the patient says will be gold dust
> (Medical educator).

In addition, in line with recommendations from the study by Marvel and colleagues (1999), registrars are encouraged to actively and explicitly solicit patient concerns both before moving on to the information gathering phase and across the consultation.

During training workshops, participants share and discuss exemplar questions designed to invite patients to elaborate on their concerns, including 'Is there anything else that's been bothering you?' and 'Are there any other issues that you might want me to know about?' Further, in the real world of clinical practice trainers model the use of such strategies for their registrars as indicated by this comment from a participant in the current project:

> Extract 5. Interview 2
>
> I had a medical student the other day and totally unsolicited one of my patients said "Oh you need to learn from this doctor... [he] keeps on saying 'Is there anything else?'" I mean that's a technique that I use with every patient. It's only natural so that I've got all of their agenda. You don't have doorstops [late arising concerns] if you get that out at the beginning (Medical educator and PBA examiner).

Clearly, findings from early studies of doctor behaviours have been of considerable value in drawing attention to the ways that doctors' actions might sideline patient concerns, and of considerable influence in the development of strategies designed to elicit a more complete patient agenda. However, as Drew (2001) points out, such studies, by attending closely to the behaviours of doctors, have tended to treat the behaviours of patients as incidental to showing how doctors exert control. The interactivity of the consultation, that is, "the capacity of one participant, [patient or doctor], to influence the behaviour of the other or to adjust behaviour in response to another" (Heritage & Maynard, 2006a, p. 358) has not been an object of attention. Consequently, the skills and strategies that these doctor-focussed studies have prompted for eliciting patient concerns, whilst drawing upon the experience of accomplished practitioner-educators, represent only the doctor's role and are not grounded empirically in close analysis of co-constructed doctor-patient interaction.

Consider, for example, the widely promoted strategy of surveying patient's concerns through use of such questions as 'Is there anything else?' In the study by Marvel and colleagues (1999) the use of this question by the doctor is associated with the emergence of additional concerns, and in training such questions are advocated as a means for prompting patients to complete their problem presentation. However, in carrying out their analysis of a large number of transcribed consultations, these researchers made use of process analysis (see section 3.2.4.1), a method that codes and

extracts utterances from their interactional context, and in so doing obscures their localised function and effect. In their study 'anything else?' was coded as a "non directive open-ended inquiry... that was hypothesized to reduce the risk of missing unstated concerns" (p. 284). A negative response to this question was coded as a 'statement of completion' of the patient's problem presentation. Yet in conversation analytical terms, 'anything else' prefers a negative response through use of the negative polarity term 'any' (Boyd & Heritage, 2006, p. 162). Whilst identified as an open-ended solicitation, and subsequently advocated in training as a means to elicit previously unvoiced patient concerns, such an utterance is in fact designed to favour a 'no further problems' response. Whether or not it would amount to an effective way of eliciting more of a patient's concerns in any particular instance cannot be pre- determined but would need to be worked out through interaction. The efficacy of such strategies needs to be examined in context.

Further, as Drew has observed (2001), in studies focussed on doctor control such as those described above, patients are generally represented as passive respondents to doctor initiated questions and passive recipients of a doctor-led medical agenda imposed by a standardised and pre-determined medical interview format in line with Mishler's 'unremarkable interview'. However, in studies that take a more interactional approach (Gill, Halkowski, & Roberts, 2001; Stivers & Heritage, 2001), including the current project, patients emerge as active and reflexive participants in the consultation who have agendas of their own and ways of communicating, often obliquely and often delicately, what is on their minds. In these studies, the interview does not develop according to a predetermined format in which the doctor speaks in the voice of medicine to impose a medical agenda. Rather it emerges as a locally negotiated and jointly constructed event that unfolds according to the communicative choices made by patients as well as doctors. Such studies are able to show what patients as well as doctors actually do to bring hidden agendas into the discourse of the consultation.

4.1.2. Interactional studies and the initiatives of patients

Two studies in particular offer 'analytical themes' and explanatory insights that have bearing on the analysis of the PBA consultations to follow. Stivers and Heritage (2001)

analysed the discourse of a single primary care consultation to provide insight into the interactional initiatives that patients take, independently of a doctor's questions and independently of the medical agenda, so as to draw attention to their concerns. Through close analysis of the discourse of a single primary care consultation, these researchers identified 'expanded answers' and 'narrative expansions' as resources that patients deploy to introduce into the discourse matters that offer the doctor a window into their underlying preoccupations.

Significantly, the patient in their study makes these initiatives within the comprehensive history-taking phase of the consultation, an interactional environment which constrains patient-initiated actions. This phase of the medical interview involves a series of routine doctor-initiated questions about such matters as past medical history and the health status of immediate blood relatives. Through questions designed for the 'optimization' (Boyd & Heritage, 2006, p. 164) of a minimal or 'no problem' response, doctors engage patients in an efficient checklist-like activity that discourages any movement beyond the immediate medical agenda. The fact that a patient breaks free of these restrictions, either to expand on an answer or to build a narrative that departs from the agenda of the doctor's question, is, as Stivers and Heritage suggest, indicative that these expansions are accountable, of significance to the patient and constructed with intention. Thus, they can be treated by doctors as a resource for learning more about aspects of the patient's life-world that may represent underlying preoccupations. For example, in the Stivers and Heritage study, the patient embeds her response to the doctor's routinised inquiry about the site of her mother's cancer in a narrative expansion that departs from the terms of the original question. Through this narrative she volunteers an extended account of her mother's fear of operations and of her resistance to seeking medical help until it was too late for treatment. This narrative, together with a number of expanded answers that allude to the patient's own fear of medical procedures, are oriented to by the doctor as a resource that provides insight into what is on the patient's mind. From these expansions the doctor infers that the patient is preoccupied by her own tendency to 'put things off', an unvoiced concern of clinical significance that he refers to directly at the end of the consultation and seeks to address by firmly asserting arrangements for an early follow up appointment.

The analytical theme of narrative expansions is significant for the current study on a number of counts. Not only does it focus attention on narrative as a resource that patients use to suggest their preoccupations, but it also draws attention to the actions of doctors in responding to these stories. As Stivers and Heritage point out (2001, p. 181) " not every occasion of life-world disclosure is an occasion for the pursuit of that disclosure". In choosing whether to address the matter raised by a patient's story, doctors make choices according to such local and professional contingencies as time constraints, their perceptions of the clinical significance of the issue and what the doctor and patient know about each other. Further to this, decisions about if, how and when a doctor responds to a patient's narrative appear to be contested within the profession. The doctor in the second of two PBA consultations to be analysed in this chapter variously attends and dis-attends to emotional issues implicated in his patient's stories. Examiners' responses to the encounter differ and their evaluations of his performance are conflicting.

In another study, Gill, Halkowski and Roberts (2001) also used conversational analysis to examine patient initiatives and doctor responses in the examination of a single consultation. In this study, the patient's expressed reasons for presentation, including a routine physical examination, mammogram and symptoms of tiredness and headaches, mask a preoccupation that she may have contracted HIV AIDS during a blood transfusion following a hysterectomy some years previously.

Gill and her colleagues draw attention to the delicacy with which this matter is brought into the discourse of the consultation, and through their commentary offer an account for such delicacy that sheds light on the actions of patients in the current study. From the perspective of the patient, raising the unlikely possibility that she may have contracted AIDS through a blood transfusion is a face threatening act that may be construed by the doctor as discrepant with what a good and 'reasonable patient' (Halkowski, 2006) is like. In putting such a concern on the table the patient risks casting herself as someone who is overly anxious and is requesting an unnecessary intervention. Yet by neglecting to raise the matter she may be derelict in her responsibility to care for her health. Such a dilemma is born of what Halkowski (2006) terms 'the patient's problem'. Whilst attending to the need to provide the doctor with information, the

patient must also " take pains not to seem too certain that this problem is definitely medically relevant" (p. 111).

It is this dilemma that accounts for the delicacy and obliqueness with which the patient hints at her preoccupation that she may have contracted AIDS. In a variety of ways, and using a variety of interactional resources, she works to underplay the issue. For example, she down-plays the significance of her concern by delaying its placement until the middle of the consultation. There it is introduced, not as her own concern but as a preoccupation that is voiced by her children in a reported interaction in which they ask her if she has had an AIDS test. Further, by injecting laughter tokens into this report she takes a light- hearted stance that contrasts her take on the matter with that of her worried children. In this way she distances herself further from ownership of a concern that may not be received as "doctorable", that is to say worthy of medical attention as a potentially significant medical matter that warrants discussion and possible intervention (Heritage & Robinson, 2006, p. 58).

In similar ways, and in order to be seen as 'reasonable patients', participants in PBA consultations to be analysed below mask and downplay the significance of matters that are on their minds whilst simultaneously drawing attention to their existence.

4.2. The current study

Continuing in the tradition of interactional studies that consider the actions of patients as well as doctors, the current study aims to contribute to understandings of how doctors and patients collaboratively accomplish the disclosure of hidden concerns.

But in addition to being a collaborative accomplishment, the disclosure of such concerns is also a cumulative and progressive activity. It is not restricted to those sequences where a patient initiates action that offers a clue to their preoccupations, and the doctor infers the significance of what is said and responds. Rather, as Beach and Dixson (2001) display in their analysis of a health appraisal interview in which the patient's experience of childhood sexual abuse was brought to the surface (see section

3.1.5.2. of this thesis), the disclosure of delicate emotional and life-world concerns appears to be an emergent activity and dependent on what has gone before.

In the context of General Practice consultations, the current study seeks to describe and explain how doctor and patient create an auspicious interactional environment that is conducive to the emergence of previously unvoiced concerns. How do they collaboratively and cumulatively accomplish the gradual transition from the initial presentation of problems that are bio-medical in nature to increasingly delicate emotional and psychological matters that may be of central significance for diagnosis and management? What part does the accomplishment of empathy and rapport play in this process of arriving at common ground about the scope of the patients' problems? Conversely, what are the actions of participants that realise the continuing marginalisation of such issues from the discourse of the consultation?

Through close analysis of the discourse of two comparable PBA consultations, submitted for examination by doctors seeking Fellowship of the RACGP, and with particular focus on the focal themes of empathy, rapport, and finding common ground this chapter sets out to offer a response to these questions.

Each of the video recorded consultations selected for transcription and analysis represents a 'crucial communicative site' (Candlin, 1987) where the patient's expressed reason for presentations masks deeper concerns. The communicative performance of the doctor in the first consultation to be analysed was evaluated highly by RACGP examiners. The performance of the doctor in the second consultation was contested.

4.3. PBA Consultation 1

4.3.1. The clinical context

The patient is a 58-year-old woman who begins the consultation with a request for information and advice about ovarian cancer screening. This is a follow-up visit and the doctor and patient already know each other. The patient has previously been diagnosed and treated for the continuing, chronic condition of slow transit colon constipation. She

has had a single panic attack in the past and the doctor is aware of this. As the consultation unfolds, the likelihood of more pervasive anxiety and serious depression begins to emerge.

4.3.2. Examiners' evaluations

Two RACGP examiners evaluated the candidate's video-recorded performance independently. Using the RACGP video-rating form described in Section 3.2 of this thesis, each examiner rated the doctor globally on five parameters along a continuum from 'poor' to 'excellent'[15], supporting their rating with written comments. Rating and evaluative comments for this candidate on the first parameter, 'Communication and Rapport' are set out below.

	Global rating	Comments
Examiner 1	Good	• Obviously caring GP with good communication skills • Rapport with patient excellent • Great problem definition.
Examiner 2	Excellent	• Very thorough and caring • Good understanding of patient's concerns • Excellent nature and friendliness • Very good empathy with patient.

Such global ratings and evaluative comments distil the responses of two experienced practitioner-examiners to the complex co-constructed interaction through which the patient's underlying concerns are brought to light. But the comments are not linked to particular moments in the interaction and so cannot enhance understanding of how, for example, 'excellent rapport' or 'very good empathy' was accomplished and how this enabled the patient to talk more freely about deeper issues.

The following analysis of the discourse of this consultation aims to make tractable some of the basis for the examiners' judgements on communication. With particular emphasis on the focal themes of empathy and rapport, it sets out to describe and explain how

[15] Descriptors provided for rating along the continuum are: N/A (not applicable), Poor, Insufficient, Doubtful, Sufficient, Good, Excellent.

doctor and patient accomplish the gradual transition from the patient's presenting concerns to the emergence of delicate emotional and psychological issues that are grounds for a broader diagnosis that encompasses debilitating depression.

4.3.3. Analysis

As the consultation gets under way, the patient professes her reason for visiting the doctor.[16] She has come to ask about a screening test for ovarian cancer. A slip of paper lies on the desk between patient and doctor and remains there throughout the consultation. As later emerges, the slip has been brought along by the patient as a memory aid to matters she wishes to discuss with the doctor, and on it she has noted a reference to an article about ovarian cancer and the words 'CT scan' and 'Paroxetene'. She believes 'Paroxetene'[17], a medication that has been recommended by a friend, to be a treatment for hot flushes associated with menopause. Ostensibly, her problem agenda is bio-medical in nature.

4.3.3.1. 'A reasonable patient' – the patient's line

From the outset of the consultation, and despite, or perhaps because of, her hidden anxieties and emotional difficulties, the patient strives to represent and sustain a version of herself as a 'reasonable patient' (Halkowski, 2006) who does not seek unnecessary tests or worry without cause. This is her 'line' (Goffman, 1967), the sort of person she wants to be seen to be in this encounter.

The patient's 'line' as a 'reasonable patient' is visible in the realisation of her opening request. By asking for a test for ovarian cancer, she risks casting herself as overly anxious or unduly attentive to her health. Further, as Gill and her colleagues suggest

[16] The greeting phase of this consultation was not recorded. The recording and transcript begin with the patient's reference to a screening test for ovarian cancer. A close reading of the transcript indicates that the patient had earlier referred to an acquaintance and fellow patient who had recently been diagnosed with ovarian cancer. It is likely that this segment was deleted from the tape by the participating doctor for reasons of patient confidentiality.

[17] As emerges during the consultation (turn 208) Paroxetene is primarily an anti-depressant that is also helpful in the treatment of hot flushes. The patient appears to be unaware of this.

(2001, p. 57) , in requesting such an intervention a patient risks being perceived as impinging on doctor's territory as it is doctors who assess the level of risk required to justify such interventions. Faced with such dilemmas the patient approaches her request obliquely, downplaying her commitment to seeking the test and leaving the way open for the doctor to refuse.

Extract 1 Consultation 1

1 P: And I was just wondering whether (.) do you think it's necessary for me to have it: o:r

By 'just wondering' she hedges any assumption that a test might be relevant and by manipulating tense to locate this wondering in the past she distances herself temporally from the act of conjecturing whether a test is needed or not. Further, what amounts to an indirect request for screening is formulated as seeking the doctor's opinion. With marked stress on 'you' she orients to the doctor as expert and to the business of assessing the relevance of a test as doctor's work. Thus, whilst putting the topic of screening on the table, she simultaneously attends to the doctor's face-needs by giving her a way out and represents herself as a good and reasonable patient who does not make any assumptions about whether a test is required.

This line or image of 'the reasonable patient' that the patient presents constitutes her 'face'; "the positive social value a person effectively claims for himself [sic] by the line other assume he [sic] has taken during a particular contact" (Goffman, 1967, p. 5). But as Goffman goes on to explain, face is not something that we *have*. It is not lodged in our body. Rather it is located in the flow of events and is sustained or enhanced or disconfirmed or lost in our interactions with others. Further, feelings are attached to face. If an encounter sustains our face, then we are unlikely to experience any feelings about the matter. If face is enhanced then positive feelings will result, but if the line we have taken appears to be threatened or disconfirmed, then uncomfortable emotions are likely to arise and the smooth harmonious interpersonal relations that constitute rapport are likely to be disturbed.

Thus, maintenance of face appears to be a condition of rapport, and in this consultation rapport is accomplished in part through the collaborative face-work that doctor and

patient do to sustain and protect the patient's line as a reasonable person who doesn't seek unwarranted interventions or worry unduly about her health. Such face-work together with other interactional strategies that protect and enhance subjective perceptions of harmonious interpersonal relations between patient and doctor, contribute to the gradual development of an interactional context that is conducive to the emergence of the patient's hidden concerns.

4.3.3.2. Sustaining rapport – attending to face sensitivities

From turn 4 the doctor takes on the task of disavowing the patient of the value of a screening test for ovarian cancer. Given the patient's 'line', and in light of the fact that she has brought along a reference to an article that appears to be about the dangers of late diagnosis and the importance of vigilance, this is a potentially face threatening act that requires delicate action if the smooth and harmonious relations that constitute rapport are to be sustained. As the following extract shows, actions that display the doctor's attentiveness to the patient's face sensitivities enable her to secure alignment over the matter of tests in a way that sustains rapport.

Extract 2. Consultation 1

1	P:	And I was just wondering whether (.) do you think it's necessary for me to have it: o:r
2	D:	um
3	P:	It's a blood test : and what other kind (.) what does it in in intail (.) entail
4	D:	Yea ::h I .hh ((sighs)) it's .hhh (.) screening for ovarian cancer is really not well(..) it's not established at all yet :
5	P:	Mm mm
6	D:	Um ((right hand gestures momentarily over the slip of paper on table)) there are some (.) well there's lots of articles out there and a lot of them are really misleading : (.) and (.) quite scary um there's some big ones that whiz around on the internet at times as well
7	P:	((nods, left hand slides from table edge to touch slip of paper)) °That was in the women's [weekly that I read that one°]
8	D:	[((nods)) Yeah] (.) um (0.3) so screening for ovarian cancer is not (.) really available (.) it's not like breast cancer or pap smears or (.) bowel cancer screening there's n:o(.) publicly accepted way of doing it:
9	P:	Mm

Across turns 2 and 4, a variety of speech perturbations including false starts, a sigh and intake of breath suggest that the doctor is experiencing some discomfort in addressing the topic of screening, an intervention that is advocated in the popular press but is not yet established practice within her profession. At turn 6, and mindful of the patient's face sensitivities, she deploys the 'negative politeness strategy' (Brown & Levinson, [1978] 1987) of generalising to mitigate the face threat involved in directly refuting the validity of the article that seems to have informed the patient's decision to seek a test. Speaking generally, she offers her 'evaluative line' (Goffman, 1967) regarding the plethora of information about ovarian cancer that circulates in the public domain, and through expressive lexical choices she displays her attitude to such material. By choosing the word 'misleading' she expresses her judgement on the veracity of many such articles and in her choice of the everyday lexical item 'scary' she alludes to the emotive impact of such material on readers and by implication on the patient herself. A fleeting gesture that momentarily focuses attention on the slip of paper on the desk accompanies this evaluation to imply, rather than state, that the article noted on the slip is encompassed by the doctor's assessment. Thus the doctor goes 'off-record', leaving the patient to infer that the article she has read may be unnecessarily frightening and misleading.

This 'off–record' politeness strategy that displays to the patient that the doctor is mindful of her face, and is, as a consequence, protective of rapport, successfully secures a response in which the patient herself acts to implicate her article in the doctor's evaluative assessment. At turn 7 the patient's unambiguous gesture establishes the slip of paper as a shared reference and her assenting nod displays agreement with the doctor's assessment. But her response goes beyond the nominal agreement that is accomplished by a nod to offer new information that appears to be consistent with the doctor's evaluative line. By identifying a popular weekly magazine as the source of her article, the patient provides information that supports the doctor's evaluation and occasions the doctor's reciprocal acknowledgement at turn 8. Through this three-part sequence of doctor assessment, elaborated agreement on the patient's part, and the doctor's reciprocating acknowledgement, doctor and patient display to each other that they are in alignment over the issue of misleading and alarming information that might prompt unwarranted testing. This alignment has been accomplished collaboratively in a

way that is protective of the patient's face and so sustains harmonious interpersonal relations.

Having achieved alignment with the patient over the matter of screening in a way that has sustained rapport, the doctor goes on to share professional reasoning that distinguishes between screening and diagnostic issues. At turn 16 she turns to the topic of the CT scan as a high risk intervention that is not recommended in the absence of significant symptoms. As the doctor introduces this topic into the discourse of the consultation, the direction of her gaze, in concert with sustained touch, functions to re-establish the slip of paper on the desk as a shared reference. In addressing this topic, the doctor is responding to a further item on the patient's agenda.

Extract 3. Consultation1

16	D:	((directs gaze towards slip of paper on the desk between doctor and patient. Left hand touches slip and remains there)) We wouldn't normally recommend that women have a CT scan (.) for no reason:
17	P:	Mm
18	D:	Because a CT scan is the equivalent of 40 X rays[18] (.) which is a lot :
19	P:	Mm
20	D:	You wouldn't (.) go and have forty X-rays and think nothing of it
21	P:	Right mm
22	D:	So ((removes hand from slip)) (..) there's not a lot of proof around > about how many CAT scans you can have in your life without increasing your cancer risk<
23	P:	((nods))
24	D:	but it's probably around two :
25	P:	Mm
26	D:	So it's not many (.) so you don't want to have a CAT scan (.) for no reason =
27	P:	= No

Notably, as she begins this sequence (turn 16), the doctor takes an authoritative stance, foregrounding an 'institutional identity' (Sarangi & Roberts, 1999b) to speak as a member of the institution of medicine rather than as an individual. Using the institutional 'we' she invokes institutionalised protocols that regulate practice and proscribe the use of CT scans, and in deploying this voice she aligns with the institution rather than with the patient to momentarily position the patient as an outsider. Arguably, this move, that emphasises the role-distance between doctor and the patient, could disturb rapport. But in ensuing moves, as the doctor builds her case against unwarranted use of these scans, she simultaneously acts to decrease distance and to strengthen

[18] This statistic was contested by one examiner in written feedback to the candidate

solidarity with the patient. Across turns 18 to 26 she engages with the patient to share the professional knowledge that informs protocols restricting use of CT scans. At turn 20, through choice of the ambiguous plural pronoun 'you', she includes the patient amongst people in general, including herself who would not unthinkingly subject themselves to such a high level of radiation. This action obtains an up-scaled agreement, token from the patient, 'Right mm' (turn 21) that displays a 'change of state' (Heritage, 1984a) at this new-found information as well as understanding of its valence and weight. Finally, at line 26 in an upshot to her argument, the doctor again deploys the ambiguous pronoun 'you' to include the patient amongst those who would not want to have an unwarranted test.. "...so you don't want to have a CAT scan (.) for no reason = " . Arguably, this utterance can be seen to appeal to the patient's line as a reasonable person. At turn 27 with a latched emphatic, unmitigated agreement response the patient accepts and upholds this image of herself to align with the medical position.

Rapport is a dynamic process involving participants' changing perceptions of harmony or disharmony, warmth or antagonism, smoothness or turbulence in interpersonal relations (Spencer-Oatey & Franklin, 2009). Up until this point in the consultation, harmonious relations have been sustained and this has been achieved in particular by the doctor's attention to the patient's face sensitivities. As the consultation continues to unfold rapport appears to strengthen and this is accomplished through interactional sequences that display collaboration and involve mutual affiliation.

4.3.3.3. Strengthening rapport – a collaborative sequence

By turn 32, doctor and patient are in alignment over the issue of tests and the doctor moves to initiate topic change. By redirecting her gaze to focus on the patient's face and reorienting her body to align with that of the patient, she increases engagement and signals a shift in frame to the history of presenting symptoms phase. At turn 32, the doctor's command-like utterance, "So tell me what symptoms you're worried about", conveys a personal as well as professional interest in the symptoms that have prompted the patient's visit and initiates a sequence of turns (33-38) in which doctor and patient collaborate to co-construct a symptoms list.

Extract 4. Consultation1

32 D: ((Directs gaze momentarily towards computer screen. Redirects gaze to patient's face and resettles body in seat to align with patient)) So tell me what symptoms you're worried about
33 P: Well (.) um (.) bloating for a start
34 D: ((nods))
35 P: And problems going to the toilet like (.) um
36 D: Constipation:
37 P: Constipation :
38 D: Bowels : ((nods))

Notably, at turn 35, minor perturbations including a pause followed by 'um', interrupt the patient's turn construction unit to indicate that she is searching for a word to describe her symptoms. In response, at turn 36, the doctor engages in this word search activity to propose a solution. Rising intonation specifically marks the doctor's suggestion as uncertain and this is in keeping with the clinical imperative to avoid presupposing a patient's symptoms. But it also marks the doctor's contribution as helpful and collaborative rather than intrusive. In response, at turn 37 the patient mirrors the doctor's suggestion to acknowledge her assistance in the word search and to accept her contribution as correct. Such collaborative work in ascertaining the patient's symptoms is purposeful and allows the consultation to move forward. But it also contributes to the participants' perceptions of co-operation and harmony, and such subjective perceptions of harmonious interpersonal relations are indicative of strengthening rapport.

4.3.3.4. Strengthening rapport – mutual affiliation

The collaborative co-construction of the patient's symptoms across turns 32-38, has been realised in a business-like and matter-of-fact way. From turn 41, however, doctor and patient disengage momentarily from the standard proprieties of the medical interview to construct an 'affiliative troubles-telling' sequence (Jefferson, 1988) that constitutes a move towards increased intimacy.

Extract 5. Consultation 1

41	P:	And I've been taking what the um molycol and normacol I'm sick of dosing it $ into my (hh)self all the time.
42	D:	Ye::ah
43	P:	That's why I was a little bit late [so I thought I've got to go] but when I go
44	D:	[O::h::::::::::::::::::::::::::::::::]
45	P	I do a certain amount [but it's just not emp]ty ;and I'm still horr[ible
46	D:	[O::h::::::::::::::::::::::] [ok
47	P:	Yeah [(inaudible)

At turn 41, the patient engages in talk that is expressive of negative affect towards the medication that she must take. "I'm sick of dosing it $ into my (hh)self all the time". This emotionally heightened talk evokes the doctor's affiliative stretched acknowledgement token (turn 42) and this in turn occasions a shift to a troubles-telling frame that puts the interaction onto a more intimate footing. The patient's confiding telling of her uncomfortable experience with constipation (turns 43,45) positions the doctor as troubles recipient and obtains elongated o::h assessments in response (turns 44, 46). As Jefferson points out (1988) such o::h assessments realise movement from distance to intimacy and, in this case, a move away from professional neutrality towards mutual affiliation. There is a consequent shift in alignment as together doctor and patient focus on the patient's trouble in its own right rather than as a medical symptom and object of purely clinical interest. Such a sequence appears to heighten perceptions of interpersonal warmth between doctor and patient and in so doing strengthens and enhances rapport.

This intimate affiliative sequence is momentary, and from turn 48 the doctor re-invokes a professional voice to return to the business at hand and engage with the topic of the patient's medical history. But communication is a cumulative and progressive activity, and the heightened perceptions of interpersonal warmth that have been accomplished through this brief sequence are carried along to contribute to a developing interactional context that is conducive to the emergence of the patient's as yet unvoiced emotional concerns.

4.3.3.5. Protecting rapport – on-going attention to the patient's line

As Spencer-Oatey and Franklin point out (2009) managing rapport involves continuing interpersonal attentiveness to face sensitivities through continuous monitoring of

interaction, and this includes on-going attention to the image that the other participant strives to present. As this consultation moves forward, at various points and in a number of ways, the patient acts to uphold, and the doctor to protect, the patient's view of the kind of person she wants to be seen to be. One subtle way that this is accomplished is through 'collaborative interruptions' (Goldberg, 1990) or perhaps more aptly 'collaborative completions' (Lerner, 1996) of the patient's turns.

Consider the following extract that begins as the doctor is consulting the patient's medical records so as to ascertain the medical history related to her presenting symptoms.

Extract 6. Consultation 1

56	D:	((lowers head to read files across turn)) So::: just having a look back you have seen doctor Nelson about your bowels over the years :
57	P:	Yes and when I had my last colonoscopy he said he didn't need to see me unless I [had
58	D	[yeah
59	P	Unless I saw (.) blood (.) So you know as I said I don't want to be alarmed (.) I don't want to have to [have things done if I [don't need it
60	D	[no [you don't need it (.) right

Note that at turn 60 the doctor produces an almost identical utterance in chorus with the patient: 'you don't need it'. She is attuned to the patient's view of herself as someone who is not an alarmist and doesn't seek tests unnecessarily. She displays this through anticipating what the patient is about to say and collaborating with her to complete her turn by a sympathetic over-lapping and shadowing of her talk. In this way, she aligns with, and ratifies the way the patient wants to be seen. This supportive, collaborative alignment appears to be one way in which the patient's line is acknowledged and protected and, as a consequence rapport is maintained.

A few turns later, however, an incident occurs that challenges the patient's line and thus threatens her face. As the patient acts defensively to defend her image and protect her face, rapport is in danger of fracturing. Momentarily, doctor and patient are in a state of 'ritual disequilibrium' (Goffman, 1967, p. 19). At such a critical moment 'corrective face-work' (Goffman, 1967) needs to be done to re-establish rapport and to restore equilibrium so that the interaction can proceed.

Over a number of turns that precede this sequence (63-67), the doctor has gone on to share the clinical reasoning that would lead her to attribute the patient's symptoms to the existing condition of slow transit colon constipation and to discount ovarian cancer as their cause. The doctor concludes this sequence with a reassuring coda "So the ovarian cancer(.) your level of worry about it should ease : ok : and then moves to shift topic: "Now let's just have a look at..."

Extract 7. Consultation 1

69	D:	So the ovarian cancer (.) your level of worry about it should should ease : ok : now lets just have [a look at
70	P:	[I'm not really worried about it [I'm not worrying
71	D:	[No but it's something as women : (.)
72	P:	↓Yes

But at turn 70, the patient interrupts the doctor to reject the implication that she is 'a worrier': "I'm not really worried about it". Face is at stake and, as a consequence, rapport is uncertain as the patient perceives that her version of herself as someone who does not worry unnecessarily is disturbed. This moment of disequilibrium requires direct attention and the doctor moves swiftly to mitigate the potentially face-threatening incident with face-work. In using the 'in-group identity marker' (Brown & Levinson, [1978] 1987, p. 107) 'as women'... she aligns with the patient as a co-worrier, implying that for women, including herself, to worry about ovarian cancer is reasonable. At line 72 the patient picks up the inference and agrees adamantly with an emphatic ↓Yes realised with sharply falling pitch. Her line as a reasonable patient is sustained. Rapport is protected and indeed strengthened by the doctor's inference that she shares in the experience of anxiety over cancer. Equilibrium is restored and the consultation can move on.

At this point in the consultation, the patient's agenda of presenting concerns has largely been addressed. Doctor and patient are in alignment over the issue of a screening test and CT scan and this alignment has been accomplished in a way that has sustained rapport. Whilst the doctor has offered a qualified, hedged undertaking to consider what diagnostic tests might be warranted in the patient's case: "I'm happy to sort of have a look at what tests you should have but (..) the symptoms that you've got (.) have been

explained (.)..." (turn 67), she has then gone on to share clinical reasoning that would attribute the patient's symptoms to the pre-existing and benign condition of slow transit colon constipation.

By turn 104 where the following extract begins, the patient's concern about ovarian cancer has been put to rest and the way is open for as yet unvoiced emotional issues to surface. Through the development and maintenance of rapport an atmosphere of interactional harmony has been created that is conducive to the emergence of such concerns, and as close analysis of the ensuing discourse shows, the accomplishment of empathy plays a central role in this process.

4.3.3.6. Towards disclosure of emotional concerns – the role of empathy

As this extract begins, the doctor's 'all right' prefaced utterance (turn 104) functions pivotally to close off the previous topic of ovarian cancer and to point the way forward to concerns that have not yet been articulated. This pivotal shift in focus is reinforced semiotically as the doctor redirects her gaze away from the computer and withdraws her hand from the slip of paper on the desk, actions that signify a move away from the patient's voiced agenda of physical problems. These moves trigger a shift in 'frame'(Goffman, [1974] 1986; Tannen, 1993) as the patient tentatively introduces the topic of panic attack into the discourse (105).

Extract 8. Consultation 1

104	D:	All right ((redirects gaze from computer screen to patient's face, reorients upper torso towards patient, placing hand on top of the slip)) so how are you apart from that ((withdraws hand from the slip)) that's one worry
105	P:	Um pretty good but : ((fall rise tone)) you know when I came last time I told you I had (.) you said I had you thought I had a panic attack :
106	D:	Yeah ((fall rise tone)) ((sits back from the desk, takes hands off paper records and places them on lap, focuses gaze on the patient))
107	P:	And I still sort of get that feeling (.)# inside : h ((shrugs shoulders))
108	D:	((leans forward elbows on desk and hands cupping her face))
109	P:	[((shrugs shoulders again))]
110	D:	[It's a rotten thing °rotten°]
111	P:	.hh
112	D:	Tell me about the feeling
113	P:	(..) ((indicates chest)) Um # seem ok during the ## day
114	D:	Yeah
115	P:	But when I get into bed at night not relaxed # # it ° sort of goes chooooo

((gestures to indicate fluttering feeling over chest and abdomen)) ((slight shrug))

116 D: What's your head doing in that time

117 P: (.) That seems to be ok just sort of ((pats stomach and chest)) in here sort of thing ((shifts posture quickly in seat))

118 D: So is your heart beating strangely ((enacts beating gesture across own heart))

119 P: A little bit yeah

120 D: mm

This sequence constitutes 'a critical moment' (Candlin, 1987) in the consultation, a moment when emotionally sensitive and clinically significant information is being gingerly broached by the patient and where an insensitive response on the doctor's part could lead to her retreat. At turn 105, the patient raises the topic of panic attack obliquely as a reported concern that she attributes to the doctor rather than as her own assessment of her symptoms: ...you said I had you thought I had a panic attack : . In this way she works to distance herself from ownership of the condition.

From the perspective of medical educators participating in this study, this is a moment where the direction of the consultation could turn.

> Extract 1. Medical Educators' Workshop [19]
> "The risk here for the doctor I think is going down the diagnosis pathway and saying 'yes I think you had a panic attack (.) this is a panic attack' (.) but ... this doctor doesn't do anything other than leave an opening to go on ... concentrates on the feelings and this allows progression".

As this educator notes, the doctor's attentive silence and bodily actions (turn 106) encourage the patient to continue. At turn 107, she offers her symptoms vaguely, tentatively hedging their certainty with the particle 'sort of'. Apologetic shrugs, pauses, voice quavers and intake of breath are visual and vocal perturbations that appear to underline her conversational discomfort with the topic.

In response, the doctor acts empathically to acknowledge the patient's discomfort by heightening her engagement, reorienting her body towards the patient and intensifying her gaze (106, 108). Then, as the patient shrugs apologetically once more (109), the

[19] As described in Section 2.3.4.5, the research methodology for this study included a number of collaborative workshops in which the researcher, her principal supervisor and practitioners engaged jointly with the researcher's analysis so as to incorporate professional perspectives into the analysis and to consider the relevance of findings to practice. This extract is from one such workshop.

doctor transforms the patient's downgraded assessment of her experience with an utterance that seems to resonate with its true intensity, "It's a rotten thing, rotten"(110). With a small intake of breath (turn 111) the patient receipts and acknowledges this assessment. This accurate, empathic formulation by the doctor, resonant with feelings that the patient was unable or unwilling to voice, displays both cognitive understanding of the quality of the patient's experience and emotional engagement. It achieves 'emotional resonance' (Halpern, 1993) and functions to diffuse the patient's embarrassment and discomfort. The patient's experience is now out in the open as a matter that can be interpersonally but professionally discussed.

From turn 112, there is a consequent shift in frame to franker discussion. Once again the doctor deploys a command-like utterance, "Tell me about the feeling" that is hear-able as a personal request and displays a personal as well as professional interest in the patient's symptoms. This occasions a response in which the patient provides a more detailed clinically useful description of her symptoms. It ushers in a series of more focused diagnostic questions and responses through which the character and intensity of her experience of panic attack begins to emerge.

From this extract, it can be seen that clinically effective empathy is not simply about perceiving, appreciating and expressing understanding of a patient's feelings, as noted by the medical educator quoted below.

> Extract 2. Medical Educators' Workshop
>
> I was just thinking about your analysis of the elements that flesh out empathy. There's no one single point where the doctor has done the single empathic thing (.) there's a set of behaviours that involve language, posture, silence...

Nor is effective empathy circumscribed by a three-part interactional sequence involving a patient initiated empathic opportunity, an empathic response on the part of the doctor and the patient's receipt of this response. Effective empathy is cumulative and consequential and, particularly in cases such as this, empathy has clinical work to do. As Beach and Dixson (2001) also found in their study of a health appraisal interview, formulations that articulate feelings that the patient has been unable to explicitly voice, together with the interactional consequences of such formulations, are one set of resources that doctor and patient deploy to put the interaction onto a new footing so as

to accomplish a gradual transition to increasingly delicate topics, such as debilitating panic attacks and, as emerges later in this consultation, significant depression.

4.3.3.7. Effective empathy –a multi-modal accomplishment

Further, as the sequence analysed above also illustrates, human action, including that of empathy, is accomplished by the simultaneous deployment of a range of semiotic resources. As Kendon points out (1986, p. 4) "... in interaction we do more than form strings of words. We also employ our bodies in visible actions that have an indissoluble connection with what is said". In this interaction, gaze, body orientation, posture and gesture function in concert with wording to intensify engagement with the patient at critical moments.

Gaze and body orientation are interrelated and the body can be seen as an organisation of segments each of which can be oriented in different directions. It is the lower segments of the body that is to say the legs and torso that are relatively more stable and so more strongly communicate participants' frames of dominant orientation with the action going on and with each other (Kendon, 1990; Mehrabian, 1967). In this consultation, as in all PBA consultations examined in this thesis, the doctor is engaged with both the patient in person and 'the patient inscribed' (Robinson, 1998) in computer records and files. In some consultations studied, including consultation 2 to be discussed later in this chapter, the doctor's engagement with records is often accompanied by dominant body orientation towards the computer. Doctors may turn their gaze towards the patient periodically, but legs and torso squarely front the desk. This communicates the doctor's dominant engagement in the impersonal, non-collaborative action of dealing with records.

However, this doctor, rated highly on the parameter 'communication and rapport' and considered by her examiners to be particularly empathic, frequently enters records with her right hand whilst legs and torso continue to align with those of the patient. Often, this body orientation is maintained as she reads records as well. Her body alignment consistently communicates that she is in interpersonal contact with the patient and poised for mutual talk.

Figure 4: Poised for mutual talk

Then, at critical moments she moves strategically to intensify her engagement with the patient. For example, at turn 106 through a series of inter-related actions she signals readiness for full collaboration with the patient in person, repositioning her body away from the desk, realigning head and torso and focussing her gaze on the patient's face. This engagement is intensified further from turn 108 as she leans forward, cupped hands framing her gaze.

Figure 5: Re-aligning (turn 106)

Figure 6: Intensifying engagement (turn 108)

It is these semiotic actions that herald and accompany her crucial empathic reformulation of the patient's experience, intensifying its impact and enabling the patient to present relevant but emotionally sensitive information for the purpose of diagnosis.

Yet, at this point in the consultation, the full extent of the patient's emotional and psychological difficulties has not yet been made accessible to the doctor. Gradually, as

this consultation continues to unfold, doctor and patient collaborate to produce delicate moments that reveal more about the patient's emotional experiences. These sequences cumulatively and progressively contribute to a more detailed picture of her symptoms and thus to the achievement of a mutual understanding about the true nature of her condition.

4.3.3.8. Effective empathy – accomplishing emotional release

Across a number of turns leading up to the sequence set out in extract 9 below, the patient has struggled against loss of emotional composure (See extract 8). Voice quaverings and dysfluencies such as reduced grammatical forms involving the omission of subject pronouns (113, 115) have betrayed her efforts to conceal her distress as she responds to the doctor's diagnostic questions.

113	P:	(..) ((indicates chest)) Um # seem ok during the ## day
114	D:	Yeah
115	P:	But when I get into bed at night not relaxed # # it ° sort of goes chooooo ((gestures to indicate fluttering feeling over chest and abdomen)) ((slight shrug))

At turn 115 she substitutes words with gesture to visually display her symptoms in a 'descriptive and verb like' way (Beach & LeBaron, 2002, p. 624) in what appears to be an attempt to avoid speech so as to maintain composure and emotional control.

But from turn 124 there is a shift to more explicit emotional talk in which the patient at first describes and then displays tearfulness that is indicative of her level of sadness and is as a consequence of therapeutic and clinical significance. This shift in frame is occasioned by a collaboratively produced empathic sequence, initiated by a gesture from the patient that offers a clue to her bewilderment and concern.

Extract 9. Consultation 1.

124	D:	But the ECG's just looking at what it's doing (.) <u>then</u> so (.) we can(...) just just tell me more [cause
125	P:	[((patient shrugs in bewilderment))
126	D:	((left hand stretches out towards the patient, palm open and fingers splayed)) You look worried like you're
127	P:	((left hand stretches out towards doctor palm open and fingers splayed))Um (..) I try not to think about it and I try not the tears when I talk the tears come um I

don't know ((shakes head)) ##I don't (.) I just sort of get all ((gestures over stomach and chest)) and I thought when you get into bed you should be relaxed :

128 D: ° yeah°

129 P: And um I just sort of hh (.) I don't know I sort of feel like everything's jumping around inside : It's all (.) and ((shrugs))# I don't know (.) I suppose ##I don't know and #I don't know if it's nerves or what it is (.) ### I don't know

130 D: What are your nerves like at the moment

131 P: ((shrugs)) um (.) ## I'm fine most of the time and I think it's just um >when I was here last time I told you about< the dog [it's sort of been since then

132 D: [°yeah°

133 P: And I don't know if that's what it is (.) I think that's what's brought it on :

134 D: °Yeah°

135 P: ((crying)) # ## and I'm trying to get over [it but I'm not :

136 D: [o:h ((doctor reaches for tissues, takes two and hands them to the patient))

137 P: ((takes tissues, sniffs)) ## I'm sorry ((dries eyes with tissue))

Note that at turn 124 the doctor again deploys a command like question, mitigated by 'just' that serves both to encourage elaboration and to communicate personal interest in the patient's symptoms: ".....just just tell me more..". Whilst the doctor's invitation to talk obtains only a bewildered shrug in response, this action in turn evokes an empathic response on the doctor's part that is enhanced semiotically by the accompanying open-handed gesture with which she reaches out to the patient (126). At turn 127 the patient receipts this response with a mirroring gesture that is a recognisable 're-performance' (Beach & LeBaron, 2002, p. 625) of the doctor's action and is thus expressive of strong affiliation.

Figure 7: An affiliative re-performance (Turns 126&127)

This co-constructed empathic sequence is effective and consequential and evokes the patient's disclosure of the delicate matter of the tearfulness that comes when she talks about her symptoms (turn 127).

Note also the patient's self repetition of the phrase "I don't know" (turns 127, 129, 133) that constitutes a coherent theme across this sequence. Repetition is evaluative and expressive of attitude (Labov, 1972; Tannen, 1989) and the evaluative effect of this accumulation of repeated phrases, accompanied by voice quavering, shrugs and head shakes that signify increasing distress, is to emphasise the intensity of the patient's bewilderment at her symptoms and their cause. Across this sequence the doctor responds with softly voiced acknowledgement and agreement tokens (128, 132, 134) that display empathic attentiveness and so encourage the patient to continue.

At turn 131 in an elaboration of her response to the doctor's question about her nerves the patient refers to the death of the family dog. She goes on to associate this event with the onset of her symptoms so as to offer an account for their cause (133). The emotive topic of the dog that the patient herself has introduced triggers a reaction that occasions her emotional release and at turn 135 the patient begins to cry.

In a consultation in which the patient has worked to at first conceal and then control her underlying emotional distress, this tearful release is a moment of clinical significance that makes available to the doctor signs that are indicative of the patient's level of sadness. It is also a moment of interpersonal significance occasioning the doctor's display of sensitivity to the patient's tearfulness as she extracts tissues from the box and offers them to her (turn 136).

But there is 'no time out from a medical encounter' (Beach & LeBaron, 2002, p. 627) and this is also a moment when doctor and patient collaborate to attend to the patient's loss of composure so that the consultation can move on. At turn 137 the patient responds to the doctor's offer by accepting the tissues with an apology and drying her eyes in a move to regain composure and to re-establish equilibrium. Equilibrium thus seemingly restored, the doctor can resume the clinical business of the consultation. At turn 138 as the patient continues to dab at her eyes, the doctor pursues her medical agenda with a question to ascertain the lapse of time since the death of the patient's dog.

138 D: ((leans forward on elbow, re-focuses gaze on patient's face)) Well how long (.) < my dog's been dead ten years and I couldn't really talk to you last time about it>

In formulating this question the doctor momentarily invokes a personal identity as she refers to the death of her own dog, but this is also a medically relevant question as length of time since loss is considered to be of significance in differentiating between normal grief and the onset of depression. It initiates the collaborative construction of a narrative that opens a window into the patient's life-world and provides clinically significant information about the central place of the family dog in her life. The doctor's empathic responses and affiliative acknowledgements play a central role in this co-construction.

4.3.3.9. Collaborative construction of a life-world account

The following extract begins with a brief three part empathic sequence triggered by the patient's projected self talk that she must get over her grief (turn 145).

Extract 10. Consultation 1

145	P:	I just thought I've got to get over it
146	D:	It's hard though
147	P:	Mm and I thought well I don't know if it's that (..) probably
148	D:	Would the dog've normally been inside with you in the evening : so when you go to bed (.) where would the dog've been
149	P:	Um in her bed by the side of the bed :
150	D:	Ye:::ah (rise fall tone) ((laughs [gently))
151	P:	[((laughs gently)) And then when she wakes up in the night she jumps up and she'd get in between us
152	D:	((leans forward smiling))
153	P:	And at the moment her ashes are on the bed-head
154	D:	O::h ((rise fall tone)) so
155	P:	And I took her away with us
156	D:	((buries head in hand momentarily)) Oh dear :
157	P:	Because she was used to coming away with us
158	D:	°oh°
159	P:	Cause once the girls left home : =
160	D:	= Yeah
161	P:	Well we found places where we could take her
162	D:	Yeah
163	P:	And when we stopped with people we know >yeah she could come in you know< and yeah she's one of the family sort of thing
164	D:	Ye::ah
165	P:	And I gather that's what it probably is
166		(2.0)
167	D:	It's probably a lot of it
168	P:	Mm

In response to this self talk the doctor offers an empathic assessment that communicates understanding of what it would be like to be this patient as she struggles to deal with her loss (turn 146). With a minimal agreement token (147) the patient receipts this assessment as an accurate reflection of her struggle, extending her response to again offer the dog's death as the likely cause of her symptoms.

Within this context the doctor moves to seek insight into the place of the dog in the patient's world with a question about where the dog slept (148) and at turn 149 the patient responds with the news that the dog slept by her bed. Note how this response is delayed slightly by 'um' and completed with rising intonation that appears to seek approval. Arguably, disclosure of this practice that may not be received favourably by the doctor is potentially face threatening for the patient.

Orienting to this face threat, the doctor responds with a stretched acknowledgement token (turn 150) realised with a rise fall tone that is strongly affiliative. The gentle laughter that accompanies this token can be seen to function as a 'positive politeness strategy'(Brown & Levinson, [1978] 1987) that recasts this potentially face threatening news as amusing and is designed to set the patient at ease. It invites and obtains the patient's shared affiliative, over-lapping laughter in response (turn 151) to create an atmosphere of interpersonal warmth that enhances rapport

Findings from other studies of medical interviews (Haakana, 2001; West, 1984) suggest that doctors usually refrain from initiating or reciprocating laughter and in so doing sustain a professional over a personal identity. In those studies, laughter was found to be generally initiated by the patient and usually to deal with delicate aspects of the interaction such as where a patient has to portray themselves momentarily in an unfavourable light. But in this consultation, where the cumulative accomplishment of empathy and the maintenance of rapport plays a crucial role in the gradual emergence of delicate concerns, affiliative doctor initiated laughter heightens perceptions of interpersonal warmth between patient and doctor to contribute to an interactional context that enables the patient to disclose further intimate details from her life-world.

At turn 151, and within this atmosphere of warmth, the patient elaborates on her initial response to disclose that the dog slept in the marital bed. Then, across a series of turns (152 -163) affiliative vocal and behavioural responses on the doctor's part, including forward postural lean (turn 152), elongated oh assessments (154), oh prefaced assessments (157), and stretched acknowledgement tokens (164), evoke further elaborations through which the patient reveals increasingly delicate details about the role of the dog in her life. This narrative from the patient's life-world, constructed collaboratively through the doctor's affiliative responses and the patient's consequent elaborations, constitutes a resource for both doctor and patient in considering the part grief may play in the patient's condition. At turn 165, in an upshot to her narrative the patient reaffirms her view that grief at the loss of her dog is the probable cause of her symptoms: "and I gather that's what it probably is". This line of reasoning is considered by the doctor in a long pause and acknowledged at turn 167: "It's probably a lot of it". But marked stress on 'a lot' implies that there are other causes as well and the patient acknowledges this minimally at turn 168.

4.3.3.10. Towards common ground –aligning lay and professional reasoning

Throughout this consultation, the patient has drawn upon lay reasoning to account for the disturbing symptoms that she is experiencing and to discount psychological causes. Earlier (turn 121) she had alluded to the possibility of heart arrhythmias as an explanation for symptoms of anxiety and at this stage in the consultation she attributes her tearfulness to grief over the loss of her dog. Consistently, the doctor attends to and acknowledges the patient's reasoning. At times, as evidenced by her assessment at turn 167 above, she incorporates the patient's reasoning judiciously into her own to display a qualified alignment with the patient's perspective.

At other times she strategically includes the patient in the clinical reasoning process so as to bring the medical perspective to bear on the patient's accounts and to put unwarranted concerns to rest. In this manner she clears the way for a gradual progression towards shared understanding of the nature and scope of the patient's psychological condition. Consider the following sequence in which the doctor attends to

the patient's concern that her experience of heart palpitations may have a physical cause.

Extract 11. Consultation 1.

169	D:	((directs gaze towards computer screen momentarily)) That last ECG looked fine but ((returns gaze to patient's face)) if you're not having the symptoms at the time (0.2) then I can't comment on what your heart [rates doing
170	P:	[the last what looked fine sorry :
171	D:	Your ECG
172	P:	ECG I thought you said CT [and I thought
173	D:	[No (.) we can do a holter monitor(.) so that stays on you over night so when those jumpy horrible feelings are there actually looking at the electrical activity of your heart (.) and looking at your symptoms and saying well it's either your heart jumping around (.) or it's not (.) and that will set your mind at ease (.) about that
174	P:	Mm
175	D:	((leans further forward focusing gaze on patient)) But the other issue is dealing with your level of (.) sadness I think ° at the moment°
176	P:	((patient nods almost imperceptibly))
177		(3.0)

Turn 169 marks a sharp shift to a bio-medical 'frame' (Goffman, [1974] 1986; Tannen, 1993). As the doctor attends momentarily to the patient's computerised medical records, she invokes a 'professional voice'(Roberts & Sarangi, 1999b) to reintroduce the topic of heart palpitations into the discourse. Foregrounding a professional identity, she speaks as a doctor to share professional knowledge and clinical thinking with the patient. A Holter monitor will investigate the possibility of an underlying bio-mechanical cause for the patient's palpitations which the doctor considers unlikely. In a long turn (173) this procedure and the clinical reasoning that informs it is shared collaboratively with the patient as a measure that will address and in all likelihood allay her fears. At turn 174, with a minimal response the patient receipts this reassuring information. The way is open for consideration of other matters.

The doctor's next contribution to the interaction is 'recipient designed' (Candlin & Candlin, 2002a; Drew & Heritage, 1992). It is carefully placed and carefully constructed to match and benefit from the patient's perceived new state of readiness to engage with deeper psychological issues. At turn 175 the doctor intensifies her engagement with the patient, leaning forward and refocusing her gaze to reinstate a more personal frame. Through choice of the high affect word 'sadness' over the

technical terms 'mood' or 'depression', and through speaking softly she invokes a more personal voice that is expressive of increased intimacy. This particular contribution at this particular moment obtains in response the patient's barely perceptible nod (176) that together with the prolonged shared silence to follow (177) appears to indicate the patient's deepening readiness to engage with an exploration of the level of her mood.

4.3.3.11. Greater openness – an unsolicited narrative account

A few turns later, and against this backdrop the patient reintroduces the topic of panic attack into the discourse. In a significant departure from her early guarded and hedged reference to such an experience (turn 107) she volunteers an extended, elaborated narrative account that dramatises a similar experience whilst on a recent holiday with her husband.

Extract 12. Consultation 1.

193	P:	When we were away stopping in someone's place we hadn't been there before I mean we knew the people (.) we were in a room and we sort of closed the door and we couldn't open the window : and I felt like sort of all closed in
194	D:	O: h
195	P:	And I was sort of saying to myself I need some air (.) he got up and he's fanning the door to get some air and I thought oh don't tell me it's another one of those coming again but it sort of (.) went away and I haven't had any more of those but I've I get these other feelings
196	D:	Those kind of (.) as if it could (.) escalate into :
197	P:	That's what I think it could happen yeah as I said it's just (.) and I thought I don't know if it's because my tummy's all upset because of not being able to go to the toilet if that's had anything to do with it if that had anything to do with it it would happen all the time (.) wouldn't it (.) you would think
198	D:	Yeah and it shouldn't just come on at night [time and when you lie [down
199	P:	[Yeah [yeah

Notice the projected clauses (195) through which the patient incorporates inner speech from the life-world context of her experience into the discourse: " And I was sort of saying to myself I need some air..... and I thought oh don't tell me it's another one of those coming again". As Tannen suggests (1989), such projections are to be understood, not as accurate reportings of what the patient said or thought to herself at the time of her panic attack, but rather as 'constructed dialogue' (p. 119) designed for effect and to make meaning in the here and now. By deploying this strategy the patient dramatises

and invokes imagination of her experience of panic attack in a manner that stands in marked contrast with her earlier, oblique, mitigated introduction of the topic (turn 107). Further, whilst displaying a new openness to frank discussion of her symptoms, this extract also illustrates the patient's increasing willingness to incorporate the clinical perspective into her reasoning about their cause. At turn 197, in light of her own bio-medical like reasoning about the sporadic occurrence of these attacks, she revises her initial thinking to set aside chronic bowel problems as a contributing factor. At turn 198 the doctor collaborates with the patient to acknowledge and extend this line of reasoning by offering the additional observation that the restriction of these attacks to night time would exclude such a cause. With overlapping and repeated agreement tokens (199) the patient aligns with this perspective. Across this sequence doctor and patient have collaborated in the diagnostic reasoning process.

Yet still, the full extent of the patient's experience of anxiety and depression remains hidden. As the consultation proceeds, and as the doctor consults the patient's medical records and takes her pulse, the patient continues to invoke bio-medical causes, such as menopause, to account for her symptoms and continues to minimise psychological causes (See turns 227 – 243 of full transcript). Further, she continues to be evasive about the pervasiveness and frequency of the episodes of anxiety and tearfulness that she is experiencing. How is this elusive information that is crucial to an accurate diagnosis of the patient's condition to be brought into the discourse?

By turn 249 where the final extract begins, the doctor has attended to the medical and administrative tasks of taking the patient's pulse and updating the patient's records on the computer. This done, she moves to re-engage with the patient in person so as to seek out this information.

4.3.3.12. Disclosure

Extract 13.Consultation1.

249 D: ((removes hand from patient's wrist)) That's good ((types into computer)) how often do you feel ((turns away from computer whilst gesturing towards her own heart and touching her chest)) (0.3) ((directs full gaze on patient's face)) churned up

250 (0.5)
251 P: # It didn't sort of happen last night :
252 D: ((nods slowly and sustains gaze on patient's face over next turn))
253 P: And it sort of happened (..) it's (..) we've been home (.) a week and a bit (.) it's happened a few times since I've been home (.) because I made this appointment to see you before I went away because I knew it'd be a while before I could get in and I thought well (.) I'm going to speak to you about it
254 D: Yeah ((leans forward towards patient, leans on elbow supporting face in her hand))
255 P: Because I've been sort of upsetting me :
256 D: Yeah
257 P: What about in the day time (.) how often do you feel a bit (..) teary or sad
258 D: (0.3) ((twisting tissue in hand)) # ° a couple of times °
259 D: A day :
260 P: ((nods)) .hhhh
261 D: (1.0) ((gazes at patient's face)) You have to dra::g it out of you (.) why don't((leans forehead into hand then raises face to gaze at patient's face)) uuhh :
262 P: .Hh hhh ((begins to cry, takes off glasses)) ## sometimes ## it [just comes out]
263 D: ((extracts two tissues from box and hands them to the patient))[It's rotten (.) it's absolutely rotten]
264 P: ##I don't know why I'm doing it =
265 D: = yeah

At turn 249, as the doctor shifts posture to disengage from the computer and re-engage with the patient, she simultaneously gestures towards her own heart and touches her chest.

Figure 8: empathic self touch (turn 249)

Typically, it is patients who self touch during medical interviews as an adjunct to or substitute for verbal description of their symptoms (Heath, 2002). But in this consultation (See also turn 118), as in the study of a medical appraisal interview conducted by Beach and LeBaron (2002), self touch on the doctor's part functions to

display empathy as the doctor registers on her own body the symptoms that the patient had previously described.

Further, in referring verbally to these symptoms the doctor chooses to use the metaphorical expression 'churned up' over a less marked 'core vocabulary' item (Carter, 2004) such as 'anxious' or 'upset'. As Carter points out (p. 117) such expressive metaphors lend 'an affective contour' to what is being said and are thus expressive of greater intimacy and intensity. Here, the doctor's empathic self touch, gaze and body orientation as well as expressive lexical choice combine to accomplish increased interpersonal engagement between doctor and patient at this sensitive moment.

The impact of this contribution from the doctor is evident in the significant moment of silence that it evokes and that the doctor allows (250), and in the quavering, cracking voice quality that accompanies the patient's hedged, evasive response (turn 251). At this critical moment, the doctor refrains from speech. Once again at a critical moment (See also Extract 8), she makes use of attentive silence to encourage further disclosure, a feature of effective empathic communication that educators participating in this study consider to be a marker of experience and expertise.

> Extract 3. Medical Educators' Workshop
>
> "She uses silence. I mean there's just a resounding silence ... to me that just reeks of someone who's learned from experience that you don't rush in (.) you let it run for awhile'

Encouraged by the doctor's slow attentive nod and sustained gaze (252) the patient tentatively elaborates, at first hedging: " and it sort of happened", and then disclosing that she had experienced symptoms of anxiety 'a few times' in a little over a week (253). Interestingly, the patient also discloses that this matter has been on her mind for some time. It is an agenda item that she had intended to discuss with the doctor. Yet, up until this point in this long consultation, the pervasiveness, intensity and frequency of her symptoms have remained hidden.

At turn 257 the doctor continues to pursue her medical agenda with a diagnostic question about the frequency of the patient's day-time bouts of tearfulness and sadness.

But in doing so she simultaneously works to sustain a relationship of intimacy with the patient by foregrounding a personal rather than professional identity. 'Teary' and 'sad' are words from the life-world that realise a personal voice. By choosing these familiar words over more technical and hence distancing terms such as 'low in mood' or 'depressed' the doctor maintains her engagement with the patient at this crucial moment.

The patient's response (258) is delayed, an indication of her discomfort with this question, and by manipulating the tissue in her hand she displays her efforts to maintain composure. Then, with quavering voice she offers a barely perceptible and unfinished fragment that implies but fails to specify the frequency of her tearful episodes. At turn 259 the doctor collaborates to assist the patient to complete this fragment. With an upwardly inflected utterance she infers and seeks confirmation that these bouts are a daily occurrence. At turn 260 the patient completes this sequence to confirm with a nod and drawn out intake of breath that this inference is correct. The pervasiveness of her symptoms is now out in the open.

The doctor's response to this disclosure (261) marks a surprising and distinctive departure from the professional neutrality that generally characterises a medical consultation. Following a significant one second pause in which the doctor gazes at the patient's face, she engages in what appears to be disclosure of her own feelings of exasperation at the patient's on-going reluctance to openly reveal the extent of her emotional distress. These feelings are injected into her utterance through deployment of the metaphorical expression 'dra::g it out of you' and intensified by elongation of the word 'dra::g'. Her frustration is also realised semiotically as she momentarily buries her face in her hand before appealing to the patient with an upwardly inflected 'uuhh :'.

But arguably this letting go of neutrality through the display of personal feelings functions to close role distance between patient and doctor. In so doing it appears to intensify their interpersonal engagement and to strengthen intimacy. This occasions a second emotional release from the patient and at turn 262, following an intake of breath, she again begins to cry. It also occasions a further disclosure that is of relevance to an assessment of the patient's condition, as, with quavering voice the patient reveals the

clinically significant information that her tearful episodes sometimes occur without instigation: " ## sometimes ## it [just comes out]".

In response to the patient's tearful display the doctor again acts empathically to offer tissues (263). This move accompanies a verbal empathic response that is a reprise of her expert reformulation of the patient's earlier hedged and downgraded assessment of her experience (110). This time however the formulation is intensified by marked word stress and the addition of the 'mood adjunct' (Halliday, 1985) 'absolutely' : "It's rotten (.) it's absolutely rotten". Thus it can be seen to resonate with the patient's heightened emotional distress and to display understanding of the intensity of her disturbing symptoms at this moment of full disclosure.

In light of this disclosure the doctor goes on to conduct a brief but systematic review of other symptoms related to depression including, sleeplessness, loss of appetite, concentration, and sex drive so as to confirm for herself and the patient the diagnosis of clinically significant depression that requires clinical intervention (See turns 275-283 of full transcript).

4.3.4. Summary of analysis

This sub-section of Chapter 4 has drawn upon close analysis of the discourse of a single consultation to describe what doctor and patient do to accomplish the gradual transition from presenting concerns that are bio-medical in nature to disclosure of debilitating symptoms of anxiety and depression.

Focussing first on the analytical theme of rapport, strategies have been identified that doctor and patient deploy to create and sustain an atmosphere of interpersonal harmony and warmth. These strategies include:

- On-going attentiveness to face sensitivities through politeness strategies that uphold the patient's line
- The co-construction of collaborative sequences that contribute to perceptions of cooperativeness and harmony

- The co-construction of sequences of mutual alignment through which doctor and patient display to each other that they are in agreement and are getting along
- Affiliative sequences that accomplish a shift towards intimacy and so heighten interpersonal warmth.

Within this consultation, these strategies have been found to be purposeful, contributing to and sustaining an interactional environment that allows the patient to offer clues to her underlying emotional concerns.

Empathic formulations that articulate feelings and experiences that the patient has been unable to explicitly express together with the interactional consequences of these formulations have emerged as a particularly potent resource for bringing increasingly delicate topics into the discourse of the consultation. Consistently, these empathic sequences have been found to be consequential in putting the interaction onto a footing of more open discussion or in occasioning an emotional display that is clinically significant or in encouraging elaborations that offer a window into the patient's life-world experiences. Significantly, at critical moments the impact of these empathic formulations is heightened by the strategic deployment of gaze, body orientation, gesture and shifts in posture.

In addition, in a consultation in which the patient deploys lay reasoning to account for her emotional symptoms and to discount psychological causes, the sharing of clinical reasoning has been deployed strategically. Consistently the doctor has worked to involve the patient in the clinical reasoning process so as to set aside unwarranted concerns, to put the patient's accounts into perspective and to clear the way for a collaborative exploration of the basis for her condition.

As a counterpoint to the foregoing analysis I will now turn to examination of the discourse of a comparable PBA consultation where the doctor was evaluated as less successful on the parameter of 'communication and rapport' by RACGP examiners. In this encounter, the patient's pre-existing diagnosis of clinical depression is out in the open from the outset. But at various points in the interaction, new material from the patient's life-world is introduced into the discourse. This new material appears to call

for the doctor to bring 'professional vision'(Goodwin, 1994) to bear on the patient's accounts so as to interpret the possible clinical significance of what the patient is saying and to bring matters that may be of clinical importance to the surface.

Chapter 4 (Part B)

Hidden agendas – marginalised concerns

4.4. PBA Consultation 2

4.4.1. The clinical context

The patient in this consultation is a middle-aged woman who has come to the surgery to request renewal of scripts for medications relating to treatment of a range of previously diagnosed conditions including high cholesterol levels and depression. The patient is a regular visitor to the practice and doctor and patient know each other well.

Ostensibly, this is a routine visit in which doctor and patient exchange information so as to ascertain the required prescriptions. But into this routine talk the patient inserts clues to her present emotional state that appear to invoke, and to require exploration of the level of her mood at this particular point in time so that its clinical significance can be considered.

4.4.2. Examiners' evaluations

Two RACGP examiners assessed the doctor's performance independently. Their global ratings and evaluative comments on the parameter 'communication and rapport' are set out below.

	Global rating	Comments
Examiner 1	Doubtful	• Didn't ask open-end questions to assess level of depression.
Examiner 2	Good	• Straight to computer. No eye contact! • Communication – non verbals improved when patient discussing unwell partner/depression etc • Listened well • Did not counsel

It would appear from these ratings that clinical communication that falls within the middle ground along the continuum from 'poor' to 'excellent' is difficult to pin down. In contrast to Consultation 1, there is less agreement between these examiners on this candidate's communicative performance.

It is of significance however that each examiner rated the candidate cautiously as 'sufficient' on the parameter of History Taking[20]. Their evaluation of this doctor's ability to follow appropriate cues so as to elicit details pertinent to the assessment and management of the patient is circumspect. This suggests shared disquiet over the possibility that matters of clinical importance may have remained hidden.

4.4.3. Analysis

Close analysis of the discourse of this consultation may account for the disparity in examiners' assessment of this doctor on the parameter 'communication and rapport'. On the one hand, the analysis set out in the following sub-section uncovers evidence for the doctor's deployment of many features of successful communication as set out in the RACGP rating pro-forma (See section 3.2). Rapport is established from the outset and consistently maintained, and throughout the consultation doctor and patient sustain a high level of interpersonal warmth that appears to enable the patient to talk freely.

But this seemingly routine consultation throws up a series of 'critical moments' wherein information that is of potential clinical significance could remain undisclosed. At a number of points the patient initiates narratives that open a window on her life-world concerns and allude to emotional difficulties that might affect her present mood. Often the doctor can be seen to perceive these cues for emotional support, to perceive the need to respond empathically and to acknowledge the patient's difficult life circumstances. Yet, at critical moments he employs formulations that appear to function selectively to shift the interaction towards a more bio-medical frame. Whereas in Consultation 1, the doctor's empathic responses consistently tap the intensity of the patient's experiences

[20] History taking is glossed in the PBA video rating form as follows: a competent candidate will take a focussed, relevant and organised history; following appropriate cues and eliciting both positive and negative details important to the assessment and management of the patient.

and function to shepherd the patient towards disclosure of increasingly delicate and clinically relevant matters, in this consultation, the doctor's formulations can be seen to function pivotally to direct movement away from patient initiated life-world topics that may have been of clinical significance. Information that could alter the established facts of the patient's history is not fully explored.

As one explanation for the disparity in examiners' judgements of this doctor's communicative ability, I propose that Examiner 2 may be orienting to the doctor's displays of empathy and to the accomplishment of rapport as ends in themselves. Examiner 1 on the other hand, may be responding to the doctor's failure to deploy these resources strategically and purposefully so as to effect a deeper exploration of the patient's mood.

4.4.3.1. Rapport - an end in itself

From the opening turns of the encounter, doctor and patient display a 'rapport enhancement orientation' (Spencer-Oatey, 2005, p. 96) towards each other that demonstrates a desire for friendly, comfortable, harmonious relations.

Extract 1. Consultation 2

1 D: How are ya ((gestures towards seat))
2 P: Hi Pete ((takes seat))
3 D: What can I do for ya
4 P: I just need some scripts ((inaudible)) please
5 D: ((Sits at desk, directs gaze towards computer and brings up files)) Right e o whad da ya need

Through choosing a contracted informal greeting: 'How are ya' (turn 1), and an idiomatic and contracted question form: 'Right e o whad da ya need' (turn 5), the doctor eschews the formality of a professional voice to speak in the life-world vernacular. This dropping down to a familiar everyday register functions to diffuse the asymmetry of the doctor-patient relationship and to encourage affiliation. Rapport is a collaborative accomplishment and this casual familiarity is reciprocated. In response to the doctor, the patient's greeting is informal (turn 2). Here and throughout the consultation (turns 61, 147) she addresses him by his first name.

In line with the patient's professed agenda, that is to renew her scripts, much of this relatively short consultation is given over to the bio-medical topic of the patient's pharmaceutical regime. Specifically, much of the opening phase of the consultation focuses on resolving some confusion over which scripts are required. This confusion arises out of the patient's request for renewal of a script for Zocor, a medication for the control of cholesterol. According to computer records, the patient is only half way through a previous six month prescription. Across turns 7 to 37 (See full transcript) doctor and patient collaborate to get to the bottom of the matter, concluding that the misapprehension is based on the patient's reading of a label stating 'last repeat' on a box of medication that had been prescribed earlier.

Such confusion over scripts, and in particular, the requesting of a script that is not required, is potentially embarrassing and face-threatening for the patient. Mindful of this, the doctor works to resolve the confusion in a way that attends to 'face sensitivities'(Spencer-Oatey & Franklin, 2009). Face-work makes light of the patient's error as strategies of alignment realise solidarity, mitigating any embarrassment so that rapport is sustained

Extract 2. Consultation 2

15	D:	((consulting computer)) [A::h let's see there was a Zoloft (.) in August :
16	P:	((directs gaze towards screen) Yeah I think I got ((inaudible)) in August
17	D:	A: nd a Zoloft not a Zoloft ah there was a Zocor in August as well :
18	P:	Right ... they're all [six
19	D:	[A::nd ((continues to direct gaze to computer))
20	P:	They're all six months the Prothieden's only a three months one is it : =
21	D:	= Yeah
22	P:	Ok well I must have them in there somewhere then
24	D:	((Reading from computer screen)) (5)
25	P:	I might have used an older script (...) It's got last repeat on it
26	D:	Right =
27	P:	= That's quite possible

Note that as the doctor directs his attention towards the computer records (turn 15), he uses the inclusive pronoun form 'let's see' to include the patient as a collaborator in resolving the confusion. In response (turn 16), the patient aligns physically with the doctor as she too directs her gaze towards the screen. Note also the rising intonation contour with which the doctor terminates each proposition (turns 15, 17). This upwardly

rising pitch invites and obtains the patient's involvement. Rather than checking on the patient the doctor engages with her as they check the records together.

Evidence for the high level of rapport that is cultivated across this encounter is most clearly available towards the end of the consultation where rapport is displayed through extended and elaborated sequences of 'mutual affiliation' (Clarke et al., 2003). It might be argued, however, that these sequences constitute rapport as an end in itself. Indeed, within the time constraints of the clinical interview, this rapport building could be seen to function as a diversion from the clinical business at hand.

At turn 106 (see full transcript), the doctor closes off a patient-initiated account of difficult life-world circumstances as he picks up the thread of earlier discussions to reintroduce the topic of scripts into the discourse. Following a short exchange in which doctor and patient reassure each other that she already has the required prescription for Zocor (turns 106 -109), this move accomplishes a shift in frame towards affiliative small talk that takes the consultation to its completion. Much of this talk involves elaborated assessments and affiliative agreements over the unnecessary complexity of script renewals and labelling practices.

We join the talk at turn 124 as the doctor affiliates with the patient by taking an evaluative 'line'(Goffman, 1967) that is critical of those responsible for the complexity that causes such confusion over scripts: "you'd think they'd make it simple to actually understand".

Extract 3. Consultation 2

124	D:	[you'd think they'd make it simple to actually understand
125	P:	((sits back in seat)) Especially for people like me ((extended laughter))
126	D	$$ Oh no it's a very common problem the first time I looked at it I thought (.) there's something obvious that I'm just miss[ing here
127	P:	[you're missing yeah ((laughs))
128	D:	Because of course I just (.) I just dispense I just [give the scripts out
129	P:	((chuckling)) [yeah ((nodding))
130	D:	I don't take anything so $$ I've never actually looked at a script closely before
131	P:	((chuckling))
132	D:	And then I noticed [that's what it says the number of times [dispensed
133	P:	[yes [plus yes
134	D:	and the number [of repeats]
135	P:	[of re] yes

136 D: so the number of times dispensed has to go up one [more than]
137 P: [Yeah]
138 D: Yeah
139 P: That'd be right because the Prothieden's for three months and the others for six months so (.) it'll be there
140 D: ((hands script to patient))

In response (turn 125) the patient aligns with, and builds on this assessment to include herself amongst people who have a particular need for labelling to be made simple. But such self-abasement, tempered by laughter, is offered on the patient's understanding that the doctor will not take this statement as a fair representation of herself (Goffman, 1967, p. 32) . It invites the doctor to respond with face-work aimed at restoring the patient's self-worth. Rapport is strengthened as the doctor complies with a bemused oh-prefaced negative response: "$$ Oh no.." (turn 126) that treats the patient's belittling self assessment as 'inapposite' (Heritage, 1998). In a subsequent expansion on this response, the patient's confusion over scripts is normalised as a common problem, and in a further elaboration the doctor deploys 'positive politeness' (Brown & Levinson, [1978] 1987) to claim common ground with the patient by including himself amongst that set of people who have been confounded by such confusing practices. Doctor and patient are in alignment and such affiliative face-work has heightened dynamic perceptions of rapport.

Across this sequence, in a variety of ways doctor and patient continue to display alignment, and as a consequence to build on rapport. Through affiliative, reciprocal smiling and laughter, shadowing repetitions (turn 126), collaborative completions (turns 133, 135), emphatic nods (turn129), and overlapping agreement tokens (turns 129, 132,137, 138) they show that they are attuned and at one with each other over the matter of scripts.

Clearly, doctor and patient are getting along, and a few turns later (turn 147), as the encounter is coming to an end, the patient volunteers an assessment that is evidence of her satisfaction with the visit: "....thanks Pete that was great". Goffman ([1959] 1970, p. 14) proposes that the conduct that participants show to each other in interaction has a 'promissory character', creating expectations that bind interactants to similar conduct in the future. The rapport that this doctor and patient have collaboratively established holds promise for on-going relations of interpersonal warmth.

Yet, the matter of examiners' disquiet over the doctor's communication remains, and in particular their shared, circumspect rating on the parameter 'history taking' that suggests that cues of relevance to patient assessment may not have been pursued. This disquiet finds resonance in comments from a senior medical educator who was participating in the previously mentioned workshop designed to bring the perspective of practitioners to bear on the researcher's analysis of this consultation

Extract 4. Medical Educators' Workshop

"I think he's [the candidate] extraordinarily skilled at avoiding the point.....it seems to me that she's [the patient] emitting quite a lot of cues of emotional distress that he's resolutely not dealing with..... there's this playing around with the naming of the drugs and so on (.) on one reading that's collusion (.) that's avoiding the other issues (Medical educator)

When considered in the context of the entire consultation, sequences of affiliative small talk, whilst predictive of continuing harmonious relations between this doctor and patient, may represent digression from matters of clinical significance. Facts that are important to an accurate diagnosis of the patient's mood may remain hidden. This proposition will be examined in the analysis to follow.

4.4.3.2. A cue for support

By turn 47, doctor and patient have resolved the confusion over scripts and have just completed an exchange around her dosage of Valium. Into this bio-medical talk the patient injects an indirect cue for emotional support: 'Things are getting a bit (.) yeah : hectic yeah".

Extract 4. Consultation 2

47	P:	Things are getting a bit (.) [yeah : hectic [yeah
48	D:	[((glances towards patient)) [((nods as redirects gaze momentarily to papers on desk))
49	P:	My husband's having another operation on his eye [next week
50	D:	[((returns gaze to patient's face sustains gaze across ensuing turns))
51	P:	He's got cancer on his (.) bottom eye lid :
52	D:	Right
53	P:	I don't know what sort it is (.) starts with an I that's all I know and (.) I don't think it's going to be pretty
54	D:	((nods)) Is it big or are they just going to do a little :

55 P: They're going to do a frozen section to start with
56 D: Right

The doctor perceives this cue as requiring attention and responds by turning his head away from the computer screen to glance towards the patient and nod (turn 48).
Encouraged, the patient elaborates to invoke the doctor's sustained attention (turn 50) as he turns his head to direct his gaze towards her face, thus facilitating a series of turns in which the patient describes her husband's pending operation for a disfiguring face cancer.

Figure 9: Sustained attention (from turn 50)

Throughout this sequence the doctor displays many features of empathic communication as suggested by communication models (Neumann et al., 2009; Suchman et al., 1997) and as made evident in the discourse of PBA Consultation 1. He perceives and responds to the patient's cue and acts both vocally and through semiotic means to display interest and concern so as to prompt elaboration of her account.

4.4.3.3. A critical moment

A few turns later, against this empathic backdrop, the patient moves to shift the topic from the more bio-medical talk of her husband's operation to her own emotional response to difficult life circumstances occasioned by her husband's plight and the breakdown of her daughter's marriage.

Extract 5. Consultation 2

61 P: ((leans back in seat))I've just gone through all that now I have to ((shakes head slightly)) I'm over it ((places hands in stop gesture in front of her)) I'm over it I'm just (..) sorry Pete.
62 D: <No no
63 P: If it's not one thing it's another
64 D: ((nods almost imperceptibly))
65 P: The kids are ((places hand on forehead)) the middle daughter's divorced and having problems there with her ex partner and the kids o:h (.) it's just ((shakes head shrugs slightly)) I'll get there
66 D: Ok ((turns gaze back to the computer screen)) um you feel you're coping ok on the Prothieden the um Valium yeah ((redirects gaze towards patient's face)) Valium
67 P: Well yeah we were thinking about putting me on the ((inaudible)) perhaps but
68 D: ((redirects gaze towards computer screen)) Mm
69 P: I don't know
70 D: < ok ((continues to look at screen)) I mean if you think you're coping then that's fine (fall rise tone)
71 P: I'm coping most of the time
72 D: ((nods as directs gaze to patient's face)) I mean as you say ((redirects gaze to computer screen))you're only taking one of the Valium a day ((redirects gaze to patient's face))
73 P: I'm really trying not to

Note here the patient's unfinished phrases, head shaking, gestures and apologies (turns 61, 65) that are strongly indicative of emotional distress. Note also (turn 65) that the patient concludes this troubles-telling with the utterance "I'll get there", accompanied by a slight dismissive shrug. In this, she displays 'trouble resistance' (Jefferson, 1988), a making light of trouble whilst simultaneously drawing the doctor's attention to its existence.

This seems to be a 'critical moment'(Candlin, 1987) in the consultation that calls for an empathic formulation on the part of the doctor that will display understanding of the patient's difficulties and so open the way for a deeper exploration of her mood. It seems to call for the doctor to bring 'professional vision' (Goodwin, 1994) to bear on the raw material of the patient's account and to attend to its possible clinical significance.

But instead, the doctor moves to direct the talk away from emotional matters. At turn 66 "Ok" functions as a pre-closing device that the doctor recruits to acknowledge the patient's difficult circumstances whilst simultaneously enforcing closure on their further elaboration.

Figure 10: 'Ok ...' Disengaging from emotional concerns (turn 66)

As the doctor physically disengages from the patient in person to refocus his gaze on the computer screen, his utterance functions pivotally to occasion a shift in frame as doctor and patient re-engage with the bio-medically relevant but less sensitive topic of medication. At turn 71, the patient again attempts to reinstate coping as a topic: "I'm coping most of the time". With marked stress on 'most' she implies that there are times when she does not cope at all. But once again (turn 72) the doctor's formulation functions selectively to exclude the patient's emotions from the discourse and to focus on medication as the topic to be pursued : "I mean as you say ((redirects gaze to computer screen))you're only taking one of the Valium a day" ((redirects gaze to patient's face)).

Notably, at this point, and across the entire consultation, this doctor's dominant postural orientation is towards the desk and towards the computer. Whilst he periodically aligns with the patient as recipient of her narratives by turning his gaze towards her, his legs and torso consistently front the desk. In contrast to the doctor in Consultation 1, whose dominant orientation towards 'the patient embodied' (Robinson, 1998) communicates continual readiness for interpersonal engagement, this doctor's 'home position' (Ruusuvuori, 2001; Schegloff, 1991) communicates a primary orientation with 'the patient inscribed' (Robinson, 1998) and a primary engagement with the more bio-medical world represented by clinical records.

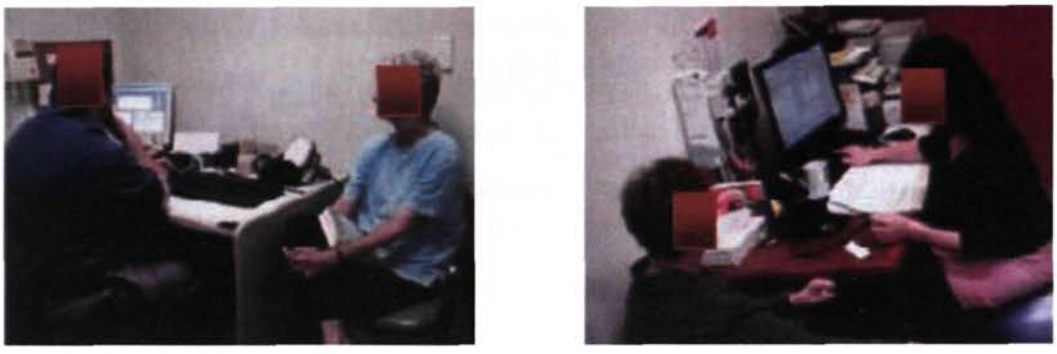


Figure 11: Contrasting 'home positions'

4.4.3.4. A recurring pattern – attending and dis-attending

As the consultation continues, the patient persists in her efforts to draw the talk back to the agenda of her life-world circumstances. A recurring sequential pattern emerges involving patient initiated-narratives that display her ways of coping with depression, and affiliative assessments and acknowledgments on the doctor's part. Consistently, however, these assessments align with the explicit, surface meaning of the patient's utterances to ratify a professed 'line' (Goffman, 1967) that she is managing, and to validate her coping strategies. Unlike the doctor in Consultation 1, this doctor generally resists empathic formulations that might reinterpret the patient's accounts or reframe the discussion in therapeutically useful ways. Rather, as the following sequences illustrate, he chooses to avoid any deeper penetration of the sensitive agenda the patient is pursuing and ultimately retreats into the world of bio-medicine to leave the clinical implications of her behaviours unexplored.

We rejoin the interaction at turn 74 as the doctor is elaborating on the bio-medical topic of medication. Whilst acknowledging the patient's efforts to limit Valium use in the long term, he invites her to consider a short term increase in dosage to assist everyday functioning.

Extract 6. Consultation 2

74	D:	I mean obviously long term it's best to keep (.) to limit that but obviously on the other hand you have to function as well so:o
75	P:	Well that can become a problem and I just shut the door and (3.0) no I'm not home ((leans slightly forward and laughs))
76	D:	Ok fair enough well no that's a perfectly [good]

77 P: [that's how I cope]
78 D: That's a perfectly good coping strategy um ((coughs))
79 P: Yeah (.) I'm just not at home (..) That's how I [cope with it]
80 D: [nods] Ok I mean people accept that as you know I'm sort of =
81 P: = Oh sure I mean I'm not backward in coming forward I mean I'm depressed : I'm down in the dumps : I'm sorry : I'm not having a good day : If they don't like it well (..) bye bye
82 D: Good (.) ok ((nods))
83 P: I don't care (fall rise tone)
84 D: ((nods))
85 P: I cope how I can
86 D: That's fair enough : (.) ((redirects gaze towards computer screen)) ok umm (..) so (.) hopefully it's just a minor thing and they don't have to do the flap because you
87 P: They don't know yet (.) they won't know till they get in there =
88 D: = No they won't until they've done the frozen (.)depends on how far they have to go (.) basically how much they have to take

The patient's response (turn 75) accomplishes a departure from the bio-medical agenda of the doctor's utterance. Picking up on the issue of everyday functioning and setting aside the implication that she might consider taking an extra tablet, she initiates a narrative account that opens a window on a life-world where she copes with depression by shutting herself away. As Stivers and Heritage (2001) have shown, such unsolicited narrative departures are of significance for the patient and are constructed with intention. Thus, for the doctor they represent a resource and an opportunity to gain new and potentially significant insights into the patient's preoccupations.

Note the shift in posture and mitigating laughter that accompanies the patient's disclosure (turn 75). Clearly, to the patient, shutting herself away is a delicate matter. With laughter she works to make light of information that could cast her in a less than favourable light. But the doctor does not attempt to draw out any implications from her disclosure. Rather, across turns 76 and 78 he responds with evaluative assessments that strongly ratify her behaviour as 'a perfectly good' coping strategy.

The patient, however, does not let the matter rest. Across this sequence she repeatedly reinstates the theme of coping, with variations of the phrase 'that's how I cope' (turns 79,81,85). This self-repetition, together with increasingly dramatic elaborations of her narrative account, appear to function as an attempt to engage the doctor in discussion and to invite his interpretation of the behaviours she is describing.

Note how at turn 81 she conjures a scene from her life-world with a series of phrases that echo her words as she turns people away. With this 'grammatical parallelism' (Jakobson, 1966; Tannen, 1989), each phrase realised with a rising intonation contour, she establishes a repetitive list-like rhythm that emphasises the variety of ways she dispatches her visitors. As Tannen explains (1989, p. 52), such a rhythmic accretion of phrases, each one altering and expanding on the meaning of the other, is designed to invite the listener's attention and involvement. But still the doctor avoids any interpretive reformulation of the patient's words, responding instead with a down-scaled evaluative assessment (turn 82) that offers a further validation of the patient's behaviours. At turn 83, the patient's attempts to pursue the doctor's response culminate with the utterance "I don't care" (turn 83) marked by a confronting fall rise tone that functions to challenge the doctor to engage. This challenge however is receipted minimally with a nod (turn 84).

Across this sequence the doctor can be seen to resist any "diagnostic formulation" (Antaki, Barnes, & Leudar, 2005, p. 630) that might reshape the patient's talk so as to clarify the facts of her depression at this point in time, or any "informative redescription" (Antaki et al., 2005, p. 632) that might offer the patient a new way of understanding the behaviour she has disclosed.

Rather, he offers a formulation that functions 'selectively' to focus on bio-medical aspects of the patient's prior talk whilst 'dis-attending' other matters that she has made available for discussion (Davis, 1986). At turn 86, his validating assessment: "That's fair enough:", realised with a falling intonation contour, expresses finality. "Ok" is deployed as a closing device, and as the doctor disengages physically from the patient to redirect his gaze towards the computer screen, his formulation, "...so hopefully it's just a minor thing and they don't have to do the flap ..." selects from the patient's life-world accounts the topic of her husband's pending operation, so as to enforce movement away from emotional matters and to redirect the discourse towards bio-medical topics.

4.4.3.5. Disengagement from emotional concerns

This pattern is repeated from turn 99. In this sequence, the patient again takes up the theme of coping as she volunteers a new narrative in which 'joking' emerges as another way of dealing with her difficult life-world circumstances. By the end of this sequence the doctor's retreat from emotional matters relevant to the patient's life-world is complete.

Extract 7. Consultation 2

99	P:	I just tell everybody I think he's got ((indicates scar position with hand)) they took the flap out of here (.) big scar
100	D:	Yeah
101	P:	What happened to you (.) oh I hit him with a broad axe don't worry about it ((Laughs))
102	D:	((Laughs loudly as directs gaze back to the computer screen)) (inaudible)
103	P:	You've got to make a joke of these things ((laughs)) When I get serious that's when I joke ((laughs))
104	D:	((Continues to focus on computer screen)) °Yeah well that's fair enough°
105	P:	That's another way I cope((laughs))
106	D:	((Reading from computer)) Ahm what've we got (.) just looking at other things here yeah you pretty well got everything in August [by the looks of it]

At turn 101, the patient's 'constructed dialogue' (Tannen, 1989) recreates a jocular interchange from the life-world. Designed for amusement, it is followed by laughter that invites and receives the doctor's shared reciprocal laughter in response (turn 102). But across turns 103 and 105, patient-initiated laughter appears to serve a purpose other than amusement. Arguably, at these points the patient's laughter constitutes 'trouble resistance' (Jefferson, 1988) as she makes light of but simultaneously draws attention to painful circumstances that require joking as a coping response. But once again the doctor chooses to refrain from any therapeutic reframing of the patient's disclosures. Rather, at turn 104 his softly voiced formulaic acknowledgement is an aside to his primary focus on the computer screen. Then, at turn 106 as he leans forward to engage with the patient's computerised records, he explicitly reinvokes the topic of the patient's prescriptions to accomplish an abrupt shift to a bio-medical frame.

The consultation does not return to the matter of the patient's mood. From this point on, as discussed earlier in this section, doctor and patient engage in affiliative banter over

the matter of confusing scripts that takes the encounter to its conclusion. Emotional matters are deleted from the discourse and the clinical facts of the patient's mood remain hidden.

4.4.3.6. A coda to this analysis – the matter of professional judgement

As Stivers and Heritage point out (2001, p. 181), "Not every occasion of lifeworld disclosure [by a patient] is an occasion for the pursuit of that disclosure". Matters such as time constraints, what the doctor knows about the patient, and the patient's personality, and perceptions about the clinical significance and relevance of what is being said, will all contribute to the choices doctors make about if, when and how to pursue the agenda implied by a patient's narrative accounts.

Indeed, during a collaborative workshop in which senior RACGP examiners were invited to comment on the transcript of Consultation 2, the candidate's background knowledge as well as the nature of previous encounters between doctor and patient were considered as factors that might account for the doctor's reluctance to pursue emotional matters.

Referring to turn 43 (See full transcript), one examiner drew attention to the fact that the patient is also seeing a psychiatrist. Yet, there was general agreement amongst these examiner-practitioners that this did not abjugate the General Practitioner from the responsibility of exploring the patient's mood.

Further, in a wide ranging discussion at a parallel workshop for medical educators, participants drew upon their own clinical experience to suggest that knowledge brought along from previous encounters may influence a doctor's interpretation of what a patient is saying as well as their actions in response. The following comment is illustrative of that discussion.

> Extract 5. Medical Educators' Workshop
>
> .....And I guess that there are patients that one has to admit that one has seen with the same story repeated (.) this is just the same story that you've heard twenty times in the

last six months from this patient (.) you know that nothing's changing and perhaps what you then do is strategically you limit you know you limit the time (.) you limit the focus you stick with what you need (Medical educator).

Nevertheless, in light of the focussed looking that transcribed interaction affords, this senior medical educator went on to express very considerable disquiet over the actions of the doctor in Consultation 2.

Extract 6. Medical Educators' Workshop

... I would be really worried if a patient said to me ((refers to transcript)) ... line sixty one on 'I've just gone through all that I'm sorry Pete I'm over it etc ... if it's not just one thing it's another' (.) she starts to open up and then doctor ((reading from transcript)) 'so are you feeling ok on the Prothieden' (.) and she's just told him that she's not coping ok (.) and then a little bit on ' so if you think you're coping that's fine' (.) and she says 'I'm coping most of the time'(.) and then he reframes it 'so you're only taking one of the valium a day' (.) so he really doesn't want to engage with [her] .. And then it happens again later on ... 'that's how I cope'. It seems to me she's emitting quite a lot of cues of emotional distress that he's resolutely not dealing with ... Now my concern is that she's at risk of self-harm ... now as I say he might know this patient very well and he might think 'oh this is an old ((inaudible))' but certainly if I was putting that up for my Fellowship I would be taking another tool out of my tool box and I would be showing that I do know how to assess somebody's [mood] (Medical educator).

The perspective of this medical educator aligns with the perspective that has emerged through close analysis of the discourse of the consultation as set down in this section. This analysis has described and explained how despite the accomplishment of a high level of interpersonal harmony and rapport the actions of this doctor have functioned to sideline from the discourse matters of possible clinical significance.

4.5. Summary of chapter

Focussing on the themes of empathy and rapport, this chapter has contrasted the discourse of two comparable consultations, each involving bio-medical problem presentations that mask an underlying agenda of emotional concerns.

In the first consultation, rapport has emerged as a purposeful accomplishment that contributes to an interactional environment that gives rise to the patient offering clues to previously unvoiced concerns. In the second consultation, doctor and patient collaborate

to create and sustain an atmosphere of interpersonal warmth through a range of rapport building practices and in particular through affiliative small talk. In this case however, rapport functions to distract from an exploration of the patient's mood.

Formulations have been found to be a particularly powerful resource for effecting the direction and outcomes of the consultations. In the first consultation, the doctor's empathic formulations, in concert with gaze, body orientation and posture, function pivotally to occasion the collaborative transition towards increasingly delicate topics of clinical relevance. Conversely, in the second consultation, formulations function to marginalise patient initiated topics from the discourse of the consultation and to enforce movement away from life-world accounts that may have been of significance in the assessment of the patient's mood.