

Politeness Strategies in Decision-Making between GPs and Patients

by

Rachel Lynette Adams

A thesis submitted to
The University of Birmingham
for the degree of
Doctor of Philosophy

Primary Care Clinical Sciences
School of Health and Population Sciences
The University of Birmingham
March 2013

UNIVERSITY OF
BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

ABSTRACT

Policy, training and research reflect the importance of patient involvement in decisions about their care. Adoption demands certain skills though, may result in conflict, or be too threatening for patients. Using an iterative process, politeness theory was used to analyse the linguistic management of these threats and challenges in videos of GP consultations.

The collaborative nature of GPs' positive politeness had persuasive effects, whilst their negative strategies gave rise to examples of ambiguity causing confusion. Patients' negative politeness demonstrated discomfort when presenting potentially contentious decisions whilst their use of positive politeness acted as a means of promoting cooperation. GPs used positive politeness when supporting patients' decisions, offering reassurance and redressing damage to face, conversely disagreement was conveyed by the absence of such strategies and lack of reparative work.

Difficulties were identified in the way in which space for patient participation was created and managed, and the strategies used to convey information. The contrast in GP responses to patients' decisions highlighted how subtle barriers to participation can be. These findings demonstrate the complexity of language and meaning and the need for a more sophisticated understanding of language use in communication skills and related training, as well as associated research.

ACKNOWLEDGEMENTS

First and foremost I would like to thank my supervisors for all their support and encouragement and most of all for taking the risk and giving me the opportunity to explore decision-making linguistically. Prof Skelton, without you there would have been no linguistic analysis, your exceptionally generous gifts of time extended far beyond the call of duty. Without your patient guidance I could never have come this far. And to Dr Gill for all your help and support with the clinical aspects of the data.

To Andy Shanks, without your tireless efforts 10 years ago there would have been no data.

I am also very grateful to Primary Care Clinical Sciences (PCCS) who funded this research.

To those who gave up their time to comment on my work: Prof Greenfield, Dr Koester and Dr Clissett.

And to those in PCCS who helped with the content: Anne de la Croix for your assistance with the transcription reliability testing, and to Dr Stokes-Lampard and Dr Aveyard for their clinical input and references for cervical screening and smoking cessation respectively.

Working within primary care has given me wonderful insights into primary care research and an opportunity to continue nursing on a range of studies as an employee. To all the friends I have made here and laughed with – Kath, Katie, Sarah, Sabrina, Debbie, Amy, Mike, Jackie, Rhona and Miriam.

And in the ISU – Karen, Connie, Julie, Jackie, Jan and Debbie.

To my linguistic student friends: Anne, Caroline and Jacquie – thank you for your endless advice regarding linguistic nuances, but most of all for the fun we've had.

To those students also using Politeness Theory: Mabelle, Sharon and Helena – for the support, friendship and of course advice. To my roommate at the Politeness Conference: Holly – for theoretical advice, but most of all friendship and for showing me that I could do it and be a new mum.

To my dearly beloved, doctorate friends Phil, Mariella and Sal for never letting me give up.

To all the students in the Post-Grad study space – thank you for helping me with my IT problems and dilemmas, and for putting up with my stories about Jessica.

Jessica, my jewel in the crown. You showed me that my plan not to mix a PhD with sleep deprived motherhood was right, but you turned the argument on its head, tipping the scales upside down. The change in plan was a fab one. The hope of graduating with you by my side has kept me going. The cuddles and kisses you've given me in those stolen early mornings and endless night-time wakings have made it possible to reach this point. Your decision to demand my attention throughout the night and whenever I tried to work at home brought

exhaustion and incoherent writing, but the person you are and the joy of watching you grow has made it all worthwhile. Before you were thought of I said I didn't ever want my PhD experience to come to an end, your arrival changed all that, but nevertheless, it nearly meant that I didn't finish the thesis! I wonder if you'll ever read this book.

To my grandparents whose legacies have enabled me to reach this point, enabling me to pay the bills and providing us with a much cherished home.

To my parents, I hope you're proud. You've always been there, you shared the journey – step by step towards the end, and helped out at home so that I could sit down and just finish. I hope you realise that it's your attitude to money that has taught me how to turn pennies into pounds and enabled us to reach this point. Without you there'd be no Jessica either, nor would this thesis have existed.

TABLE OF CONTENTS

CHAPTER 1 - INTRODUCTION	1
Research Aim	4
Outline of the Thesis	6
CHAPTER 2 - BACKGROUND LITERATURE	8
INTRODUCTION TO CHAPTER 2	8
PART 1 - THE RESEARCH SETTING:	8
Primary Care	9
GMC	12
RCGP	13
PART 2 - DOCTOR-PATIENT COMMUNICATION	14
Introduction to Doctor-Patient Communication	14
Reviewing the Literature - Strategy	14
Effects of Good Communication	16
Decision-Making	18
<i>Decision-making theory</i>	18
<i>Discursive practice</i>	19
<i>Medical decision-making</i>	19
<i>Clinical decision-making</i>	20
Shifting Ideologies in Doctor-Patient Communication	20
Policy, Guidelines and Clinical Decision-Making	22
<i>GMC policy</i>	24
<i>MRCGP</i>	25
<i>The Government & health agendas</i>	26
<i>Society's influence</i>	29
<i>Policy summary</i>	29
Patient-Centred Ideology	30
<i>PCM - Patient-centred medicine</i>	30
<i>SDM - Shared decision-making: a patient-centred approach</i>	32
<i>Patient participation</i>	34
<i>Preferred levels of involvement</i>	36
<i>Patient participation – barriers</i>	37

<i>Critique and promotion of patient-centred approaches</i>	41
<i>Inviting patients' contributions</i>	41
<i>Conflicts between PCM & other targets</i>	43
<i>Patients prefer paternalism & distrust alternative attitudes</i>	44
<i>It's too time consuming</i>	45
<i>Patients lack the necessary skills</i>	45
SUMMING UP DOCTOR-PATIENT COMMUNICATION TODAY	46
PART 3 - LINGUISTICS & PRAGMATICS	47
Indirectness: Saying One Thing, Meaning Another	47
Politeness	53
<i>1st and 2nd order politeness</i>	53
<i>The conversational-maxim view</i>	54
<i>The face-saving view (Brown & Levinson)</i>	57
<i>Other approaches to politeness theory</i>	58
<i>Defining politeness</i>	60
Brown and Levinson's Politeness Theory	61
<i>Face (positive & negative) and facework</i>	62
<i>Face threatening acts (FTAs) & breaches</i>	64
<i>Level of threat</i>	66
<i>Politeness strategies – mitigating FTAs</i>	66
Politeness and Cooperation	71
Politeness – Summarising Remarks	73
Politeness and Healthcare Communications	73
SUMMARY OF CHAPTER 2	75
CHAPTER 3 - METHODOLOGICAL APPROACH & DATA CONTEXT	77
<hr/>	
INTRODUCTION TO CHAPTER 3	77
1) THEORETICAL APPROACH	80
Qualitative Methods – Thematic Analysis, the Iterative Cycle & Deviant Case Sampling	80
Coding, Constant Comparison, Memo Writing & Theoretical Saturation	84
What is a Clinical Decision?	85
Capturing and Representing Language Data	89
<i>Video data – strengths and limitations</i>	89
<i>Transcribing dilemmas and theory</i>	92
<i>Backchannelling theory</i>	94
2) METHODOLOGICAL PROCESSES FOR THIS THESIS	96
Protecting Participants - Ethical Approval, Consent, Confidentiality, Anonymity	96

<i>Ethics committee and R&D approval</i>	96
<i>Confidentiality and anonymity</i>	97
<i>Identity numbers - IDs</i>	98
Number of Participants	99
<i>Excluded Data</i>	99
Data Storage	103
Transcription Process	103
<i>Transcribers</i>	103
<i>Alternative pronunciations & grammatical errors</i>	104
<i>Backchannels and their representation</i>	104
<i>Reliability testing - transcription</i>	105
Coding – Politeness Outputs and Clinical Decisions	106
<i>Coding and interpretative reliability</i>	107
Summarising the Data	108
Identifying Themes and Theoretical Saturation	109
3) ORIGINAL DATA COLLECTION	110
Period of Data Collection	110
Purpose of the Original Research	110
Data Collection Sites	111
Recruitment & Consent of Patients	111
<i>Inclusion/exclusion criteria for patients</i>	113
Demographic Data Collection	114
Sample Size	114
Recording the Consultations	115
4) SAMPLE DESCRIPTION	116
Responses	116
<i>GP responses</i>	116
<i>Patient responses</i>	117
<i>Number of Participants</i>	117
GP Demographics	118
Patient Demographics	119
<i>Other persons accompanying patients</i>	120
<i>Excluded patients</i>	121

CHAPTER 4 - RESULTS	122
<hr/>	
INTRODUCTION TO CHAPTER 4	122
PHASE 1 RESULTS	123
Mechanisms for Politeness	123
<i>Negative politeness outputs</i>	124
<i>Conventional indirectness</i>	124
<i>Deference</i>	124
<i>Gratitude</i>	125
<i>Hedging</i>	125
<i>Positive Politeness Outputs</i>	126
<i>Giving gifts</i>	126
<i>Inclusive strategies</i>	126
Decision-Making – Common Themes	127
<i>Patients’ ideas</i>	128
<i>GPs’ decision-making</i>	129
<i>GPs’ declaratives in decision-making</i>	129
<i>GPs’ use of invitations to agree in decision-making</i>	130
PHASE 2 RESULTS	133
The Case of P2: Patients’ negative politeness to express dispreferred ideas & GPs’ positive politeness to express agreement	136
The Case of P6: Patients’ lack of facework to express dispreferred ideas & GPs’ off record disagreement	153
<i>Patients’ positive politeness to create space</i>	169
The Case of P29: GPs’ positive politeness: persuading during decision-making	173
GPs’ positive politeness: persuading throughout the consultation	182
GPs’ imprecision replacing jargon	205
GPs’ hedging during decision-making	211
CHAPTER SUMMARY	221
CHAPTER 5 – DISCUSSION	223
<hr/>	
INTRODUCTION TO CHAPTER 5	223
Space - Patients’ Use of Politeness	223
Space - GPs’ Use of Positive Politeness	225
Endorsement	228
Confusion	230
Relationship with Existing Literature	234
Strengths and Limitations	235

<i>Representativeness of the study sample</i>	235
<i>Bias</i>	236
<i>Doctor-patient relationship</i>	238
<i>Alternative methodologies</i>	239
Clinical Applications to Practice and Training	241
Recommendations for Future Research	244
CHAPTER 6 - CONCLUSION	247
APPENDIX I – DEFINITION OF POLITENESS TERMS	250
APPENDIX II - GLOSSARY	255
APPENDIX III - ETHICS APPROVALS	261
APPENDIX IV - CONSENT FORM	268
APPENDIX V – GP CORRESPONDENCE	270
APPENDIX VI - PATIENT CORRESPONDENCE	274
APPENDIX VII - PATIENT QUESTIONNAIRE	278
APPENDIX VIII - GP QUESTIONNAIRE	281
APPENDIX IX - CLINICAL ISSUES	282
REFERENCES	287

APPENDIX X – ALL TRANSCRIPTS

The primary data, the transcripts,
are held by the Interactive Studies Unit

LIST OF FIGURES

Figure 1 – Iterative phases & methodological processes.....	79
Figure 2 – Number of participants included in the analysis here.....	102
Figure 3 – The emergent themes and their categories	134
Figure 4 – Positive politeness	252
Figure 5 – Negative politeness.....	253
Figure 6 – Off record politeness	254

LIST OF TABLES

Table 1 – Overview of participant numbers.....	118
Table 2 – GP demographic data.....	118
Table 3 – Patient demographic data.....	120
Table 4 – Persons accompanying patients	121
Table 5 – Demographics of excluded patients.....	121
Table 6 – Clinical issues	282

LIST OF BOXES

Box 1 – Summary of search terms used.....	15
Box 2 – Summary of electronic resources used.....	16
Box 3 – Neighbour’s aide-memoire “ICE”	23
Box 4 – Scale of patient involvement (Degner et al 1997).....	37
Box 5 – Examples of barriers to patient participation	38
Box 6 – Eliciting ICE.....	42
Box 7 – Form & function.....	48
Box 8 – Positive & negative face-needs	63
Box 9 – Super-strategies	68
Box 10 – Outputs: definition of	70
Box 11 – Transcribing key.....	93
Box 12 – Participant IDs.....	98
Box 13 – Alternative pronunciations/dialect usages changed in transcripts.....	104
Box 14 – Alternative pronunciations left unchanged in transcripts.....	104
Box 15 – Transcribing reliability	106
Box 16 – P6’s reasons for not needing a cervical smear	157
Box 17 – Face threat	250
Box 18 – Positive face	252
Box 19 – Negative face.....	253

LIST OF EXTRACTS

Extract 1 – Non-clinical decisions (D2-P62).....	86
Extract 2 – Clinical decision (D2-P62)	87
Extract 3 – GP agrees to patient request for medication (D7-P39)	128
Extract 4 – GP agrees with patient suggestion (D5-P20)	129
Extract 5 – GP declarative stating decision (L61, L63 & L65) (D1-P8).....	130
Extract 6 – Invitations to agree (D5-P24).....	131
Extract 7 – Diverging from GP advice (D1-P2).....	137
Extract 8 – Positive politeness to give feedback (D1-P2)	143
Extract 9 – Protecting expert position (D1-P2)	145
Extract 10 – Continued redress (D1-P2)	146
Extract 11 – Patients’ negative facework: Patients’ ideas (D4-P19).....	151
Extract 12 – Positive politeness & feedback: Declining medication (D2-P62)	152
Extract 13 – Positive politeness & feedback: Healthy lifestyles (D4-P65).....	153
Extract 14 – Declining best practice (D1-P6).....	155
Extract 15 – Reasons for declining smear (D1-P6)	156
Extract 16 – D1’s minimal utterances (D1-P6)	158
Extract 17 – The chemicals used (D1-P6)	159
Extract 18 – Risk (D1-P6)	160
Extract 19 – Absence of reassurance (D1-P6).....	162
Extract 20 – Declining in writing (D1-P6)	163
Extract 21 – Fear of cancer (D1-P6).....	164
Extract 22 – Expressing frustration (D1-P6)	165
Extract 23 – Off record disagreement: Climate & Asthma (D2-P58).....	168
Extract 24 – Off record disagreement: Epidurals & back pain (D5-P46)	169
Extract 25 – Patients’ use of positive politeness to create space (D5-P24).....	170
Extract 26 – Positive politeness to present patient idea (P68-D6)	172
Extract 27 – Diagnosis & treatment (D6-P29)	174
Extract 28 – Patient breach (D6-P29).....	175
Extract 29 – D6’s response to P29’s breach (D6-P29).....	177
Extract 30 – Opening greeting (D5-P23).....	183
Extract 31 – Invitation to present symptoms (D4-P19).....	185
Extract 32 – Involving the hearer: Blood pressure readings (D2-P12)	186
Extract 33 – Involving the hearer: Cholesterol risk (D1-P32).....	187
Extract 34 – Shared remembering: Dislike of being weighed (D2-P12).....	189
Extract 35 – Shared remembering: Herbal remedies (D4-P65).....	189
Extract 36 – Shared remembering: A mutual acquaintance (D5-P24)	190
Extract 37 – Showing interest: Combining activities (D5-P23)	191
Extract 38 – Showing interest: How’s work? (D5-P20).....	191
Extract 39 – Showing interest: Moving house (D2-P58)	192
Extract 40 – Showing approval: Healthy diet (D1-P32)	193
Extract 41 – Showing approval: Child’s injection (D4-P45)	194
Extract 42 – Understanding: Bereavement (D2-P62) (110 words)	194
Extract 43 – Understanding: Abandoning quit attempt (D4-P65).....	195
Extract 44 – Tag questions: Agreement that treatment is needed (D4-P65)	197

Extract 45 – Tag questions: Accept counselling (D6-P27).....	197
Extract 46 – Tag questions: Return if worse (D1-P4).....	198
Extract 47 – Universalising (D1-P1).....	199
Extract 48 – Summarising (D2-P10).....	201
Extract 49 – Follow up (D6-P69).....	202
Extract 50 – Leave taking: Humour & reassurance (D4-P19).....	203
Extract 51 – Leave taking: Humour & personalisation (D5-P46).....	204
Extract 52 – Imprecise terminology: Some cream (D1-P4).....	206
Extract 53 – Need for patient precision (D6-P28).....	207
Extract 54 – Imprecise terminology: A different cream (D1-P4).....	208
Extract 55 – Imprecise terminology: Brand names (D6-P29).....	209
Extract 56 – Imprecise terminology: Inhalers (D2-P58).....	210
Extract 57 – Hedging (D1-P1).....	212
Extract 58 – Scene setting for Extract 59 (D7-A37).....	214
Extract 59 – Hedging treatment decisions (D7-P37).....	214
Extract 60 – Evidence of uncertainty (D7-P37).....	216
Extract 61 – Uncertainty hedges or persuasive devices (D2-P10).....	218

LIST OF ABBREVIATIONS

BC	Backchannel (see Glossary p255)
B/P	Blood pressure
BMI	Body mass index
BNF	British national formulary, standard drug manual containing information and advice including dosages
DoH	Department of Health, state department providing strategic leadership to healthcare organisations in England (2011a)
DVD	Digital versatile disc, used to store film & other data digitally.
EBM	Evidence based medicine (see p20)
F/T	Full-time
FTA	Face threatening act (see Glossary p256)
GMC	General Medical Council (see p12)
GMS	General Medical Services (Contract) (see p9)
GP	General practitioner – sometimes referred to as primary care/community physicians or family doctors (see p9)
HAY?-type elicitation	“How are you” type enquiries oriented toward moving onto health related matters (see Glossary p257)
ICE	Ideas, concerns & expectations (see Glossary p258)
ID	Identity (see p96)
ISU	Interactive Studies Unit formerly known as the Interactive Skills Unit
L1	First language (see p120)
LPRG	Linguistic Politeness Research Group
MeSH	Medical Subject Headings used to index medical articles (see p14)
MRCGP	Membership of the Royal College of General Practitioners (see p25)
MREC	Multi research ethics committee (see p96)
NHS	National Health Service (see p9)
NICE	National Institute for Health and Clinical Excellence (see p9)
NVivo	Software brand name (see p92) reflecting a) its development from NUD*IST (hence the “N” in NVivo – the acronym NUD*IST portrayed the software’s characteristics: Non-numerical Unstructured Data Indexing, Searching & Theorizing) and b) that one can code “in-vivo” – meaning in this context that one can create a new coding node directly from a selected portion of text, labelling it with the highlighted text and simultaneously coding that text to the new node (Richards 1999).
P/T	Part-time
PCM	Patient-centred medicine (see p30)
PCT	Primary care trust (see p9)
PhD	Doctor of Philosophy
QoF	Quality outcomes framework (see p9)
RCGP	Royal College of General Practitioners (see p13)
REC	Research ethics committee (see p98)
SDM	Shared decision-making (see Glossary p260)

SVO Subject-verb-object (see p48)
UK United Kingdom
VHS Video home system, method of storing film on tape
VS Verb-subject (subject-verb inversion) (see p48)

CHAPTER 1 - INTRODUCTION

The consultation can be viewed as a meeting point of two differing worlds, a point where individuals with different backgrounds, skills, perspectives and objectives come together. Verbal communication functions as the vehicle for the management of this coming together. However, this mainstay of the consultation also functions as a means of symbolising and therefore reinforcing divisions between the two worlds. This is further reinforced by the interactants' varying degrees of language proficiency and differing verbal codes and registers. These speech variants in turn influence individuals' access to group membership as well as their ability to communicate with and move between groups. Within this, both aim to find effective means of communication in order to facilitate mutual understanding and encourage mutual cooperation. It is the way in which communicative strategies are used to facilitate cooperative relations within the consultation that is of particular interest here. It is the way in which communicative strategies are used to facilitate cooperative relations in relation to decision-making in primary care (to be explained on p9) consultations that is of particular interest here, reflecting the primary care grant providers' interest in "*The linguistic analysis of ... decisions within the consultation*".

Historically, the relationship between doctor and patient has been entrenched in paternalism, with the physician holding authoritative control (e.g. Parsons 1951; Foucault 1963). Today there is much more emphasis on a patient-centred model of care, one which involves active patient participation throughout the consultation as a means of facilitating a shared approach to decision-making. There is, however, much debate as to what constitutes such an approach,

and what constitutes appropriate and desirable levels of patient participation (e.g. Henbest & Stewart 1989; Guadagnoli & Ward 1998; Towle & Godolphin 1999; Mead & Bower 2000; Lewin et al 2001; Elwyn et al 2001a; Epstein et al 2005; de Haes 2006; Haywood et al 2006; Makoul & Clayman 2006; Collins et al 2007; Moumjid et al 2007; Joosten et al 2008; Robinson et al 2008; Hoving et al; Eyssen et al 2011). In developing the research question then, it was necessary to consider what was meant by patient participation in decision-making and what framework of analysis to use as a means of examining communicative strategies and language use in the consultation.

The notion of *shared decision-making* (SDM) is specifically concerned with the participation of patients (and their relatives and carers) in clinical decision-making. Within the field of SDM, Charles et al's (1997) viewpoint is the most commonly cited (Makoul & Clayman 2006; Moumjid et al 2007) and is to a large extent reflected in current political attitudes, policy, and licensing and training edicts (Waterworth & Luker 1990; Makoul 2001; Crisp 2005; GMC 2006; DoH 2010; RCGP 2010a; Salzburg 2011). Their exposition of shared decision-making outlines some of the key characteristics involved in SDM. As will be discussed in Part 2 of Chapter 2, their view, combined with that of others, forms the notion of patient participation in decision-making for this thesis whereby:

Patient participation here refers to: The inclusion of patients' ideas, concerns, expectations and preferences in clinical decisions.

This interpretation of patient participation and the characteristics identified by Charles et al (1997) have, for the purposes of this thesis, been combined to produce the following summary of SDM:

SDM actively encourages patient involvement in decisions about their healthcare at their preferred level of involvement. These shared decisions should incorporate the patient's ideas, concerns and expectations relating to their health, information which should be actively elicited if not already volunteered. Choices should be discussed with the patient, including the option of doing nothing, and, where patient and practitioner cannot agree, the patient's choice should be actively endorsed.

The general approach for this research draws on the traditions of applied linguistics, and the analysis of discourse. More specifically, the linguistic analysis uses *politeness theory*, more usually known as *2nd order politeness*, as a means of approaching how decisions are reached and how meanings are conveyed and understood. The emphasis therefore is on language meaning as opposed to structure, and will highlight why we appear to mean more than we say. The most detailed and widely cited thesis within the field of politeness (Fraser 1990; Eelen 2001; Harris 2003; O'Driscoll 2007) is Brown & Levinson's (1987) theory of facework. Their concept of facework will form the central focus of attention here. As with many theoretical notions, definitions of linguistic politeness vary. A summary of what *2nd order politeness* means in this thesis is therefore presented here:

Politeness is an umbrella term for the intuitive way in which individuals use language to attend to face (Holmes 1995) – that is, the need for both inclusion and privacy (Brown & Levinson 1987), largely achieved through both the active expression of positive concern for the feelings of others and the use of non-imposing means of communication.

In essence, this view of politeness is concerned with the way in which language is modified in order to adhere to social norms and to promote cooperation through the management of face-needs (one's need for both solidarity and autonomy).

Research Aim

The research design benefited from having access to an existing dataset of videos of naturally occurring consultations between doctors (general practitioners – GPs, explained on p9) and patients in primary care in the United Kingdom (UK), collected between October 2003 – March 2004. The aims of the research were developed as a means of analysing this dataset and set out to:

Explore the way in which participants use politeness strategies to attend to face-needs in relation to decision-making during the consultation, in particular how these strategies open and close patient participation.

The research examines clinical decision-making within the consultations (as will be explained in Chapter 3). “Participants” refers to all those in the consultation: GPs, patients and those accompanying them. Politeness strategies are those aspects of language use that attend to face-needs as will be outlined subsequently (in Part 3 of chapter 2). The decisions identified for analysis were limited to those labelled here as *clinical decisions*, ones which were identified as:

Utterances which commit to a particular endpoint in relation to the patient's healthcare, and which have an action arising from them.

The investigation has been conducted from a qualitative perspective, using an *iterative* methodology, that is, a cyclical approach was used with regard to the data interpretation, one which involved constant comparison of data and theory, and in this case, comprised two phases (Glaser & Strauss 1967; Crabtree & Miller 1999; Bryman 2001). The second phase used the identification of deviant cases as a form of sampling (Patton 2001; Mertens 2004), that is, the identification of cases whose characteristics unexpectedly differed from those typically found in this dataset. Such a strategy gives one the opportunity to learn from the unusual, facilitating the identification of themes that can inform future research and clinical practice. By addressing the grant providers' interest in both a linguistic analysis of doctor-patient communication and decision-making in primary care consultations, this thesis comes under the umbrella of both doctor-patient communication, as well as applied linguistics. The findings should therefore be of relevance not only within medicine and linguistics, but also to other expert service providers.

The topic area is an important one. Patient participation is becoming increasingly prominent in healthcare policy, as is the need for good communication skills as a vehicle for furthering this ideal (GMC 2006; GMC 2009; DoH 2011b). Dialogue involves the management of relations between individuals, a characteristic which is the concern of Politeness Theory (Brown & Levinson 1987). An exploration of the impact of politeness strategies on patient participation in decision-making will therefore endeavour to further understanding of the potential impact that subtle differences in the way in which things are expressed can have on participation with a view to advancing these ideals more effectively.

Outline of the Thesis

The chapters presented here follow the model of Literature Review (Ch2), Methodology (Ch3), Results (Ch4), Discussion (Ch5) and Conclusion (Ch6), though in some cases more detailed titles have been used to better reflect the chapter's content. Chapter 2 is intended to situate the research, to provide the reader with a background to certain aspects of primary care, doctor-patient communication and relevant areas of applied linguistics. Part 1 briefly describes primary care in the UK with some background regarding medical regulation. Part 2 looks at the importance of communication skills in healthcare, and outlines some of the different models used to describe and analyse the consultation and decisions within it. It also looks at issues around patient participation. Part 3 then turns to Applied Linguistics and in particular the domain of Pragmatics. This section begins by introducing the complex notion of meaning making and the role of "indirectness" within this, demonstrating that utterances (things we say) and their meaning comprise more than simply the string of words uttered. Politeness theory is then presented as a means of explaining the range of linguistic strategies used to facilitate affective relations and cooperation through language use. This section closes with a review of previous research exploring the use of politeness in healthcare settings.

"Methodological Approach & Data Context" (Ch3) comprises four parts, beginning with a description of the methodological theory underpinning this thesis. The various processes involved in managing the data within the two iterative cycles are then outlined. Part three provides a description of the way in which the raw data were originally collected. The chapter then closes with a description of the study participants – the GPs, their locations, the patients and those accompanying them.

The Results chapter (Ch4) then reports the findings of this research. The chapter begins with a description of some of the politeness outputs that will be referred to in Phase 2 of the analysis. There then follows an overview of the preliminary findings from the first phase of the analysis. The greater part of the chapter is then devoted to the presentation of the themes identified in the second phase of the analysis. For the purposes of presentation these have been grouped into three categories: *Space*, *Endorsement* and *Confusion*. The way in which these themes come together to illustrate decision-making within the consultations is then discussed in Chapter 5. The relationship between this study and the existing literature is also commented on, followed by a critique of the research. Recommendations then follow as to how these findings might be applied to training and practice and also used to inform future research. Finally, the key findings and implications are summarised in the Conclusion (Ch6).

The first two appendices contain linguistic reference material and figures (Appendix I contains a reference guide to Politeness Theory and Appendix II a Glossary of Terms). Documentation relating to the data collection can be found in Appendices II – VII and the clinical issues relating to each of the consultations are summarised in Appendix IX. The transcripts have been reproduced in Appendix X, made available to the examiners for the purposes of the examination, and available to others on request from the University of Birmingham's library services. [This appendix cannot be made available through the library services due to ethical restrictions].

CHAPTER 2 - BACKGROUND LITERATURE

INTRODUCTION TO CHAPTER 2

This chapter starts, in Part 1, with a brief introduction to the research setting, primary care, both at the time of data collection (2003-4) and the present day (Part 1). The remainder of the chapter looks at the background literature for this investigation. This begins in Part 2 with an outline of the search strategy(ies) used and explores some of the literature relating specifically to doctor-patient communication. Part 3 then introduces linguistic theory and perspectives relevant to this thesis.

PART 1 - THE RESEARCH SETTING:

PRIMARY CARE & MEDICAL REGISTRATION

This section introduces the context in which GPs were working at the time of data collection, and in which, to a very substantial extent, they still work. The conflicting pressures that they are under form the backdrop to this thesis. Aspects of the conflicts relating to clinical decision-making and patient participation will be explored in Part 2. Endeavours have been made to try and maintain awareness of these various tensions throughout what follows.

Primary Care

The setting for this research is Primary Care, the tier of healthcare in which GPs (doctors known as general practitioners – sometimes referred to as primary care/community physicians or family doctors) work. Services are provided as part of the NHS (National Health Service) healthcare system in the UK which is state funded and free at the point of delivery. Most healthcare problems (with the exception of emergency conditions) need to be assessed in primary care in order to obtain access to medications such as antibiotics and strong painkillers, tests and investigations and specialist referrals (including physiotherapy and private consultations). At the commencement of this study, more than 90% of healthcare consultations took place in primary care (RCGP 2005: 1806) as opposed to secondary care (hospitals where patients are seen by specialists and where investigations and surgical procedures most usually take place). One can therefore see the important role that the GPs in the present study have as gatekeepers.

NHS budgets are limited and as a result tight constraints are placed on resource allocation, potentially influencing GPs' clinical decisions about their patients. Some of these constraints are therefore highlighted here. During the time of data collection and analysis GPs were contracted by the local NHS Primary Care Trust (PCT) to provide primary care to local populations. PCTs distributed funding to the practices, commissioned secondary care services and produced guidelines outlining, and sometimes limiting, the treatment options available to GPs and patients e.g. prescribing may have been limited to an approved list (practitioners do however have a professional duty to challenge these if necessary). PCT policies were influenced by, amongst other things, NICE guidelines - "The National Institute for Health and Clinical Excellence" who produced recommendations as to the most appropriate treatment options on the basis of research evidence.

In addition, national directives served to monitor GP performance and promote common standards of practice. At the time of data collection NICE had only been in existence for 4 years (since 1999). “The New General Medical Services (GMS) Contract” (DoH 2003b) had been accepted by GPs in ballots both just before data collection (Chamberlain-Webber 2004) as well as during the previous year (McKenna 2002), coming into force in 2004 (Chamberlain-Webber 2004). The GMS contract which modernised GP payments and remuneration for meeting certain performance targets was supported by the “Quality Outcomes Framework” (QoF) (Doran et al 2006). QoF was introduced alongside the GMS contract in April 2004 (DoH 2004). It provided a new means of measuring performance indicators in general practice and of financial remuneration, building on and replacing the payment tariffs listed in the “Statement of Fees and Allowances,” more commonly known as the Red Book (DoH 1995). As with the GMS contract, draft proposals of these QoF targets had been widely consulted upon in the run up to data collection. These QoF targets were also closely linked to NICE guidelines and supported priorities from the national service frameworks and strategies (see NHS 2010 for their history). Much of the changing policy around this time was a response to a series of high profile scandals within the medical profession (McGivern & Adams 2006) e.g. the trial of 3 cardiac surgeons in the Bristol Royal Infirmary Paediatric Department in June 1998 for professional misconduct; the Kent gynaecologist, Ledward, struck off in 1998 for surgical failings; and, at a different order of magnitude, the GP, Harold Shipman, arrested in Sept 1998 and subsequently found to have murdered over 200 of his patients. These various initiatives were only just being developed and were not yet policy at the time of data collection. However, GPs being interviewed in 2003 commonly referred to them (McGivern & Adams 2006). At the very least the targets

proposed by QoF certainly provided indicators as to the standards expected from GPs during this period.

The financial remuneration received for meeting performance targets is an important way of maintaining practice funds. GP practices operate similarly to small businesses run by a group of partners. As independent contractors for the PCT, unlike hospital doctors, the partners (principal GPs) are not NHS employees. Their employees' and their own salaries, as well as patient services, are dependent on money secured from the NHS. This included target payments from the Red Book (DoH 1995) for things such as cervical screening for women and providing immunisations. Subsequently, individual quality standards in QoF, known as quality indicators, also included aspects of care such as discussing smoking cessation. Where patients chose to opt out of care which attracted these kinds of target payments the practice could avoid penalisation by obtaining a letter from the patient confirming their decision. Although radical changes to the NHS are now due to come into force in April 2013 (DoH 2010; DoH 2012) changes to this aspect of operations are not currently apparent.

One of the proposed QoF guidelines around the time of data collection related to appointment times. It was proposed that appointment slots should be booked at 10 minute intervals (DoH 2003c) and this was the time allotted to prospective GPs in their membership exams (see "MRCGP" on p25). During the target time GPs had to consult patients' notes, call and wait for patients, take histories, examine, discuss treatment and write up consultations. Indeed it is common today for GPs to operate with 7 minute time slots.

21st century healthcare in the UK classes patients as consumers (e.g. Richards 2001; DoH 2010) with much emphasis on the provision of "choice" (DoH 2006) a feature which will be

discussed and critiqued later (p26). Service provision entitled patients to specifically request a second opinion from a specialist and to change their GP at any time without explanation or negative consequences. As a measure of the quality of care being offered to patients one of the QoF directives being prepared for was a mandatory, annual patient satisfaction survey whose findings they would be required to act upon, though it was not unusual for practices to undertake such surveys even before the implementation of QoF. Thus, there was pressure on GPs to maintain congenial relations in order to promote patient satisfaction.

GMC

The General Medical Council (GMC) is responsible for providing doctors with a licence to practise medicine in the UK. In turn they oversee the content of UK medical training programmes, produce guidelines for practice (GMC 2006) and investigate allegations of malpractice. The NHS only employs or contracts work to doctors registered with the GMC.

Therefore, registered doctors are required not only to operate within the remit of their employer's or commissioner's contract, but also within the GMC's code of practice (GMC 2006). This advises, amongst other things, that doctors have a professional responsibility to challenge constraining policies if they impair the provision of appropriate care for the patient (GMC 2006: 9). In addition, doctors are charged with making patient care their first concern, to treat all patients with respect, equally and without discrimination, all patients being entitled to care and treatment on the basis of clinical need regardless of the GP's personal feelings (GMC 2006). These sentiments echo what many might understand the Hippocratic Oath to have represented, that is, a commitment, although not explicitly stated, to do no harm (e.g. see North's 2002 translation), a sentiment which arguably underpins medical morals and perceptions of them, and is today portrayed in the GMC's code of conduct (GMC 2006).

RCGP

In addition to being registered with the GMC, doctors may also become members of a Royal College related to their particular area of care. The most usual route to such membership today is to pass the college's particular membership exams. The college for GPs is the Royal College of General Practitioners (RCGP). The RCGP has a range of functions including acting as a voice to support GPs and to improve patient care through working with Government and Department of Health committees/working groups as well as other healthcare organisations, including Trusts. They also provide education and training for GPs, publish a monthly journal and have an active research role including the provision of funding and research fellowships (RCGP 2011). The college's membership exam is known as the MRCGP (Membership of the Royal College of General Practitioners); its assessment of communication skills will be explained on p25. GPs contracted by the local PCT have to be on the "General Practitioner (GP) Register" in order to practise. The main route to such registration for new doctors at the time of data collection was via the MRCGP.

PART 2 - DOCTOR-PATIENT COMMUNICATION

Introduction to Doctor-Patient Communication

It has been said that “the spoken language is the most important diagnostic and therapeutic tool in medicine” (Platt et al 2001), with the exchange of information being described as a central and essential part of the consultation (Ong et al 1995) - inter-personal communication is the primary means of making such exchanges (Street 1991). Good communication skills have been demonstrated as comprising a key part of patient care (Simpson et al 1991; Brown 2008) and are now a core part of medical education in the UK, embedded in the GMC’s new outcomes for undergraduate medical education (GMC 2002; GMC 2009). However, as with many other types of inter-personal relationships, this most fundamental aspect of the consultation is complicated by the fact that relations between doctors and patients are complex - the participants hold unequal positions, the interaction may not be voluntary, there is a need to maintain close cooperation and there can be emotional overlay where issues of vital importance are involved (Ong et al 1995). The issue of doctor-patient communication is therefore an important and relevant topic of enquiry, and as will begin to unfold here, is one which is wide ranging.

Reviewing the Literature - Strategy

The importance and relevance of the topic is further evidenced by the wealth of material pertaining to doctor-patient communication. As a single example: a PubMed search was conducted on May 31st 2007 going back to 1996 (May 2007 - 1996, just over 10 years) looking for papers on health with “communication” in the title revealed 9,314, and an additional 112,990 were found looking for “communication” as a MeSH term, totalling

117,969 (MeSH terms are “the Medical Subject Headings” used by the National Library of Medicine to control vocabulary for the purposes of indexing articles). Conducting one’s own review of the current literature in this field would therefore be an ambitious task. Rather than reviewing this wealth of literature then, this part of the thesis focuses on background material relevant to the present investigation. The topics explored include:

- Defining decisions
- Choice
- Power
- Patient preferences and participation
- Patient-centred medicine

To elaborate, literature searches were conducted using a wide range of resources, focussing on specific topics and utilising different techniques and strategies to manage the large numbers referred to above. These strategies included the use of expert guidance and searching for specific combinations of terms (summarised in Box 1) in different electronic sources (listed in Box 2). All searches were limited to English. Some of the terms in Box 1 were also searched as MeSH terms.

Box 1 – Summary of search terms used

Various combinations of the following terms were searched:

Decision + definition

Health + choice / communication

Power + medicine / doctor / communication

Patient + decision-making / choice / preference / desire / passive / defer / participation

Patient acceptance of healthcare

Patient-centred

Physician-patient relations

The initial searches were conducted in 2006 and either went back five or ten years, depending on the amount of material identified and its potential contribution to the present enquiry.

However, there were variations on this, for example some searches went back to 1970 in order to include material from around the time at which the RCGP published “The Future GP: Learning and Teaching” in 1972 – to be discussed on p21) and some searches relating to the notion of patient-centeredness went back to 1950 because it was the mid 50s when Balint’s papers on the topic were first published (Balint 1955).

Box 2 – Summary of electronic resources used

- University of Birmingham Library Catalogue
- Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R)
- Social Sciences Citation Index (SSCI) and Arts & Humanities Citation Index (A&HCI)
- Social Science & Medicine journal (title searches only)
- National Institute for Health Research Service Delivery and Organisation (NIHR SDO)
- The National Research Register for Health
- The Database of Systematic Reviews for the Campbell Collaboration
- The Society for Medical Decision-Making
- Medicines Partnership Programme (which promotes concordance/shared decision-making in relation to pharmacotherapy)
- Department of Health (DoH) publications

Using the search strategies outlined, literature classed as ‘relevant’ i.e. pertinent to the topic being searched and offering additional insights were reviewed. This literature then was used to inform the remainder of this part of the chapter, turning first to an introduction to the evidence regarding the benefits of good communication skills in healthcare.

Effects of Good Communication

The importance of good communication is evidenced by research demonstrating that: more accurate and thorough information is gathered when patients’ concerns, feelings and ideas about their illness experience are sought (e.g. Kurtz et al 2005), that it reduces wastage

(Aronsson & Sätterlund-Larsson 1987; Beisecker & Beisecker 1990; Williams 1994; Haynes et al 1996; Marinker 1997; Platt et al 2001; Marinker & Shaw 2003; Marshall et al 2006), increases patient adherence (Beisecker & Beisecker 1990; Haynes et al 1996; Platt et al 2001; Dowell et al 2002 cited in Collins et al 2011; Brown 2008), satisfaction (Campion 1987; Roter & Hall 1992; Williams 1994; Stewart et al 1995; Marinker 1997; Elwyn et al 1999; Platt et al 2001; Marinker & Shaw 2003; Marshall et al 2006; Brown 2008) and clinical outcomes (Britten et al 2000 cited in: Collins et al 2011) and that consultation style consult can actually improve health (Huygen et al 1992; Brown 2008). The need for good communication skills in clinical consultations is widely accepted (Richards 1998; DoH 2000; DoH 2001; GMC 2001; GMC 2002; Kaplan 2004; Brown 2008).

Poor communication and failure to address patients' concerns are often thought to be a source of patient dissatisfaction (Ong et al 1995; McWilliam et al 2000; Stevenson et al 2000; DoH 2003a; de Haes 2006; Brown 2008), non-compliance (Williams 1994; Marinker 1997; Platt et al 2001; Marinker & Shaw 2003; Marshall et al 2006; Brown 2008), complaints and litigation (Gillespie et al 2002; Kurtz et al 2005; Brown 2008). In reviewing the literature around patients' experiences of doctor-patient communication, McWilliam et al (2000) found that doctors' attitudes had been a source of distress for some patients. They also reported that there was "substantial" literature demonstrating that "excellent" communication "empowered" patients (McWilliam et al 2000: 192).

Poor communication is often cited as an underlying factor for poor outcomes in healthcare. The evidence as to how to improve practitioners' communication skills, and indeed that doing so will actually improve outcomes can be difficult to come by (e.g. Ong et al 1995; Kinmonth et al 1998; Elwyn et al 1999; Skelton 2008), not least because of the complexity of doctor-

patient relations (Ong et al 1995). Nevertheless, the published support for the need for good communication skills in medicine is overwhelming and in particular is supported by Stewart's (1995) review of randomised controlled trials of doctor-patient communication and health outcomes – although as Skelton (2005) has remarked, this can be said to be a fairly common sense conclusion that hardly needs proving.

Decision-Making

Turning now to the analysis of decision-making, this section briefly introduces some of the different ways in which such an analysis can be approached.

Decision-making theory

Decision-making theory is concerned with identifying rules to help explain individuals' rational preferences (Kaplan 1996). It examines how people organise, manage and respond to large volumes of data and heuristics (strategies that provide short cuts to decision-making) (Eva & Norman 2005) as well as how they manage uncertainty. It is informed by a range of disciplines including mathematics, sociology, psychology, economics, political science, philosophy, history, business studies and of course medicine, and includes the study of gambling and gaming theories, as well as probability. Theories within this field include *utility theory*, *prospect theory* and *Bayesian theory*. These, however, go beyond the scope of this thesis – but are mentioned in order to clarify that this is not the aspect of decision-making for analysis here.

It is however worth noting the importance of “weighting” in decision-making. Utility theory, for example, highlights the fact that the way in which potential outcomes are valued (their

utility/usefulness) will vary not only from one individual to another, but also that individual choices will vary according to time and place (Kahneman & Tversky 2000). Healthcare professionals' personal values and beliefs (as opposed to expert professional opinion) should not influence patients' decisions (Charles et al 1997); patients' beliefs should take precedence (Marinker & Shaw 2003).

Discursive practice

The decision-making process comprises a number of stages and discursive moves (Marra 2003 cited in: Lohrova 2011). Analysis and comparison of the way in which these occur in different decision-making scenarios might be undertaken using a conversation analytical (CA) approach to examine, for example, the dynamic construction of decisions (Lohrova 2011). The importance of context is paramount to CA and ethnographic material is commonly used to complement analysis. CA is concerned with the analysis of naturally occurring talk as a form of social action which is systematically organised (Lohrova 2011). Suited to both macro and micro analyses, it is typically characterised by its interest in both the minutiae of speech production involving a close reading of the micro-structural aspects of speech as well as the relationship of the sequences in which utterances occur (e.g. Drew 2005; Wooffitt 2010 cited in: Lohrova 2011).

Medical decision-making

“Medical decision-making” tends either to refer to the analysis of the way in which healthcare practitioners make decisions for their patients, or the way in which healthcare providers make decisions about resource allocation, or policy. Research in this area invariably leads to the development of tools like decision support systems and health economic models respectively. Outcome measures are concerned with cost effectiveness, efficacy of treatment choices and

the use of evidence based medicine (EBM) i.e. utilisation of the best available clinical evidence from systematic research when making decisions about the care of individual patients (Sackett et al 1996).

Clinical decision-making

This approach explores the style of communication adopted by practitioners when consulting with patients and making decisions. Examples include: traditional, paternalistic models (Charles et al 1997), evidence-based decision-making, informed decision-making, informed participation, informed shared decision-making, integrated decision-making and shared decision-making (Trevena & Barratt 2003). These models vary in the degree to which each interactant (e.g. carers, patients and practitioners) participates in the decision-making process.

It is this latter approach (the degree of patient involvement) to the analysis of decision-making that is of interest here and which the remainder of part 2 is based upon.

Shifting Ideologies in Doctor-Patient Communication

The practice of medicine today has to varying degrees moved away from a paternalistic, medically centred model where doctors functioned as expert providers and patients as passive recipients (e.g. Elwyn et al 1999; Mead & Bower 2000) to a more patient-centred approach where patient involvement is actively encouraged. Some of the steps contributing to this move are described below.

By the middle of the twentieth century there was a growing recognition that the era of modern scientific enquiry had placed doctors in a position of hegemonic power over the patient with

the result that the patient had been reduced to a de-humanised, scientific object. The patient had become the subject of what Foucault described as “the medical gaze” (1963). In the mid 1950s Balint (1955 and 1956 cited in: Lewin et al 2001) proposed a more patient-centred approach to care called “patient-centred medicine.” It necessitated good communication skills - skills which in turn needed to be taught - not then a feature of medical training. By the 1970s there was growing recognition that the quality of communication between doctors and their patients influenced the quality of healthcare (Kurtz et al 2005). However, it was not until the 1980s that the teaching of communication skills to healthcare professionals began to take shape (Kurtz et al 2005) and became an important topic for research (Ong et al 1995: 2). During this time a more holistic approach, encompassing biological, psychological and social aspects of care began to be advocated in healthcare, including RCGP guidelines produced in 1972 (RCGP 1972). The approach came to be known as the biopsychosocial approach (Engel 1977).

An increasing number of “Consultation Models” promoting a less paternalistic style of consultation began to emerge. These acted as aids, many of which can be adopted in conjunction with each other, for the teaching and practice of doctor-patient communication. Examples of these models include Byrne & Long’s (1973) 6 phase model, Stott & Davis’ (1979) “Exceptional Potential” model & Pendleton’s 7 tasks (Pendleton et al 1984), Neighbour’s (1987) 5 “checkpoints” which were argued to be less task-oriented than the preceding models, McWhinney’s (1989) “Transformed Clinical Method” (TCM) which emphasised the need to take a patient perspective when history taking, and the “Disease Illness Model” (Levenstein et al 1989; Stewart et al 2003) - a framework to help practitioners adopt the TCM. Later examples include the Calgary-Cambridge Consultation Model &

Observation Guide, part of a communication skills training package with its own assessment tool (Silverman et al 1998).

A number of these models now inform what is today known by Balint's (1969) term - "patient-centred medicine" (PCM) (Byrne & Long 1976; Levenstein et al 1989; McWhinney 1989; Stewart & Roter 1989; Stevens 1974 cited in: Campion et al 1992; Stewart et al 2003). As will be seen below, there has been increasing interest in adopting a patient-centred approach towards the consultation (Stewart et al 2003) with a shared approach towards decision-making – i.e. shared decision-making (Stewart 1995). As will be demonstrated below, this model is now increasingly advocated in policy and guidelines.

Policy, Guidelines and Clinical Decision-Making

The role and benefits of the different approaches toward consulting and clinical decision-making, along with discussion around what constitutes "appropriate" levels of involvement and sharedness, have become increasingly prominent within clinical communication skills training (Ockene et al 1995; Ford et al 1996; Kinmonth et al 1996 cited in: Lewin et al 2001; de Haes 2006), a mark of the way in which such approaches are valued. A shared approach to clinical decision-making, one which entails increased patient involvement is now advocated in policy (Crisp 2005; DoH 2010) as well as guidelines (Waterworth & Luker 1990; Makoul 2001; GMC 2006; RCGP 2010a; Salzburg 2011). Examples of these guidelines include: the World Health Organization who state that patient involvement in care is not only desirable but a social, economic and technical necessity (Waterworth & Luker 1990 cited in: Guadagnoli & Ward 1998) and the Kalamazoo statement (Makoul 2001) which identifies the essential elements of communication, including the need to "explore beliefs, concerns, and

expectations ... and respond to the patient’s ideas, feelings, and values” (Makoul 2001: 391) and to encourage patient participation at the patient’s preferred level (to be discussed later).

This reference to the inclusion of patients *ideas, concerns* and *expectations* in decision-making often occurs in the literature (e.g. Rosenstock 1966; Becker & Maiman 1975; Pendleton et al 1984; e.g. Neighbour 1987; Stewart 1995; Kurtz et al 2005), and, as will be seen shortly, in current policy (GMC 2006; GMC 2009). It is used here as a means of determining what is meant by patient participation. These aspects of the patients’ perspective are commonly abbreviated to *ICE*, a mnemonic devised by Neighbour (1987: 43) as an “aide-memoire” for practitioners seeking to actively elicit patients’ preferences (see Box 3).

Box 3 – Neighbour’s aide-memoire “ICE”

I deas C oncerns E xpectations

Turning to the UK specifically, the Chief Executive’s 2005 Report to the NHS urged that the challenge for the organisation’s future was to “move from being a service that simply does things to or for people to one which works with them in supporting them to make decisions about their health and about the services they will use” (Crisp 2005: 28). These sentiments continue to be highlighted in the more recent *Equity and Excellence* (DoH 2010) and the GMC and RCGP have produced clear guidelines advocating the principles of SDM and PCM which are outlined below.

GMC policy

The GMC's guidelines for "Good Clinical Practice" (2006) state that patients should not only be involved in decision-making, but be actively encouraged to participate, and that their concerns and preferences should be identified and their decisions respected:

"The duties of a doctor registered with the General Medical Council" include:

"Respect [of the] patients' right to reach decisions with you about their treatment and care" (GMC 2006: i).

21) *"To fulfil their role in doctor-patient partnership doctors must ..."*

f) "Encourage patients who have knowledge about their condition to use this when they are making decisions about their care" (GMC 2006: 15).

22) *"To communicate effectively doctors must ..."*

a) "... ask for and ... respond to [patients'] concerns and preferences"

b) "Share with patients ... the treatment options available to them, including associated risks and uncertainties" (GMC 2006: 16).

This guidance states that patients have the right to be involved in decision-making and that all "treatment options" irrespective of "risk" should be shared with the patient. These sentiments support the new ideology of a patient-centred approach and are underpinned by specific learning outcomes in both pre-registration education (GMC 2002; GMC 2009) and the specialist training programme "MRCGP."

MRCGP

Adopting a patient-centred approach in the MRCGP has been described as a central skill in doing well in MRCGP examinations (Edwards & Elwyn 2006), along with a decision-making style that involves the patient (Campion et al 2002; Elwyn 2006) expressed today as:

“involving the patient in developing a shared management plan. All of this has to be done in a patient-centred way, obtaining [his/]her ideas, concerns and expectations and incorporating these into the explanation given to [him/]her. ... and should be manageable in the 10 minutes allowed for the case” (RCGP 2010a: 7).

This quotation is from one of 3 areas examined in the MRCGP’s clinical skills assessment, the “Interpersonal Skills” section in which candidates have to participate in a range of role plays and demonstrate their ability to manage different scenarios from this patient-centred perspective. As a way of identifying how their performance is measured today, candidates are advised that they will be given feedback against 16 specific statements, 3 of which relate to the role of the patient within the consultation:

12. *“Does not identify or explore information about patient’s agenda, health beliefs & preferences.”*
15. *“Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient.”*
16. *“Does not use language and/or explanations that are relevant and understandable to the patient”*

(RCGP 2010a: 7)

From this, one can see that there is an expectation that the consultation should function as a partnership (statement 15), outcomes should build on patients’ preferences (statement 12) and that interaction should be meaningful to the patient (statement 16). It is worth noting, however, that Champion et al’s (2002) analysis of over 2000 MRCGP video examinations, whose performance criteria echoed those above, found that candidates “showed only limited ability to achieve patient-centred outcomes” and rarely elicited the components of ICE.

The Government & health agendas

At the time of commencing this literature review (2006-8) *Building on the Best* (DoH 2003a) was a key report outlining the direction and emphasis in healthcare. It opened by stating that patients would be given “more choice” (DoH 2003a: 3), and there was also a commitment to the provision of “patient-centred” (DoH 2003a: 6) care. In relation to the provision of treatment and care, shared decision-making was presented as the ideal where patients “work in partnership” with healthcare professionals, sharing “their own perspective” and priorities to reach “shared decisions” (DoH 2003a: 38), an approach “welcome[d]” by the RCGP (DoH

2003a: 38). However, the detail relating to how practice should change in order to incorporate SDM or how it would be monitored was vague and referred only to chronic conditions, ante-natal care, end of life decisions and the empowerment of disadvantaged groups.

Another directive at this time was *Enabling Choice* (originally known as the Choice Agenda (DoH 2006)) where it had been intended that “choice” be facilitated by the electronic resource HealthSpace. This would have been linked to patients’ electronic summary care records (SCRs) so that patients could “make their preferences known” (DoH 2003a: 19). However, the choices were limited to areas such as faith, organ donation, birth plans, advance directives, language preference and preferred advocates. Furthermore, when *Equity and Excellence* (DoH 2010) was produced for consultation the site was still not accessible to healthcare staff and the timeline for addressing this was stuck at “under construction”. These policies (DoH 2009b), including that of the later NHS constitution, “Implementation of the right to choice” (DoH 2009a) were centred around changes to the provision of services, the promotion of healthier lifestyles (DoH 2004) and convenience (e.g. moving services from secondary to primary care, access to prescriptions, “Choose and Book” system for secondary care referrals, changes to maternity services, flexible opening hours & greater choice of GP) (DoH 2003a), not increasing participation in clinical decisions.

Today, the above themes, and limitations, have been repeated in the new Government’s proposals to revise NHS care, “*Equity and Excellence White Paper*” (DoH 2010). Points addressing themes relevant to this thesis are listed below:

1) *Liberating the NHS*

1.9 “*The NHS ... lacks a genuinely patient-centred approach*” (DoH 2010: 8).

2) *Shared decision-making: nothing about me without me*

2.1 “*The Government’s ambition is to ... involv[e] patients fully in their own care, with decisions made in partnership with clinicians...*”

2.3 “*... the principle of “shared decision-making” to become the norm: no decision about me without me. International evidence shows that involving patients in their care and treatment improves their health outcomes, boosts their satisfaction with services received, and increases not just their knowledge and understanding of their health status but also their adherence to a chosen treatment. It can also bring significant reductions in cost ...*” (DoH 2010: 13).

Increased choice and control

2.18 “*... patients ... will have ... more ... choice*” (DoH 2010: 16).

The Government is advocating a patient-centred approach (1.9), patient involvement in decision-making (2.1, 2.2 & 6.2) with the latter being reiterated with reference to the benefits of such practice (2.2, 4, 5 & 6.2) and proposes increased choice (2.18, 3.36 & 6.2). Although the paper refers to the limitations of the choices previously available through the Choice Agenda (2.20), the authors themselves really only list the same areas – choice of provider (2.19, 2.22 & 4.21) and appointment dates and times (2.21). Choice of treatment is referred to (2.20-2) but the issue of conflicts with best clinical practice and resource management are not addressed.

Society's influence

In addition to the above described policies, there are also other agendas within society that are likely influencing the change in ideologies around the doctor-patient relationship. These include a shift in society's view regarding moral and ethical obligations (Merz & Fischhoff 1990; Entwistle et al 1998; Taylor 2009), consumerist principles, patients' democratic rights as tax-paying citizens, the desire to increase accountability throughout the health service (Gwyn & Elwyn 1999; Gillespie et al 2002; Skelton 2005; Lester et al 2006), the rise of the internet's "new informed consumer" (Brown 2008; Hellenthal & Ellison 2008), the desire to reduce expenditure on unused treatments (Merz & Fischhoff 1990; Entwistle et al 1998) and not least the need to reduce the risk of litigation (Gwyn & Elwyn 1999).

Policy summary

These guidelines and policies indicate support for a more egalitarian relationship between doctor and patient, one where patient participation, perspectives, ideas, concerns, expectations and preferences are valued. However, implementation has proven to be challenging, with the net result that the practice of patient-centred approaches toward decision-making can be limited (Lewin et al 2001; Champion et al 2002; Edwards & Elwyn 2006; Edwards et al 2009). Nevertheless, it would seem that for the time being at least, a more egalitarian approach to the consultation is considered the ideal. Having identified that there appears to be widespread support, at least for the notions of patient-centredness, shared decision-making and associated concepts, these are examined in more detail next.

Patient-Centred Ideology

Over the next few pages, key features of this new patient-centred ideology will be introduced, these include the previously mentioned notions of “patient-centred medicine” (PCM), shared decision-making (SDM) and patient participation with the attendant critiques and counter responses. An important issue to note in this area is the fact that in the literature, these terms are not always used to refer to the same thing. This, and poor research design, have therefore limited research into patient participation and the application of PCM and SDM (e.g. Henbest & Stewart 1989; Guadagnoli & Ward 1998; Towle & Godolphin 1999; Mead & Bower 2000; Lewin et al 2001; Elwyn et al 2001a; Epstein et al 2005; de Haes 2006; Haywood et al 2006; Makoul & Clayman 2006; Collins et al 2007; Moumjid et al 2007; Joosten et al 2008; Robinson et al 2008; Hoving et al; Eyssen et al 2011).

PCM - Patient-centred medicine

Patients’ whose beliefs and perceptions of health differ from those of their GP are more likely to be dissatisfied with the GP’s explanations, dismissing them as irrelevant (Campion 1987; Keirns & Goold 2009). Understanding and thereby working within the patients’ framework of belief will facilitate shared understanding of utterances (things people say), promoting more effective communication (Kleinman 1975; McWilliam et al 2000). This then is the premise of a patient-centred approach, something which necessarily involves patient participation. However, at PCM’s origins this participatory aspect was much more subtle with Balint describing PCM as a belief that the patient:

“has to be understood as a unique human being” (Balint 1969: 269 cited in: Beach 2006).

This continued to be borne out by McWhinney as the model of PCM began to evolve:

PCM “*acknowledges the patient as a person with unique needs and life-history*”

(McWhinney 1981)

within PCM “*the physician tries to enter the patient's world, to see the illness through the patient's eyes*” (McWhinney 1989)

It is intended as a flexible model, not a prescriptive one, providing a means of communication that is:

“*respectful of and responsive to patients' preferences*” (Stewart 1995; Jarosch &

Allhoff 2001: 104)

And as can be seen from the quotation below, PCM includes what are in effect the components of ICE, necessitating patient participation in order to extract them:

“*Patient-centered communication is respectful of and responsive to individual patient preferences, needs, and values*” (IOM 2001: 6 cited in: Beach 2006).

PCM then is a model which incorporates both biological and psychosocial aspects of illness (Lipkin et al 1984 cited in: Beach 2006) and is considered to be central to high-quality healthcare (Epstein et al 2005). One of the key publications describing PCM in detail is that by Stewart et al (2003), updating earlier outlines (e.g. Levenstein et al 1989; McWhinney 1989; Stewart et al 1995).

SDM - Shared decision-making: a patient-centred approach

PCM advocates patient involvement in decisions about their healthcare (Stewart & Roter 1989), an approach supported by the shared decision-making (SDM) model (Elwyn et al 1999) which promotes all parties' participation in the decision-making process (Charles et al 1997). As a distinct decision-making model, SDM seems to have evolved from discussions around informed consent and is said to have first been defined in 1982 (President's Commission 1982 cited in: Makoul & Clayman 2006: 304) as something that should:

“consist of discussions ... that bring the knowledge, concerns, and perspective of each to the process ... [it] requires that a practitioner seek not only to understand each patient's needs and develop reasonable alternatives to meet those needs, but also to present the alternatives in a way that enables patients to choose one they prefer.”

Much of the literature on SDM comes from the team based at the Department of General Practice, University of Wales, Cardiff. Authors include Elwyn, Edwards, Gwyn and Sarangi. Their definition of SDM is based on that of Charles et al (1997) which they summarise as:

“involves both the patient and the clinician being explicit about their values and treatment preferences (Charles et al 1997) ... [an] approach ... to which both parties have contributed their views.” (Elwyn et al 2001a: 6)

Charles et al's (1997) important paper has been described as the most cited in relation to SDM (Makoul & Clayman 2006; Moumjid et al 2007). In addition to the above, it also emphasises the need to:

- Establish patients' preferences regarding participation
- Give patients choices
- Respect patients' choices
- Do more than merely invite agreement

Within this, Charles et al (1997) advocate the inclusion of the option to “do nothing.” They also encourage practitioners in the face of doctor-patient disagreement to show active support for the patient and to “endorse” and “respect” such decisions (Charles et al 1997: 688, 689) and address the issue of directing patients toward agreement. Communication styles in consultations have been noted as being oriented toward expert agreement (Houtkoop 1986; Heritage & Sefi 1992; Stivers 2005) and Charles et al (1997) advocate that merely obtaining agreement does not constitute patient participation. Asking patients whether or not they agree with a proposal necessitates the use of a closed question e.g. *I think we should do xxx, OK?*, actively discouraged because of the limitations placed on participant responses (Fletcher 1980; Maguire et al 1986; Spencer 2003; Cox 1989 and Wissow et al 1994 both cited in Kurtz et al 2005; Sullivan & Jeremy 2005). Supporting this, Aronsson & Sätterlund-Larsson (1987) point out that when healthcare professionals use such strategies, there are few strategies available for the patient to express resistance or opposition. As a result the patient might deliberately use minimal agreement tokens e.g. *mmm, yes*, exploiting their ambiguous nature as a means of avoiding confrontation without actually intending to convey agreement. One cannot be sure then if patient responses to such questions really indicate a joint decision.

Patient participation

These approaches to patient care, PCM and SDM, are underpinned with the belief that patients should be encouraged to participate in their consultations, attitudes which, as have been demonstrated, are reflected in government policy and teaching practice, an approach also justified on humane grounds as a “patient’s right” (Guadagnoli & Ward 1998). The notion of patient participation is however, a many faceted animal, the manifestation of which and related problems vary depending on context. Contextual items that can vary include *what* it is that the patient is participating in, the context in which the person is defined as a *patient* and what is meant by *participation*. There is a wealth of literature emanating from different contexts all labelled as patient participation with varying foci, definitions and conclusions.

To elucidate, up to the present point in this thesis, participation has been referred to as something which happens in the consulting room between doctor and patient, but it can also refer to involvement in activities such as the Expert Patients Programme (NHS 2007) where patients participate in processes such as policy development and communications training. This example includes activities in which there is no immediate effect on the participant’s health issues, a distinct variation in the notion of *what* is being participated in. Similarly, the notion of the *patient* has so far been presented here as someone requiring NHS healthcare, but there is much to be learnt from encounters outside of the NHS e.g. homeopathy where healthcare providers use different resources and approaches as standard practice (Chatwin et al 2007).

Adding to this, there are many different ways of approaching the investigation of patient participation for example the data collected might be recordings of naturally occurring interactions, or patient feedback via focus groups or questionnaires. Analysis can be

quantitative e.g. the use of coding systems to measure participation, or qualitative e.g. exploring the interrelationship between patient and medical agendas. Coupled with this, there are different aspects of *participation* on which one can focus e.g. attendance, opening greetings, rapport building, turn taking, the role of silence, physical examinations and their on-line commentary and closing. As a final point, the views and perspectives generated during such research will also vary depending on things such as the patients' state of mind, that is, depending on how anxious they are about the particular event being analysed or reflected upon.

We can see that the notion of patient participation is complex and far-reaching, something which cannot be encompassed with an all embracing definition. This complexity is both valuable and problematic. On the one hand, it makes measurement, analysis, data comparison and evaluation challenging (Collins et al 2007). This in turn makes it difficult to demonstrate evidence of the pros and cons of trying to increase levels of participation, and to identify ways in which patient participation can be developed. As Collins et al (2007) have pointed out, this can raise the question as to whether or not one should promote something where there is such limited understanding. However, patient participation is by its very nature heterogeneous, it cannot be catalogued or practised as if it were a fixed, homogenous intervention. Thus, the value of the diverse nature of the associated literature is that it captures the complexity of patient participation, the fact that it is not a single thing that can be achieved with a single tick, but rather that it means different things to different people and in different contexts.

That said, as long as these complexities are not forgotten, patient participation can be summarised as something which constitutes involvement, collaboration and partnership (Thompson 2007), something which is advocated in policy and guidelines (GMC 2006;

RCGP 2010a). However, to leave it here would be to leave the issue of “level of involvement” as barely touched. Patients’ preferences regarding the level of preferred involvement in the consultation varies, understanding and identifying these preferences is another complex issue, one where all is not necessarily as it seems – as will be demonstrated next.

Preferred levels of involvement

Returning the focus then to the consultation, PCM advocates that consultation styles should be tailored according to patient preference, failure to do so can result in lower levels of patient satisfaction (Schwartz et al 2006). To this end, patients’ preferred level of involvement should be actively explored (Charles et al 1997) and not assumed – such assumptions having been found to be unreliable (Charles et al 1997; Rothenbacher et al 1997; Guadagnoli & Ward 1998) and potentially biased by previous experiences (Elwyn et al 1999).

Research in this area explores the drivers behind people’s preferred level of involvement. Methods for doing so vary and include the examination of hypothetical scenarios (Elwyn et al 1999) and the use of different measurement tools (Guadagnoli & Ward 1998) - an example of which (Degner et al 1997) can be found in Box 4 below. Findings show that people’s preferred level of involvement varies, not only from one individual to another but also according to the nature of the healthcare issue (e.g. Blanchard et al 1988; Sutherland et al 1989; Degner & Sloan 1992; Degner et al 1997; Back & Huak 2005; Hamann et al 2005; Kuch et al 2005; Hack et al 2006). However, because of the hypothetical nature of many of these studies, there is concern about how accurately they reflect people’s true views (Elwyn et al 1999). Furthermore, as will be demonstrated next, patients may, for example, merely express a preference for a passive role because they feel unable to adopt a participatory role.

Box 4 – Scale of patient involvement (Degner et al 1997)

Preferred Statement	Grouping
I prefer to make the decision about which treatment I will receive	Active Role
I prefer to make the final decision about my treatment after seriously considering my doctor's opinion	
I prefer that my doctor and I share responsibility for deciding which treatment is best	Collaborative role
I prefer that my doctor make the final decision about which treatment will be used but seriously consider my opinion	Passive role
I prefer to leave all decisions regarding treatment to my doctor	

Patient participation – barriers

The consultation is a vulnerable place (Bliesener & Siegrist 1981; Charles et al 1997; McWilliam et al 2000; Henderson et al 2006). Consequently, patients do not necessarily raise all the ideas, concerns and expectations that they intend to (Stevenson et al 2000), there being a number of potential barriers to participation that patients might encounter. Some of these potential barriers are listed in Box 5, in addition, issues around power and institutions are briefly introduced below.

Box 5 – Examples of barriers to patient participation

Barrier	References
Lack of information or failure to understand it.	(Degner & Sloan 1992) (Wolf et al 1996; Charles et al 1997; Henderson et al 2006)
Factors such as pain, anxiety, dependency on the GP and to varying degrees their carers, limiting and restricting one's resources of negotiation.	(Bliesener and Siegrist 1981; Cassell 1991 cited in: McWilliam et al 2000)
Feelings of loss of control and power due to the illness and its effects and the need to adapt to a new role also issues around intimacy and embarrassment.	(Bliesener & Siegrist 1981 and Cassell 1991 cited in: McWilliam et al 2000) (Parsons 1951)
Underlying issues e.g. problematic attitudes, emotional or physiological experiences.	(Siminoff 1989; Meyer & Mark 1995)
Blame avoidance – in case outcomes are not ideal.	(Rothenbacher et al 1997)
Inability to accept diagnosis.	(Hack et al 1994)
Refusal to participate in management of own health generally - counter to current healthcare ideals.	(Gore & Ogden 1998) (DoH 2010)
Personality type influencing the individual's preference regarding involvement in low and high stake decision-making.	(Guadagnoli & Ward 1998)
Perceptions around the importance of the decision either that it is too inconsequential or socialisation into the belief that lay persons lack the necessary expertise to participate, or fear of making the wrong decision particularly in high stake decisions.	(Thompson et al 1993 cited in: Guadagnoli & Ward 1998) (Charles et al 1997) (Hack et al 1994; Kenny et al 1999)
Learnt behaviour.	(Towle & Godolphin 1999; McGregor 2006)
Belief that trusting therapeutic relationships entail trusting expert judgement and fear that one's preferences are unwelcome, that questioning medical advice may damage relations and risk removal from the practice register.	(Charles et al 1997) (McWilliam et al 2000; Stevenson et al 2000; Lester et al 2006) (Elwyn 2006) (Lester et al 2006)
Fear of the unknown.	(Elwyn et al 1999)
Prior experience of mechanical, ritualistic approaches to SDM - making SDM seem unsatisfactory.	(Elwyn et al 1999)
The hierarchical nature of the doctor-patient relationship preventing patients asserting themselves. combined with the disempowering obligation to legitimise one's reason for consulting.	(McWilliam et al 2000; Carabine 2001; Fairclough 2001; McGregor 2006) (Parsons 1951; Robins & Wolf 1988)
Assumed obligation to accept advice so decision to seek expert help not undermined.	(Heath 1992; Pilnick 1998)

*Additional evidence for many of these barriers can be found in Guadagnoli & Ward (1998).

A key overarching issue in relation to participation is that of the power imbalance between doctor and patient arising from their asymmetrical relationship (Bliesener & Siegrist 1981; Heath 1992; Ong et al 1995; Gwyn & Elwyn 1999; Brody 1993 cited in: Robertson 2004; McGregor 2006). This power differential is created by factors such as:

- The doctor's position as expert
- The doctor's position as a representative of a specialist and respected institution
- The doctor's social status

Although there is evidence of this power imbalance shifting – due to new attitudes in policy (patient as consumer) and the advent of the internet (Brown 2008; Hellenthal & Ellison 2008) – the asymmetry still exists (Pilnick & Dingwall 2011). It has been argued that this imbalance can be of benefit – facilitating the interactants' shared goal of finding an accurate diagnosis and optimal treatment (2005; Maynard & Heritage 2005 cited in: Pilnick & Dingwall 2011) and as part of social order provides individuals with a circumscribed role within which to operate – determining behavioural norms and thereby facilitating communication (Pilnick & Dingwall 2011). However, as explained below, the power imbalance is also disadvantageous and is the point from which many of the barriers in Box 5 emanate.

As experts, healthcare professionals' have access to a specialist discourse. Patients' restricted access to this discourse reduces their ability to converse authoritatively, impeding unambiguous, efficient communication as well as the ability to articulate questions and to legitimise *dispreferred* (to be discussed on p48) preferences (Cheek 2004). Similarly, patients' lack of expertise can make it difficult for them to assess what is and is not relevant to

the consultation, further disadvantaging them (Spencer-Oatey 1992; Thomas 1995; Holmes & Stubbe 2003; Brody 1993 cited in: Robertson 2004; Wang 2006).

The institutional nature of healthcare further adds to the asymmetry (e.g. Wang 2006). Historically, there is a normative character of institutional interaction e.g. the sick role described by Parsons (1951), which, as indicated in Box 5, places an expectation on the patient to behave in a certain way – beholden to the expert practitioner, issues relating to this can also be found in Box 5. The practitioner's power is in turn manifested, for example, through the dominance of the questions posed to the patient (Gwyn & Elwyn 1999; Wang 2006) – an undertaking necessary to arrive at or exclude diagnoses, but one which can seem strange and unrelated to the lay person.

Social status is a composite of status, age, sex, degree of intimacy, etc – psychologically real factors which together determine the overall degree of respectfulness in a given situation (Thomas 1995). Today, despite increasing emphasis on widening access, medicine carries a legacy of having been a profession practised by the wealthy and by those of high social status (Goodyear-Smith & Buetow 2001), the elite few. It is certainly a profession that commands a salary higher than that of the average worker. Whether real or assumed, patients may well perceive that there is a difference in the social distance between them and their doctor, in turn affecting their ability to assert themselves (Brown & Levinson 1987).

This is just a brief look at the impact of power on the consultation. The sociological and linguistic literature relating to power in institutional discourse and other unequal interactions is extensive. Examples of reviews in this area include Lohrova (2011) and Koester (2006). The patient role can be a vulnerable one, one where the motivation to initiate contributions

and/or to deviate from normative roles is limited (Parsons 1951) creating, for example, a belief that *dispreferred* responses (see p48) should be avoided. As part of a PCM approach practitioners have a responsibility not only to be amenable to patient participation, but also to actively facilitate it (Simpson et al 1991; McWilliam et al 2000; Stevenson et al 2000; Makoul 2001; GMC 2002; GMC 2006; Collins et al 2007; GMC 2009; RCGP 2010a). Importantly, patients have been noted to shift from a preference for a passive to an active role once they have understood the pros and cons of the available choices (Wolf et al 1996), they may simply need empowering to participate.

Critique and promotion of patient-centred approaches

So far, the notion of increased patient participation has been presented in a purely positive light. However, there are concerns, for example, about some of the drivers behind increased patient participation such as consumerism and politics (Collins et al 2007). Additional concerns about the adoption of a patient-centred approach are outlined below.

Inviting patients' contributions

Some practitioners argue that they lack the skills to invite patient involvement (Platt et al 2001), that when trying to elicit the components of ICE their attempts have been met with retorts such as “Why are you asking me, you’re the doctor” (Elwyn et al 2001b: 218).

Responses to such dilemmas can be found in the literature, suggesting ways of inviting patients' contributions:

- Asking: “*I’ve got some ideas as to what it might be, what were your thoughts?*” (Neighbour 1987: 172) to elicit the components of ICE.
- Brainstorming and rehearsing ways of exploring ICE (Kurtz et al 2005)
- Discovering for oneself suitable ways of framing such enquiries (RCGP 2009)
- Purposefully giving patients the option of asking questions and to express their preferences and importantly helping them to do so (Guadagnoli & Ward 1998; McWilliam et al 2000; Stevenson et al 2000)
- Creating a supportive atmosphere (Charles et al 1997; Guadagnoli & Ward 1998)
- Fostering relationships over time which in turn results in mutual understanding and thereby enhanced information sharing (McWilliam et al 2000)
- Using research findings to raise awareness of one’s own practice and to promote reflection (Collins et al 2007).

Similarly, Helman (2001) makes some suggestions useful for eliciting patients’ ICE, see Box 6.

Box 6 – Eliciting ICE

- | |
|--|
| <ol style="list-style-type: none"> 1) <i>What has happened?</i> Description of symptoms and onset. 2) <i>Why has it happened?</i> Aetiological cause. 3) <i>Why has it happened to me?</i> Relationship between symptoms & individual’s body. 4) <i>Why now?</i> 5) <i>What would happen to me if nothing were done about it?</i> 6) <i>What are its likely effects on other people (family, friends, employers, workmates) if nothing is done about it?</i> 7) <i>What should I do about it – or to whom should I turn for further help?</i> <p style="text-align: right;">(Helman 2001: 86)</p> |
|--|

Adopting a consultation style that gives patients sufficient control to enable them to air problems that might not otherwise be uncovered through more traditional diagnostic routines

(Guadagnoli & Ward 1998; Elwyn et al 1999; Fairclough 2001; Feinmann 2011; Gulland 2011) should help the practitioner enhance their ability to involve the patient.

Conflicts between PCM & other targets

Key ideologies and targets in and for today's healthcare (of EBM, governance, standardisation, QoF, guidelines, time constraints and best clinical practice) can appear to, and indeed to a certain extent do, conflict with PCM and SDM (Charles et al 1997; Marinker & Shaw 2003; Elwyn 2006; GMC 2006; Barratt 2008; Keirns & Goold 2009; The Lancet 2011). By encouraging patients to make their own choices, does one increase the risk of them opting for things that run counter to best clinical practice? Is it good time management to invite discussion where only one option is apparent (DoH 2003a; Lester et al 2006)? Why raise the option of doing nothing when the patient's very attendance suggests that they want treatment? These conflicts can understandably cause practitioners some anxiety (Marinker & Shaw 2003; Elwyn 2006; Keirns & Goold 2009) especially alongside the principles of Good Medical Practice which charge doctors to "provid[e] ... treatment where necessary" (GMC 2006: 7).

When it comes to the management of disagreement within a patient-centred approach Charles et al (1997) explain that disagreement and SDM are not mutually exclusive when approached sensitively, through concordance:

"an agreement that respects the beliefs and wishes of the patient, and not compliance — the following of instructions" (Marinker & Shaw 2003: 348).

Echoing Charles et al's (1997) directive that patients' dispreferred decisions be endorsed and respected, Keirns & Goold also advocate that such decisions should be "honored" as long as patients have had the opportunity for full discussion and their comprehension, including that of any potential risks and implications, has been thoroughly explored (2009: 1806).

Patients prefer paternalism & distrust alternative attitudes

A number of rationales have been identified for a more directive, paternalistic approach to decision-making: patient preference for such a style (Freedman 1993; Ong et al 1995; Elwyn et al 1999; Back & Huak 2005; de Haes 2006; Taylor 2009); concern that less directive approaches undermine patients' trust (Thompson et al 2007) and are perceived as "doctor uncertainty" (Elwyn et al 1999); fear of the damage caused by insisting patients make final decisions they are not comfortable with (Chisholm & Askham 2006; Edwards & Elwyn 2006), to reduce patient anxiety levels (Davey et al 2004); to prevent distress (Steginga et al 2002), to promote patient satisfaction (Lam et al 2003); or to avoid conflict, alienation of patient or family (Lee & Wu 2002). PCM and directive approaches are not mutually exclusive. PCM is by definition flexible and does not require practitioners to impose final decision-making on patients (e.g. Stewart 1995; Charles et al 1997; Entwistle et al 1998; Guadagnoli & Ward 1998; Elwyn et al 2001b; Trevena & Barratt 2003). However, normalising patient participation as an everyday approach to patient care will not only help the practitioner to develop new skills, but will also help to ease patients' anxieties and to increase their own participatory skills (Elwyn et al 1999; Feinmann 2011; Gulland 2011). One can still encourage participation even if the clinician accepts ultimate decision-making responsibility (Guadagnoli & Ward 1998).

It's too time consuming

Another concern is that PCM is too time consuming (e.g. Charles et al 1997; Platt et al 2001; Gillespie et al 2002; Levinson et al 2000 and Langewitz et al 2002 both cited in: Kurtz et al 2005). A directive style of consulting quickly and concisely conveys the best, and sometimes only, treatment option to the patient (The Lancet 2011). However, the RCGP, for example, believes that a PCM approach is achievable within the constraints of a 10 minute consultation (RCGP 2010a: 6) and research has shown that PCM can actually shorten consultations (Levinson et al 2000 cited in: Kurtz et al 2005) and that even patients with complex problems can be succinct when given the opportunity to present, uninterrupted (Langewitz et al 2002 cited in: Kurtz et al 2005).

Patients lack the necessary skills

Finally, there is concern about patients' ability to reason and understand the complexities of medicine. With this in mind, fear has been expressed about the risk of patients making ill-informed decisions (King et al 2005) or unsystematic ones e.g. based purely on previous experience or misunderstandings (Steginga et al 2002).

There has been much interest in identifying the participatory skills needed by patients and how they could be taught (e.g. Kaplan et al 1989; Anderson & Sharpe 1991; Milne & Oliver 1996; Towle & Godolphin 1999; Gaston & Mitchell 2005; Hoving et al 2010). Gaston & Mitchell's (2005) systematic review, for example, identified the benefits of question prompt sheets, audio-taping of consultations and patient decision aids in facilitating patient involvement. As with other aspects of PCM, there is a lack of robust research in this area (Towle & Godolphin 1999; Hoving et al 2010), and a need to explore how patients

themselves can utilise research findings to enhance their ability to participate (Gafaranga & Britten 2007).

SUMMING UP DOCTOR-PATIENT COMMUNICATION TODAY

Although not always easy to evidence, it is widely agreed today that good communication skills are an important aspect in meeting healthcare objectives and patient satisfaction. In keeping with this there has been a move away from paternalistic styles of consulting toward more patient-centred ones, and, despite concerns about increasing patient participation and its drivers (Collins et al 2007), this is currently advocated in policy and guidelines (see p22).

Although people are unlikely to disagree that healthcare ought to be patient-centered (IOM 2001 cited in: Beach 2006), whether or not moves toward PCM are truly representative of a change within the medical profession or instead merely reflect society's view as to how one should interact is uncertain (Skelton 2005). Others have previously noted that although the language of practitioners can change to appear more patient-centred, the activities and attitudes can remain unchanged (Gillespie et al 2002). Henbest & Stewart (1989) alluded to this also. There is a risk that the need to at least appear to be in keeping with society's demands may have resulted in the notion of patient-centeredness becoming overused, to the extent that it now means little more than "good" (Skelton 2005). Nevertheless, the assumption in this thesis is that a more patient-centred approach to decision-making with active patient participation is a good thing. The way in which language is used in relation to these goals will be the focus of the remainder of the background literature.

PART 3 - LINGUISTICS & PRAGMATICS

Making decisions and getting things done in the consultation relies upon language and communication. Achieving one's goals requires "subtle and complex negotiation" (Holmes & Stubbe 2003: 14). This next section introduces a few basic concepts in linguistic theory demonstrating language's multi-functional nature and factors which influence language choice.

Indirectness: Saying One Thing, Meaning Another

"Ambiguity, prevarication, politeness, respect for others – however you want to label it, we talk in riddles a great deal of the time" (Skelton 2008). What people appear to say and what they actually mean do not always correlate. "Meaning" is a dynamic process negotiated between speaker, hearer and context and not something inherent in words alone (Thomas 1995: 22; see also Spiers 1998). Language is not merely *referential/transactional*; that is, it is not just a means of exchanging or transmitting information. It also has an *affective/relational/interactional* (interpersonal) function (Holmes 1995; Brown & Yule 1983 cited in: Spencer-Oatey 2000a; Harris 2003; Koester 2006); it is involved in "the management of social relations" (Spencer-Oatey 2000a: 2).

Context, power, social distance and the nature of individual utterances all influence the purpose of our utterances and thereby the way in which we say things (Thomas 1995).

Language *form* is what we think of as the grammar and grammar rules of a language. We might, for example, classify the things we say as *declaratives*, *interrogatives* and *imperatives*. In English, the way in which these are recognised is driven by the order in which subject, verb and object appear in the utterance (see columns 1-4 of Box 7). However, actual language use

and *function* can differ from form. Examples of this are given in column 5 of Box 7. These examples show that form does not necessarily dictate function and vice-versa, e.g. suggestions can be made by using either declaratives or interrogatives. There is a close, but by no means complete, overlap between the formal categories of declarative, interrogative and imperative and their functional equivalents: statement, question and instruction. Examples of further reading in relation to word order include Bullon (1990), Halliday (2004), Leech (1975), Biber (2002) and Quirk (1972).

Box 7 – Form & function

Form	Prototypical example	Function of prototypical example	Word order	Functional uses of interrogatives
Declarative	You should take your painkillers.	Suggestion	SVO (subject-verb-object)	Why don't you try taking your painkillers? (interrogatives can be used to used to make a suggestion)
Interrogative	Are these your painkillers?	Question	VS (subject-verb inversion, with or without auxiliary such as do, does, have etc)	These are your painkillers? (tone can be used to produce a declarative that functions with the force of an interrogative)
Imperative	Take the painkillers!	Instruction	(VO) (subject usually omitted and base form of verb used)	Take them as needed? (tone can also be used to produce an imperative form used to make a suggestion)

These examples of actual language use and function versus form exemplify issues of particular interest to the sub-discipline of *pragmatics*. Some of the relevant theories from this domain are now introduced.

The theory of *adjacency pairs*, and more specifically the notion of *preferred/dispreferred responses*, provides useful insights into patterns of language use. Adjacency pairs are successively occurring sequences of turns characterised by a first part which demands a

response producing a second part directly related to the first (Sacks n.d. cited in: Coulthard 1985). For example:

- a) 1st pair part: *What's your name?*
- b) 2nd pair part: *Jane Smith*

The first part of an adjacency pair comes from the speaker (e.g. line (a) above) with the second part being the listener's response (e.g. line (b) above). The first pair part predicts the occurrence of the second and also determines what would and would not be a relevant response from the listener, creating an expectation which the listener is expected to fulfil and leading the listener to a preferred response (Coulthard 1985). Failure to provide a satisfactory response (in this case a name) breaches social norms.

Building on the notion of adjacency pairs, Pomerantz (1978; 1984), Atkinson & Drew (1979) and Levinson (1983 all cited in: Coulthard 1985 & Brown & Levinson 1987) examined *preference organization*, classing responses as satisfactory – *preferred*, or unsatisfactory – *dispreferred*. In example (a), above, providing the requested information (b) is the *preferred* response, avoiding doing so would be a *dispreferred* response (Taylor 1989). Different types of adjacency pairs include: *questions, greetings, complaints and invitations* (Coulthard 1985). Of most relevance to decision-making within doctor-patient consultations are invitations. Invitations naturally prefer acceptances (Levinson 1983 cited in: Coulthard 1985), their structure is such that the routinised response is agreement and so are described here as *invitations to agree*, for example:

c) 1st pair part: *Let's do x*

d) 2nd pair part: *OK*

As can be seen in (d) preferred responses tend to be simpler and more routinised, making them easier to construct and reproduce, becoming almost automatic, unconscious responses (Levinson 1983 cited in: Coulthard 1985). Conversely, dispreferred responses relate to the telling of things such as the individual's specific circumstances or viewpoint and as a result are not routine. Dispreferred responses breach social norms and therefore require careful consideration in order to ensure that the response does not damage relations by causing offence demanding a greater level of conscious thought to construct and are likely to be complex in nature because they also serve to repair potential damage to the relationship (Levinson 1983 cited in: Coulthard 1985). This type of adjacency pair is structured, whether conscious or not toward an assumption of agreement. The level of risk to the listener of offending the speaker with a dispreferred response is potentially heightened not only by the fact of being unable to help the speaker, but also by the need to construct and offer a dispreferred response. Importantly, these theories highlight the social pressure imposed by such invitations.

Modification strategies enable us to soften utterances, such as dispreferred responses in order to reduce conflict. This softening makes utterances seem less direct, avoiding a directness that might otherwise be interpreted as tactless or discourteous, a feature of language use that contributes to the management of social relations. Modification strategies include *compliments, rapport management, hedging, indirectness* and *paralinguistic signals* (tone, inflection, rhythm, tempo, intonation and stress) (e.g. Searle 1969). The degree of

modification used in an utterance is influenced by factors such as power, social distance and the nature of the utterance (Thomas 1995).

Speech Act Theory also offers important contributions to our understanding of language use. Described by Searle (1969) in his development of Austin's (1962) ideas about language use, *Speech Act Theory* is concerned with the meaning or purpose behind utterances. It identifies different ways in which utterances can be interpreted – according to their *locutionary force*, *illocutionary force* or *perlocutionary uptake*. To demonstrate:

Patient: [walking towards the door]

GP: Are they your painkillers?

Patient: Oh yes, thank you [turns back to GP and reaches for tablets]

GP: [Smiles approvingly]

Patient: [leaves]

In the example above the GP says, “Are they your painkillers?” The *locutionary force* is the propositional meaning which in the literal sense here is a closed, yes-no question regarding ownership. The *illocutionary force* is what the speaker intends to mean, in the GP's case above, this is as yet unclear. The illocutionary verb to be, here in the form of “are,” does not give any clues as to the illocutionary intent, as is often the way (Searle 1979b). The *perlocutionary uptake* is what the hearer believes the speaker means, in this case that the utterance is intended as a reminder not to forget the tablets. Since the GP does not make any further responses indicating an alternative illocutionary intent it would seem that in this case the listener's perlocutionary uptake matched the speaker's illocutionary intent. The GP does not explicitly remind the patient about the tablets by saying something like “Don't forget your

tablets,” rather the reminder is made indirectly exemplifying an *indirect speech act*. The illocutionary purposes of utterances include things like requests, commands and advice (known as *directives*).

This distinction between the proposition, the intention and the uptake is central to how languages work, to how misunderstandings arise, and to how people allow a degree of ambiguity in their interactions with each other. For the purposes here, one could argue that when a doctor says *Is that OK?* what he or she really means includes *I believe this to be the best course of action, therefore I expect you to say yes* and this indeed may be how the patient interprets it. Under these circumstances, the patient might say afterwards *It's really hard to object ...*, meaning that he or she felt forced into acquiescing to the perceived illocutionary intent. The doctor on the other hand might say *but I checked to see if they were happy with what we had agreed*, a justification based on the fact that this was the illocutionary intent.

This simplified introduction to Speech Act Theory does not touch on the array of associated terminology found in the literature, or the variation in use of the different terms. However, it introduces the notion of illocutionary force and associated concepts. Identifying indicators of the speaker's illocutionary intent, and observing its subsequent perlocutionary effects are important tools in the interpretative analysis of meaning making in discourse analysis.

From all of the above, one can see that meaning is not always explicit and yet, despite this, interactants do not labour over how to interpret utterances; rather, “rapid, routinized interpretations ... [are made] based on the predictability of a large part of human interaction” (Ervin-Tripp 1976: 52 cited in: Tsui 1994: 110). These skills are gained experientially (Malmkjær 1991) through routinised use (Tsui 1994). As part of the process of socialisation

we learn to interpret utterances using: knowledge of the social rules which govern interaction, shared background information with the speaker, our general powers of rationality and inference, and the principles of cooperation (Malmkjær 1991; Spiers 1998). Knowing how and when to modify one's language is an important aspect of language proficiency. The influence of principles which govern such decisions are of crucial interest here, since understanding the rules and principles behind devices like modification and its interpretation will help us understand their effects. This in turn should reveal strategies which promote and inhibit communication. A key principle in this aspect of language use is that of *linguistic politeness* and this is examined next.

Politeness

1st and 2nd order politeness

Understanding and describing the notion of *linguistic politeness* can be quite a challenge. Not only is there confusion between the linguistic and lay usages of the term, but also, those writing about linguistic politeness have a tendency not to specify what they mean by the term (Fraser 1990; Sifianou 1992; Eelen 2001; Watts 2003), and as will be demonstrated, authors' approaches and perceptions differ.

Politeness occupies two different fields within linguistics. The first area is concerned with the conventional, lay understanding of politeness. Literary analysts' interest in politeness examines the way in which the language of politeness, in literary texts, has changed over time. In this context "politeness" refers to the everyday concept of politeness i.e. good manners, or one's ability to be considerate or courteous (OED Online 1989b; 1989c; Fraser

1990), the opposite of being rude. This view of politeness has been referred to as *1st order politeness* (Watts 1992) or *the social-norm view* (Fraser 1990).

Over recent times, interest has emerged within the field of pragmatics in a different aspect of politeness known as *2nd order* or *linguistic politeness* (Watts 1992) aimed at explaining the structure and indirectness of verbal communication (Spiers 1998). From this perspective, politeness is commonly viewed as a concept referring to the strategic management of conflict-avoidance, one which involves social indexing (Eelen 2001:29) and functions as a means of managing social relations. Following is a much simplified introduction to 2nd order politeness.

The conversational-maxim view

The field of linguistic politeness appears to have developed largely as a response to Grice's theory (Fraser 1990) that the overriding principle in conversation was the "Cooperative Principle" (Grice 1975 cited in: Wardhaugh 2006: 287). The success of conversations depends, in part, upon cooperation, to a mutual commitment to making the interaction work. Grice (1989) identified four principles (known as Grice's Maxims) which influence the way in which people speak and its subsequent interpretation:

- **Quantity:** Contributions should be as informative as required – do not provide too much information.
- **Quality:** Contributions should be true – one should not say things believed to be false, or for which there is insufficient evidence.
- **Relation:** Contributions should be relevant.
- **Manner:** Contributions should be perspicuous - one should not use obscure expressions or be ambiguous, one should be brief and orderly.

Grice's maxims were based on the belief that, generally speaking, conversationalists' primary concern was efficiency. As Fraser (1990) points out, Grice's logical, reasoned maxims failed to explain why in reality these rules were often flouted in ways that were actually considered to be socially acceptable e.g. "pass the salt" is far more efficient than saying "please could you pass me the salt," the latter being more ambiguous in terms of interpreting illocutionary intent. Lakoff (1973 cited in: Fraser 1990) presented an explanation for this, one which described linguistic politeness as a device for reducing friction in personal interaction (Lakoff 1979 cited in: Fraser 1990). She identified different types of politeness:

- Formal/Impersonal Politeness
- Informal Politeness
- Intimate Politeness

Lakoff also emphasised the significance of context and the possibility of utterances being interpreted in more than one way (Lakoff 1972 cited in: Spiers 2000). Her criteria demonstrate that if, for example, the main goal of an utterance is the message, then the emphasis of the speech act will be on clarity; whereas politeness will become the emphasis if

the status of the participants and/or the situation is the speaker's main concern (Spiers 2000). One of the limitations identified in relation to Lakoff's theory is that she is said to use terms such as formality and aloofness to mean politeness without defining them, when in actual fact such behaviours are not always intended to convey politeness (Spiers 2000).

Leech's (1983 cited in: Fraser 1990) contribution to this view of politeness was to provide explanations for the factors which guide and constrain conversations by elaborating on Grice's. His work, along with that of Lakoff's (1972; 1973; 1979 above) and Brown & Levinson's (1978, to follow) has been described as forming part of the "core" of politeness research (Eelen 2001: 23). He identified 3 different sets of maxims known as:

- Grice's Cooperative Principle (CP)
- A Politeness Principle (PP)
- An Irony Principle (IP)

His principles focus on the importance of minimising expressions that might be unfavourable to the hearer and maximising those that are more favourable, classifying utterances as either polite or impolite. His theory is therefore slanted toward the management of impoliteness (Fraser 1990; Watts 1992). CP explains how utterances might be interpreted and PP why indirectness might be used (Fraser 1990). Limitations identified with Leech's approach include the fact that the maxims do not address the expressive aspects of language (Spiers 2000), or the way in which language is used to address interpersonal issues (Sifianou 1992 cited in: Spiers 2000).

The face-saving view (Brown & Levinson)

A brief overview of Brown & Levinson's (1987) work is given here as part of the introduction to politeness theory. However, since the analysis for this thesis is based on their work, further detail is provided from p61.

Central to Brown and Levinson's (1987) detailed theory of politeness is the management of cooperative relations through attention to *positive* and *negative* face. The notion of *face* is explained more fully on p62 but can be summarised as both the need for appreciation and not to be imposed upon. As with Lakoff (1973) and Leech (1983), Brown & Levinson see the notion of linguistic politeness as a means of explaining why interactions do not adhere strictly to Grice's conversational maxims (Fraser 1990). Unlike Leech (1983), however, their face-saving view is not evaluative (Watts 2003). They do not view speech acts as either inherently polite or impolite, rather they view such acts as have varying degrees of face threat (Fraser 1990; Watts 1992) – either to positive or negative face and provide a model with which to measure the degree of such threats. Brown & Levinson also describe, in great detail, 5 different super-strategies (discussed later), as opposed to maxims, that individuals use to manage such face threat, each reflecting the increasing amount of threat involved, and having different linguistic *outputs* associated with them (these will be revisited on p70).

The most contentious aspect of Brown & Levinson's theory is their claim that it is universally valid – that their interpretation of positive and negative face, the principles of face threat and social reasoning are valid across all cultures (Eelen 2001). As a response to these criticisms they republished their thesis in 1987 with a 54 page response in which, amongst other things, they conceded that their notion of a “model person” was subject to cultural elaboration (Brown & Levinson 1987: 13) - that there will be cultural variation around such things as

causes of face threat, the types of relationship that engender face-protective strategies and preferences around politeness styles. Other criticisms include the view that their theory does not account for such things as sarcasm, humour and irony (Fraser 1990) since even within cultures the notion of being rude or over-polite etcetera are disputed (Locher & Watts 2005).

Other approaches to politeness theory

Indeed, much of the work in the field of politeness today is oriented toward trying to fine tune and develop aspects of Brown & Levinson's (1987) work, either the labels that they use, their use of facework or its universal application. For example, Locher & Watts (2005) argue that facework and politeness are entirely different, that the linguistic strategies used to manage face should be known as *relational work*, of which politeness is just a small part. Spencer-Oatey (2000a) suggests the term *rapport management* instead of *facework* to take the emphasis off self. Another variation is Holtgraves' (1992) argument that the predominant use of strategies numbered more highly does not necessarily indicate a high level of threat. Other variations can be found in the 2008 LPRG conference proceedings (LPRG 2008), and O'Driscoll (2007) also provides a comprehensive review of such variations (including at least 9 alternative labels for Brown & Levinson's notion of facework).

Ide describes politeness as "language usage associated with smooth communication" (1989: 225 cited in: Watts 2003: 52). She changes the emphasis others place on what she labels as "Volition" - the choices that Lakoff (1973), Leech (1983) and Brown & Levinson (1987) all cited in Eelen (2001) associate with politeness (Ide 1982 cited in: Eelen 2001). Her concerns centre around what she refers to as the notion of "Discernment" in Japanese. Inscribed in Japanese grammar are certain social obligations which mean that certain types of utterance can only be made with the use of honorific verbs. In these examples social neutrality and

choice is impossible. She argues that this important aspect of Japanese politeness is not adequately explained by theories such as Brown & Levinson's (1987 as cited in: Eelen 2001).

Others have also highlighted this lack of choice. Blum Kulka (1982 cited in: Eelen 2001) argues that in an Israeli-Jewish context face-wants are culturally determined and discernment highly conventionalised, bringing into question the scope for free-will. Gu (1990 cited in: Eelen 2001) based his theory on Leech's, going on to argue that Chinese morality dictates the way in which politeness is used – that Chinese politeness constitutes a prescriptive set of rules as opposed to a means of explaining the modification of utterances. As with others (Fraser 1990; Locher & Watts 2005), he does not see the management of individuals' face-needs as being part and parcel of the politeness phenomena.

Conversely, Arndt & Janney (1979 cited in: Eelen 2001) like Brown & Levinson (1987) refer to positive and negative face. However, they replace the term *politeness* with “interpersonal supportiveness” (Arndt & Janney 1985 cited in: Watts 2003) and focus on the way in which interactants consciously modify their behaviour in order to convey their emotional, not sociological, position (e.g. level of confidence, feelings towards the situation). Also of particular interest is their emphasis on the importance of paralinguistic signals. In Fraser & Nolan's (1981 cited in: Eelen 2001) view, interactants have a conversational contract with rights and obligations, a shared understanding as to how to behave towards each other in order to avoid being impolite. Fraser & Nolan group these rights and obligations into 4 different “dimensions” a view that involves abiding by Grice's cooperative principle as being central to politeness, and their notion of the “conversational contract” (Fraser 1990). Unlike the face-saving view, they do not see the management of interactants' emotions as being part of the

notion of politeness and they view deference as being an activity separate from politeness (Fraser 1990).

Defining politeness

Despite the paucity of explicit definitions given by the various authors it is evident from the way in which they write that their interpretations of politeness vary (Fraser 1990; Sifianou 1992; Eelen 2001; Watts 2003). Brown & Levinson (1987) can be said to view politeness as a complex system for softening face threatening acts (Sifianou 1992 cited in: Watts 2003), whereas Arndt & Janney (1985 cited in: Watts 2003) see politeness as the provision of interpersonal supportiveness. Others echo these perspectives, for example, Kasper (1990 cited in: Watts 2003) describes communication as dangerous and antagonistic with politeness being a tool for defusing the danger and minimising antagonism. Leech (1980 cited in: Watts 2003) sees it not only as strategic conflict avoidance but also as the establishment and maintenance of comity (friendliness/courteousness). Sifianou (1992 cited in: Watts 2003) points out that meeting the needs of others e.g. by attending to face, not only acts as an archetype for others to follow, but also instils in individuals a sense of satisfaction. Common to many of the differing views pertaining to politeness theory (but not all) is the idea that politeness is a strategic means of conflict management involving social indexing (Eelen 2001). Underpinning these various views is the fact that language is a tool for maintaining harmonious relations, that one's utterances are multifunctional, having the potential for communicative meaning that goes beyond literal semantics, that there is a difference between pragmatic force and semantic sense. It is this phenomena that is of interest in the analysis of the data here, in particular the dominant face-saving view presented by Brown & Levinson (1987). Their politeness theory is therefore presented in greater detail next.

Brown and Levinson's Politeness Theory

Brown & Levinson's *Politeness Theory* (1987 & 1978) was first identified as a potential means of analysing the discourse in this dataset because of the way in which it dominates the field of politeness research. As well as being a "core" piece of politeness research (Eelen 2001: 23) it has been described as:

One of the "*best known*" in the field (Fraser 1990: 228).

The most "*influential*" (Eelen 2001: 3).

As having "*attained canonical status, exercised immense influence, and ... [being] the model against which most research on politeness defines itself*" (Harris 2003: 27-8).

And "Brown & Levinson" as having "*become almost synonymous with ... politeness*" (Eelen 2001: 3).

One can see therefore that despite having been widely criticised, their thesis remains a powerful and useful tool for the linguistic analysis of politeness, which even critics have said should not be dismissed (O'Driscoll 2007). The concerns regarding the measurement of face threat and the universality of their theory are not disputed in the present thesis. However, the research question here is not a cross-cultural analysis, rather, the population in question bears similarities to that analysed by Brown & Levinson (1987). Unlike other approaches to politeness, their theory provides extensive tools for the interrogation of discourse (O'Driscoll 2007) and in particular the effects of the various lexical choices made on illocutionary force. Their focus on the management of face threat is most apt for the context of this data and the interactants' position in relation to each other. Finally, the wealth of literature pertaining to it provides a valuable range of resources.

Face (positive & negative) and facework

Brown & Levinson's (1987) theory of politeness builds on Goffman's (1967) observation that when people interact they constantly worry about maintaining a commodity called *face* (Pinker 2007). First proposed by Goffman (1967), the notion of *face* is derived from the Chinese, and first appeared in the English language in this mode in 1876 (Thomas 1995); it resonates with the English folk-term of *losing* or *saving face* referring to embarrassment or humiliation (Brown & Levinson 1987). Goffman defined *face* as:

“the positive social value a person claims for himself”

(1967 cited in: Holtgraves 1992: 141)

adding to this Brown and Levinson (1987: 61) explain face as:

“the public self image that every member wants to claim.”

As Spiers (1998) points out, it is important to understand that although face can be compared with the concept of “self,” the comparison is of limited use since face does not refer to something that resides within the individual, but rather is manifested through interactions with others, although as Brown & Levinson (1987: 85) explain, face-needs and the performance of facework are not something that one is necessarily conscious of. Spiers (1998) goes on to explain that one's sense of self (certain aspects of) can be enhanced through self-gratification, whereas face-needs can only be satisfied by others. Because of this reliance on others for the satisfaction of face-needs, known as *mutual vulnerability* (Brown & Levinson 1987: 61), it is in everyone's interests to attend to each others' face-needs. To this end, supporting others' face also functions to attend to one's own face-needs (Spiers 1998).

The needs associated with the two different aspects of face, *positive* and *negative*, are listed in Box 8:

Box 8 – Positive & negative face-needs

Positive face:	Portrayal of self as appealing to others Need to be appreciated and approved of Need for one's wants to be desirable to others
Negative face:	Territorial claims (e.g. to that of expert status) Preservation of self Right to non-distraction/imposition The right to freedom of action (Brown & Levinson 1987: 61-2)

It is important that these terms, negative and positive, are not confused with the evaluative concepts good and bad respectively, since both are equally valid (this caveat applies to all such references in relation to Brown & Levinson's theory). In short, these two aspects of face can be summarised as:

positive face - "the desire to be approved of, liked, understood and appreciated"

(Spiers 1998: 31) and

negative face - the "desire for autonomy, freedom from imposition and freedom of action" (Spiers 1998: 31).

From this, the notion of face is understood here to refer to:

Aspects of self that we want others to recognise and respect such as the desire to be appreciated and not to be imposed upon, qualities which can only be maintained

through interaction with others. Failure to protect one's claim to these values results in offence.

One's mutual face-needs are managed and protected through *facework* and the use of politeness strategies (see later). Positive face is enhanced by giving and receiving affection, solidarity, positive evaluations, appreciation of individual qualities and by showing understanding (Spiers 1998). This aspect of face is threatened by things such as violent and negative emotions, disapproval, criticism, mention of taboo subjects and noncooperation, which in turn threaten the individual's sense of self esteem, belonging and competence (Spiers 1998). Negative face is threatened by impinging on the individual's desire for autonomy, territoriality and independence in thought and action (Spiers 1998): e.g. by putting the hearer in a position whereby cooperating causes inconvenience, but where failure to do so would offend. Negative face is enhanced by respecting the individual's need for privacy and independence, giving the option of not acting/getting involved, respecting hierarchical differences and being conventionally polite. Risks to the management of face result in face threat (next).

Face threatening acts (FTAs) & breaches

Any utterance has the potential to threaten face, to be a *face threatening act (FTA)* (Brown & Levinson 1987). Examples include:

- Initiating dialogue
- Making suggestions
- Making requests
- Providing responses

Initiating dialogue threatens the hearer's face since it intrudes on silence and demands a response. Constructing such a response in turn involves the management of threat, particularly if the respondent cannot meet the speaker's needs, or if the management of harmonious relations conflicts with the respondent's personal needs. Failure to receive a response would in turn threaten the speaker's face, causing embarrassment if the preferred response was not forthcoming. Making suggestions and requests are similarly intrusive. Cooperative norms demand that such threats be avoided or managed according to social norms (Brown & Levinson 1987: 61-2). Failure to avoid such threats results in a *breach*. *Redressive* action is then required from the interactants to *repair* perceived breaches (Brown & Levinson 1987: 1, 236). The factors influencing the degree of face threat within a speech act are outlined next.

Level of threat

The degree of threat perceived in a speech act varies according to the:

- Act's degree of imposition
- Power relations between the interactants
- Social distance

(Brown & Levinson 1987: 74)

For example, one can imagine that a GP would find it far more threatening to approach an external organisation with a funding request than a receptionist would find it to ask a peer to pass a pen. In the first setting one can envisage the request as highly imposing, the organisation would have power over the GP by the very fact that they held the coveted funds, in addition the person being approached may also be of higher status than the GP. Conversely, to pass a pen is not usually very imposing, power relations would be comparatively more neutral amongst peers and social standing more likely to be similar. So, decisions about communication style are influenced by social indexing – judgements that interactants make about the relationship of each other's social status. Within Brown & Levinson's (1987) thesis, a formula is proposed to enable analysts to measure such variations in face threat, or the weightiness of an FTA (1987: 74-84). Use of this formula entails analysis of the politeness strategies utilised by the speaker. Although said formula will not be used here, the politeness strategies will form the analytical framework here and are therefore described next.

Politeness strategies – mitigating FTAs

Brown & Levinson (1987) identified 5 politeness strategies involved in the management of face. They refer to these as *super-strategies*:

- 1) Bald, on record
- 2) Positive politeness
- 3) Negative politeness
- 4) Indirect, Off record
- 5) Not doing the FTA

The strategy names indicate the degree of *mitigation* used (whether consciously or unconsciously) to soften utterances with the first, “Bald, on record” involving the least mitigation and the last, “Not doing the FTA” containing the most. *Bald, on record* refers to efficient utterances (in terms of Grice’s (1989) quantity maxim) that do not contain any mitigation e.g. the utterance “deep breaths.” *Positive politeness* strategies protect and attend to an individual’s positive face i.e. they are utterances which convey either the speaker or hearer to be: appealing, worthy of approval or having wants and needs shared by others, the features of which are listed in Box 9. Similarly, *Negative strategies* are concerned with the maintenance of the individual’s (either the speaker or hearer) negative face i.e. maintaining their autonomy, avoiding imposition and maintaining appropriate social distance. In these 3 strategies the speaker’s illocutionary intent is classed as explicit/on record, but the degree and type of mitigation varies.

Box 9 – Super-strategies

- 1) Bald, on record
The utterance is made explicitly, without any attention to face i.e. without any mitigation or modification. It is direct.
- 2) Positive strategies
 - Be complimentary and gracious
 - Bolster the listener's ego
 - Show shared understanding and empathy
 - Show cooperation
 - Reduce social distance
 - Convey common ground
 - Make proposals seem attractive to the listener
 - Fulfil the listener's needs/wants
 - More likely to be informal
 - Be humorous
- 3) Negative strategies
 - Minimise imposition to the listener
 - May be more formal
 - May serve to maintain *appropriate* social distance
 - Use of conventional indirectness e.g. please, could you...
 - Use of hedges to make speech seem less abrupt and more vague e.g. It's likely that...
- 4) Off record
The request/response is hinted at, but not made specifically
- 5) Not doing the FTA
The individual decides not to say anything

(Brown & Levinson 1987)

Indirect, off record strategies refer to utterances that do not make the illocutionary intent explicit, but rather, in order to protect face and provide the listener with the option of responding or not, the intention is only hinted at. Even more indirect than this is the final strategy where the speaker decides on *Not doing the FTA*; the individual perceives the speech act to be too threatening, so decides not to perform it. As can be seen, as one travels down the list, from “bald, on record” to “not doing the FTA” the strategies become increasingly indirect and are associated with increasing levels of threat. Within Brown & Levinson's (1987) framework there is no evaluation as to how polite or impolite these strategies are, rather they are concerned with the degree of threat carried by the utterance. For example “deep breaths”

is a bald utterance but in the appropriate context, examining the chest of someone familiar with the procedure, it is not considered to be rude.

As can be seen from Box 9 there is an association between positive strategies and informal relations and negative strategies and more formal ones. However their usage is not limited to such dynamics; the strategies are neither that simple, nor that rigidly defined. Rather, individuals make judgements as to how to protect face, and thereby what politeness strategies to use on the basis and context of individual situations (Spencer-Oatey 2000a). Brown and Levinson (1987) go on to elaborate, explaining how the different components of one's utterances can be understood and interpreted in relation to face management. At this micro level they refer to the utterances which attend to face as *outputs*.

An understanding of the term “outputs” is key to working with Brown & Levinson's (1987) thesis and is a term used continuously in this thesis, therefore its meaning warrants further exploration. Brown & Levinson (1987) do not offer specific definitions for their usage of the terms: *super-strategy*, *mechanism* or *output*, but they can be understood from the hierarchical content of the charts produced for each of the middle three super-strategies. Over 40 outputs are listed in these charts (reproduced here in Appendix I). Brown & Levinson (1987) offer a limited explanation regarding the hierarchy of these charts placing super-strategies at the “highest level” and “output strategies” as “the final choices of linguistic means to realize the high[er order] goals” (Brown & Levinson 1987: 92). They also go on to explain that they use the word “ ‘strategy’ to refer to a plan at any of these levels, relying on the context to make clear which hierarchical level [is being] talked about” (Brown & Levinson 1987: 92), to this end, they often use the terms strategy, mechanism and output interchangeably. Brown & Levinson (1987) do not make explicit whether these “final choices” are the words that people

say or whether what is at stake is what people say plus their intention when saying it. That is, they do not explicitly state whether locutionary or illocutionary force is the focus. However, the outputs listed seem generally to be intentional in nature (intentional here referring to illocutionary intent/force, an intent or force which can be either conscious or unconscious and not necessarily deliberate or premeditated) and this interpretation is reinforced in their intricate description of the various super-strategies, mechanisms and outputs which spans 226 pages. This then is the way in which the word *outputs* has been interpreted here, a summary of which is in Box 10.

Box 10 – Outputs: definition of

To reiterate, outputs are summarised here as:

Utterances which attend to face.

Utterances can involve the use of a mixture of strategies, i.e. outputs from more than one of the super-strategies (Brown & Levinson 1987: 17-21, 230-2). Brown & Levinson (1987) advocate that the dominant strategy within the discourse enables one to determine the level of threat that the speaker perceives the speech act to hold (Brown & Levinson 1987: 74-84).

Whilst, as already said, it is important to understand the limitations of Brown & Levinson's work, it would be impractical and unhelpful to follow all of the criticisms and develop lots of separate models covering the nuances that Brown & Levinson's misses. As O'Driscoll (2007) points out, the critiques stimulate valuable discussion highlighting important details regarding linguistic interaction.

Politeness and Cooperation

Bringing decision-making, language and politeness together, this next section briefly looks at the way in which language can be used to promote cooperation. To begin, Critical Discourse Analysis' concern with power relations has in the past highlighted how those of higher status have relied upon oppressive discourse strategies as a means of obtaining conformity amongst those of lower status (e.g. Fairclough 1995 cited in Holmes & Stubbe 2003). However, such open expressions of power are less common today, having been replaced by more covert strategies (Fairclough 1989 cited in: Holmes & Stubbe 2003). One is now more likely to see interactants modulate and adjust their utterances in order to maintain social relations in ways, for example, like those described by Giles et al (1991 cited in: Holmes & Stubbe 2003) in their Communication Accommodation theory. The use of politeness strategies to "treat... others with consideration is more likely to result in cooperation" (Holmes & Stubbe 2003: 6 who also cite Watts 1992 and Eelen 2001 as making similar points). Politeness strategies provide individuals with a range of mechanisms for obtaining cooperation. For example, those of higher status might use positive politeness strategies, such as developing rapport and maintaining collegiality, as an indirect means of expressing power (Spencer-Oatey 2000b cited in: Holmes & Stubbe 2003), a feature that Holmes & Stubbe (2003) refer to as *collaborative power*. Or, another strategy might be to use indirect *repressive strategies* to covertly and coercively minimise status differences and emphasise solidarity in order to gain willing compliance and goodwill (Holmes & Stubbe 2003).

On the other hand, those of lower status might use politeness to present themselves as cooperative, polite and deferent (*deferential politeness*). Such strategies not only attend to the listener's right not to be imposed upon and their claim to territory, but also serve to increase the speaker's appeal (Holmes & Stubbe 2003). In situations of higher threat, such as having

to make declaratives or anticipating a dispreferred response, subordinates have been noted to manage the interaction with particular care, displaying much more intricate levels of facework than usual. This can result in complex negotiation (Holmes & Stubbe 2003). Mitigation and hedging are strongly associated with subordinate behaviour (Holmes & Stubbe 2003), but have also been noted to increase amongst those of higher status in situations which involve the management of more peripheral relations (Holmes & Stubbe 2003).

People can also be influenced toward cooperation by toning down their demands with linguistic devices like tags (e.g. *can't you* in the example below) or intonation (Biber et al 2002) e.g.:

You can prescribe this for me, can't you? in a pleading tone.

Or by using infinitives (Biber et al 2002) e.g.:

It would be a good idea to take some tablets.

Other ways of obtaining cooperation include: constructing requests in a way that favours the speaker (Holmes & Stubbe 2003), the possibility of obtaining rewards – whether offered explicitly or not, or the use of factors like guilt, role, age, status, access to expert knowledge or the listener's positive regard for the speaker as persuasive tools (Spencer-Oatey 1992; Thomas 1995). Hinting, although most likely found in the face of highly threatening acts, is also found amongst interactants of equal status, particularly those with a close, relaxed relationship where the degree of familiarity between them means that they do not always need to express themselves explicitly in order to be understood (Holmes & Stubbe 2003).

Politeness – Summarising Remarks

This thesis is interested in the way in which 2nd order politeness explains the pragmatic use of language, particularly of indirectness. Brown & Levinson's (1978 & 1987) thesis is the most influential approach to this. It has been chosen as a framework for analysis here despite various criticisms, many of which could simply be said to represent changes of emphasis. Politeness here is therefore understood largely within the confines of Brown & Levinson's (1987) facework theory and, given that understanding of the notion of politeness varies across the field, is defined here as:

An umbrella term for the intuitive way in which individuals use language to attend to face (Holmes 1995) – that is, the need for both inclusion and privacy (Brown & Levinson 1987), largely achieved through both the active expression of positive concern for the feelings of others and the use of non-imposing means of communication.

It is important, however, to remember that this is not the only understanding of linguistic politeness.

Politeness and Healthcare Communications

Having identified politeness as a potential tool for analysis, the literature was examined for examples of other research exploring the use of politeness in healthcare communications. The term *politeness* was searched for in combination with the terms: *communication / patient / workplace / doctor / decision / Brown & Levinson*. Within Linguistics, there is no precise equivalent to the kind of comprehensive search facilities offered by search engines like

PubMed list in Box 2. Searches were therefore limited to Medline, SSCI, A&HCI (as detailed in Box 2), Google Scholar and the Linguistic Politeness Research Group's (LPRG) webpage for "working papers" (LPRG c2002). Very few papers were identified when recent date limits were set, so these were extended to 1960.

30 articles were found relating to politeness and health, only 1 of which (Lambert 1995) referred to 2nd order politeness - the aspect of politeness for analysis here. This article analysed the predominant super-strategy (this will be explained on p66) used in notes clipped to patient's drug charts in hospitals from doctors to pharmacists, but it did not relate to doctor-patient communication or patient participation. Similarly the only relevant working paper on the LPRG website revealed a study which had examined the politeness strategies used between nurses and in-patients (Grainger c2002), again not the perspective of interest here.

Over the course of the research 3 additional papers of interest were identified (Aronsson & Sätterlund-Larsson 1987; Robins & Wolf 1988; Spiers 1998). These were found inadvertently whilst using Google Scholar, a hand search of Social Science & Medicine and following up a citation in Sarangi & Roberts (1999) respectively. None of these were based in the UK. Robins & Wolf (1988) investigated medical students' hypothetical, written exam responses to various scenarios, concluding that GPs' positive politeness can be used to promote "mutual cooperation" which they equate with "mutual participation" (1988: 220). Spiers (2000) studied home care nurse-patient "negotiation of vulnerability" during the delivery of care, observing that during such negotiations, social distance in "culturally mismatched home care nurse-patient dyads" could have either positive or negative outcomes (Spiers 2000: vi). Spiers' (2000) work examines a very different kind of healthcare encounter to the one in question here, one which does not involve making diagnostic or treatment

decisions; however, her review of the role of politeness theory proved very informative. The third paper analysed doctor-patient consultations in an out-patient department, focussing exclusively on particular negative politeness strategies in the management of social distance, as opposed to politeness per se. In this study, Aronsson & Sätterlund-Larsson (1987) found that doctors' "thinking-aloud sequences" prompted patient participation, that patients used avoidance strategies and minimal feedback to indicate "opposition" (Aronsson & Sätterlund-Larsson 1987: 18) and that doctors' use of indirectness to soften requests ambiguated communication. Whilst these papers explore questions about the role of politeness in various healthcare encounters, none are directly related to decision-making in a British primary care setting.

SUMMARY OF CHAPTER 2

There is a range of principles guiding language use which competent users may or may not be explicitly aware of, some of which have been introduced here. How and when to modify one's language and the use of indirectness are important social skills. Patients today are commonly treated as consumers with certain expectations of service providers such as GPs. In addition, they are encouraged to express themselves and make choices regarding the management of their own health. Whilst these factors seek to raise the status of the patient within the consultation, numerous other issues remain which can inhibit patient involvement. These include: fear, pre-existing expectations regarding social norms, emotional or physiological problems affecting sense of control, and their inferior position as layperson. In turn, GPs have to conform to a number of agendas including: resource management and policy, best practice, and increased patient participation in the delivery of healthcare.

Cooperation relies on the maintenance of congenial relations, an important aspect of doctor-patient communication (Lester et al 2006) and one which can be threatened by breaches to contextual norms. Brown & Levinson's (1987) theory of politeness and facework provides a useful tool with which to explore the linguistic strategies used to obtain cooperation and to manage FTAs.

In conclusion then this research is underpinned by the following beliefs:

- Patients have a right to participate in decisions made about them.
- Both GPs and patients want to be cooperative in the consultation.
- GPs are under pressure to conform to a number of agendas.

GPs and patients meet and construct dialogue with these key elements in the background. To understand what actually takes place during a consultation, it is essential to consider the further factors:

- What people appear to say and what they actually mean do not always correlate.
- The consultation comprises a face threatening situation.

The research aims to provide new insights into and descriptions of linguistic strategies that open and close patient involvement in decisions made about them in primary care consultations.

CHAPTER 3 - METHODOLOGICAL APPROACH & DATA

CONTEXT

INTRODUCTION TO CHAPTER 3

This thesis is an empirical investigation of a sub-set of pre-existing video-recordings of primary care consultations and their transcriptions, the aim being:

To explore the way in which participants used politeness strategies to attend to face-needs in relation to decision-making during the consultation, and in particular how these strategies opened and closed patient participation.

As was demonstrated in the preceding chapter, language does not depend on form alone. The way in which linguistic meaning is produced is complex; linguistic form is not the same as linguistic function. Ostensible meaning, intended meaning, and meaning interpreted by the hearer are potentially different. The linguistic devices adopted by interactants, the structure of these and the assumptions made about what is and is not normative behaviour vary from one context to another. The wide ranging conditions then, involved in the production of language and dialogue, lend themselves to an interpretative, qualitative analysis.

Before continuing, a few notes are necessary regarding the organisation of this chapter. As will be seen overleaf, the chapter is divided into four parts:

1) “Theoretical Approach”

Overview of the theoretical background underpinning the methodological approach to the present analysis.

2) The “Methodological Processes for this Thesis” (depicted in Figure 1)

Details the way in which the raw data were managed during the analytical process.

3) Information about the “Original Data Collection”

Provides the background to the original data collection by a third party.

4) The “Sample Description” then follows

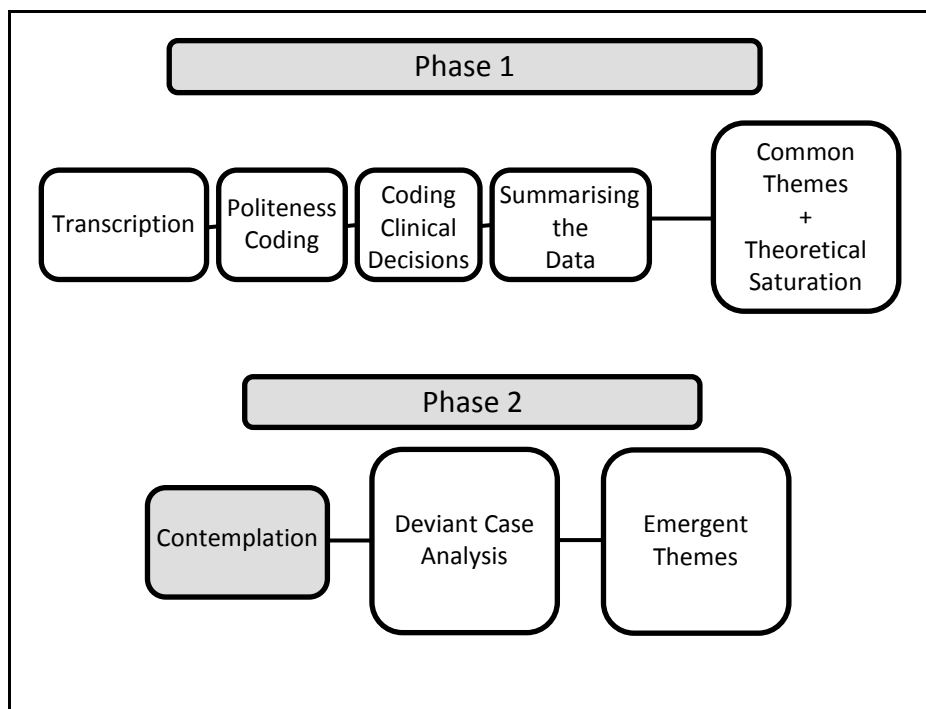
This provides demographic information about the GPs and patients included in the present analysis.

One might expect a Methodology Chapter to begin by discussing the way in which the data were collected. However, as can be seen from the above list, the Methodology Chapter here begins, in part 1, with an overview of the theoretical background to the analysis, this is then followed by details of the way in which the raw data were managed. One of the key objectives of doctoral research is to showcase the author’s own, original work. In this case, beginning the chapter with a discussion about data collection would have meant beginning by foregrounding somebody else’s work. Instead, the present organisation makes the author’s contribution to the methodological processes underpinning the research clear.

An iterative approach was used for the analysis, one which comprised 2 phases. A brief overview of these phases is given here, in this introductory section, and then explained further in the main body of the chapter. Phase 1 involved a number of components: the transcription

of the video data, coding of the politeness strategies used by the interactants, identification of the clinical decisions made within the consultations, summarising the data and the identification of the findings therein. This process highlighted in particular common themes within the findings, paving the way for the second phase in this iterative cycle. Phase 2 involved fewer components, but entailed a much more in-depth analysis of the data. It was here that deviant cases were identified, guided by the Phase 1 findings. The close analysis of these cases resulted in the identification of the emergent themes which form the core findings for this thesis. This summary of the methodological processes is also depicted in Figure 1.

Figure 1 – Iterative phases & methodological processes



1) THEORETICAL APPROACH

Qualitative Methods – Thematic Analysis, the Iterative Cycle & Deviant Case Sampling

The following overview summarises the methodological theory underpinning the analytical approach taken here. It highlights and outlines the particular qualitative approach adopted along with the strengths of deviant sampling. Also included is an introduction to thematic analysis and coding, a discussion outlining how clinical decisions were determined, a review of the strengths and limitations of using video data for analysis of this type and some theoretical considerations regarding the choices made when deciding which conventions to use in the transcription of the video recordings.

In order to consider how an utterance might contribute to facework, analysis will rely heavily on interpretation. Although this interpretation will be informed by existing linguistic theory it is quite feasible that the interpretations made will not be all encompassing, a phenomenon embraced by qualitative methodologies which do not assume single truths (Berger & Luckmann 1967). By adopting a qualitative approach it is hoped to explore a view of the world as experienced by the participants, rather than just that of the researcher (Jones 1995).

In keeping with the aspirations of other qualitative approaches, this research sought to “locate significant themes [with]in ... [the] data” (Richards 1999: 108), in order to produce “tiny insights” (Richards 1999: 108) resulting from an in depth analysis which could be “thread[ed]” together with different concepts to produce *themes* (Richards 1999: 108). This type of thematic analysis is a powerful means of producing explanations for such things as behaviours and actions (Bryman 2001). The subsequent emergent themes then form the

research findings with new and novel themes adding to our understanding of the world (Jones 1995).

An *iterative* approach was adopted for this particular analysis, a process which involves “weaving back and forth between data and theory” (Bryman 2001: 10 referring to Glaser & Strauss 1967). In such an approach, the steps taken toward analysis and interpretation are, by design, cyclical and flexible (Crabtree & Miller 1999). This type of analysis and interpretation involves a multi-phase iterative, interpretative strategy comprising, for example:

- Description
- Analysis
- Representation of the account
- Resumption of the cycle

Such an approach allows the various stages to be revisited during the research, an evolving process which entails circling through various iterative cycles (Crabtree & Miller 1999).

Using this type of approach was particularly relevant to this study since no pre-existing model was found that could have been used to explore the research question, a circumstance which Crabtree & Miller (1999) suggest particularly lends itself to an iterative approach.

Firstly, then, this process identified *common themes*, answering the question: “What typically happened?” The central finding at this stage was that the consultations were oriented towards agreement; that is, the decision-making process most usually entailed the participants agreeing with each other. These findings largely echo those of previous research (Houtkoop 1986; Heritage & Sefi 1992; Stivers 2005) and did not therefore add to the body of knowledge

regarding clinical decision-making in primary care or generate any new understanding of the role of politeness within the process. For this reason, it was decided to focus on the analysis of *deviant cases*, these deviant cases being defined as ones where patients expressed dispreferred responses to clinical recommendations.

There are well-understood advantages to sampling such cases as part of a qualitative process, the main point being that doing so aims to broaden one's perspective on the topic of enquiry or as Lindesmith puts it:

“The progressive refinement of theory that is brought about by the necessity of taking negative instances seriously regardless of their frequency also makes for a progressively closer articulation of theory with the empirical evidence” (Lindesmith 1968:20 cited in: Sullivan 2011).

From this stage, taking account both of the typical and the atypical, emergent themes were identified. It is suggested that deviant cases may have considerable explanatory power: by looking, for example, at the “extremely good” or the “extremely bad”, one may be more able to build theories about what excellent and deficient practice or behaviour is. An example of this is the study of “good boys” in “bad neighbourhoods” which was undertaken 50 years ago, producing influential findings (Reckless 1957 cited in: Sullivan 2011). The same logic can be applied to this dataset.

Deviant sampling is a form of *purposeful* or *theoretical* sampling where cases that are “information rich” (Patton 2001: 230) are selected by the researcher for analysis (Shatzman & Strauss 1973; Miles & Huberman 1984; Strauss & Corbin 1998). The aim of the approach is

to allow such cases to be studied in-depth (Patton 2001), in the expectation that the information-rich content will enable the research to derive new and instructive findings which will contribute to the overall picture. The cases selected are ones which deviate from the more “typical” occurrences within the data or topic for investigation (Patton 2001), cases which in quantitative research would be known as outliers. However, where outliers may finally be de-emphasised, precisely on the grounds that they are not typical, and therefore distort the overall picture, the argument is that purposefully identifying deviant cases gives one the opportunity to learn from the unusual (Patton 2001). In doing so one can produce information which “illuminate[s] the ordinary” (Patton 2001: 234), revealing issues that might be “relevant to improving more “typical” cases” (Mertens 2004: 262).

In addition to the adoption of an iterative approach and the use of deviant sampling, a range of theoretical and methodological tools and processes were used to facilitate a robust and consistent approach to the analysis, thereby adding to its validity (Glaser & Strauss 1967; Strauss & Corbin 1998; Bryman 2001). These will be described in greater detail over the course of the chapter and include:

- Coding
- Constant comparison
- Memo writing
- Theoretical saturation

Having set the scene for the overall theoretical stance taken here, attention is now turned to theoretical considerations relating to other aspects underpinning the methodology.

Coding, Constant Comparison, Memo Writing & Theoretical Saturation

Themes, the ultimate unit of production in the analysis here, are produced by linking *codes* together (Bryman 2001). Coding, a key tool within qualitative research, with its origins in grounded theory (Glaser & Strauss 1967; Bryman 2001) enables one to break data down into its component parts for categorisation (Glaser & Strauss 1967). Qualitative coding is a fluid process (Bryman 2001) involving constant comparison of, and reflection on, the data and analytical process(es) (Glaser & Strauss 1967); that is, features identified for coding in one document or transcript are, where relevant, compared with the contents of other such material. As the material and coding process become more familiar, and less absorbing, previously unnoticed phenomena come to the fore. As a result, coding schema are repeatedly revised (Bryman 2001). Coding diaries enable one to keep a record of when and why new codes are generated, and descriptions of them enable differentiation from others as well as their systematic reproduction. Coding dilemmas and interpretative insights are also recorded here and referred to as *memos* (Glaser & Strauss 1967).

Finally, there is a need to identify when to stop collecting and analysing new data – the in-depth analysis involved in qualitative research is not intended to be applied to large quantities of data. The tool used here to establish the identification of this point was *theoretical saturation* (Glaser & Strauss 1967) – referring to the point at which no new themes and insights seem to be emerging from the data (Glaser & Strauss 1967).

What is a Clinical Decision?

Part of the iterative process involved arriving at an understanding of what would be interpreted as a *decision*. Therefore, a period of reflection on the literature was undertaken, alongside an analysis of a purposive selection of transcripts representing a range of ages, conditions, GPs and varying lengths of consultation (P20, P24, P62, P63, P64, P65, P66, P68, P69, P70).

To begin, the definitions used by others investigating decision-making were examined. Charles et al's (1997) seminal paper on SDM refers from the outset to "treatment decisions," focussing on cancer and decisions with major consequences; the authors do not, however, explain what they mean by "treatment decision." This is not surprising since others have previously noted that whilst there is an array of literature concerned with decision-making, little tends to be said about what constitutes a decision (Lohrova 2011). However, other decision-making research which did define decisions was found. Saba et al (2006) define a decision moment as "an implicit or explicit choice of action," Braddock et al defined a "clinical decision" as "a verbal statement committing to a particular course of action" (1997: 340) and Entwistle et al (1998) limited their analysis of "decisions" to matters relating to healthcare interventions and patterns of care. Huisman (2001), a linguist, took a flexible view when defining decisions, arguing that the classification of interactional episodes as decisions depended entirely on the interpretative norms of the team. The on-line Oxford English Dictionary definitions are indicative of "solutions" and "conclusions" (OED Online 1989a).

The aim of the study was to examine issues around clinical decisions. The term "clinical" here refers to decisions which relate to healthcare matters, utterances containing information that might typically be added to a patient's notes or shared with other practitioners concerned

with the patient's care, the intention being, as Lohrova puts it, "to filter out decisions that have no real impact on the ... objectives [of the encounter]" (2011: 105). Non-clinical decisions were therefore excluded.

Extract 1 – Non-clinical decisions (D2-P62)

135. D2: And, there ain't nothing {isn't anything} [D2 nodding] <i>serious</i> (1),
136. P62: [P62 nods]
137. D2: [D2 nodding] that would go on for 16 months [P62 nods] that causes that.
138. P62: Good.
139. D2: So that's good.
140. P62: [P62 nods] Yeah.
141. D2: Erm, what else do we want to say? [D2 copies patient details from screen to research paperwork] I want to say (2) we talked about your, your brother [D2 looks at P62] <u>didn't we last time?</u>
142. P62: <u>yeah, yeah</u> . [P62 gesturing] Yeah, sorry about erm, [P62 smiles, shaking head] getting upset but [D2 shakes head] erm, just touched a nerve <u>like so</u>
143. D2: [D2 nodding] <u>Of course it did</u> ,
144. P62: <u>yeah, yeah</u>
145. D2: [P62 nodding] of course it did. [D2 nods] I would feel exactly the <u>same</u> ,
146. P62: <u>yeah</u>
147. D2: and, and er (.) and I, [D2 looks down, shaking head] and I would have done <i>exactly</i> the same.
148. P62: Yeah.
149. D2: [D2 types] Erm, what are your thoughts about your brother?

An example of what is dealt with in this study as a non-clinical decision can be seen in Extract 1. This example is chosen because it also illustrates the difficulty of reaching a judgment on such matters. Here the GP (D2) is moving the discussion back to the issue of the patients' (P62) brother (the brother committed suicide and the GP is concerned about the way in which he is coping with this, and that the physical symptoms he is experiencing are due to stress). At L141 D2 introduces the brother as a topic *I want to say we talked about your, your brother didn't we last time?*, a move marking a *decision* to talk about the patient's deceased

brother. The question is whether or not this is a *clinical decision*. It is not clear at this point in the transcript why D2 has made this enquiry or how the introduction of the topic relates to P62's health; therefore, the view taken, at this point in the transcript, is that there is insufficient evidence at this point in the consultation to class the utterance as a *clinical decision*. Instead, the aspect of this topic that has been classed as a clinical decision can be seen in Extract 2 at L343 and L345 *There are certain things that can make things easier though ... talking about him*, where one can see that D2 has made the decision to advise P62 to *talk ... about* [his brother].

Extract 2 – Clinical decision (D2-P62)

- | |
|---|
| 342. It's just a <u>matter of time</u> . |
| 343. D2: <u>I do</u> , I do, [P62 nods, sniffs] I do. [D2 gesturing] ⁶ There are certain things that can make things easier though. |
| 344. P62: yeah |
| 345. D2: Erm, and, [P62 sniffs] actually thinking about him, ⁶ talking about him, |
| 346. P62: yeah |
| 347. D2: [D2 nodding] like we've been doing, [P62 nods] I think is very helpful. |
| 348. P62: Yeah of course. |

Analysis of the selected transcripts revealed that diagnostic decisions were invariably part and parcel of the decision-making process and responses to them appeared to contribute to that process. Diagnostic decisions therefore needed to be included in the analysis. The analysis also revealed that utterances identified as “clinical decisions” were not always located at a single point, but could instead be spread across several utterances and interspersed with dialogue not directly related to the decision being analysed. This mirrors Marra's (2003 cited in: Lohrova 2011) analysis of decisions in meetings – that decisions are invariably interwoven with other discourse topics that may or may not come to bear on the decisions in question.

The definition adopted for the purposes of this study incorporates all of the above sentiments and was able to withstand critique from the supervision team. It incorporates utterances which might occur in more than one stretch of talk and is summarised as:

Utterances which commit to a particular endpoint in relation to the patient's healthcare, and which have an action arising from them.

This is not, however, an all-encompassing description, and in an interpretivist analysis one would not be expect it to be so. Despite having devised a definition, dilemmas about what was and was not a clinical decision, as seen above, were still experienced. Utterances exemplifying these types of dilemma included:

- i. *Take paracetamol regularly* (e.g. D4-P52 L416)
- ii. *Drink plenty of fluids* (e.g. D4-P64 L410-4)
- iii. *Dry your feet last* (e.g. D5-P48 L122)

From these examples (i) and (ii) were classed as clinical decisions, but not (iii) because:

- i. The primary reason for not prescribing paracetamol is that it is easily available and cheaper to obtain over the counter than by prescription.
- ii. In very young children (P64) (and frail, older adults), failure to drink plenty can rapidly become life threatening resulting in hospital admission.

- iii. This is not prescribable and failure to adhere to it will not cause the patient harm.

Whilst on the one hand constant comparison (Glaser & Strauss 1967) was used as a tool to decide what was and was not a clinical decision, this was coupled with the interpretivist view that there are multiple realities and truths, each dependent on one's interpretation (e.g. Berger & Luckmann 1967). Analysis therefore had to be fluid and context driven, and its representation as transparent as possible.

Capturing and Representing Language Data

Video data – strengths and limitations

This section considers some of the strengths and limitations of the use of video cameras to record patients' consultations.

Video vignettes of simulated events (as opposed to written vignettes/scenarios) are a useful tool for analysing individual decision-making, especially scenarios which are then subtly altered to portray different characteristics amongst the actors (McKinlay et al 2006; Adams et al 2008). Video technology is used in teaching (e.g. Kahn et al 1979 cited in: Pendleton & Hasler 1983) and the assessment and research of communication skills, either by video recording students and practitioners role playing with each other (e.g. Maxwell 1976 cited in: Pendleton & Hasler 1983; Larsen & Risor 1997; Brown 2008), or with the use of standardised patients (SPs - lay people who volunteer to be trained to simulate medical problems and assess medical students' responses in a reproducible way) (Campion et al 1992; e.g. Humphris

& Kaney 2000; Roberts et al 2003; de la Croix & Skelton 2009). It has also been used to record and assess the performance of SPs (e.g. Tamblyn et al 1991; Vu et al 1992).

Turning now to naturally occurring consultations, concern has been raised about the appropriateness and validity of recording such situations. In the past, concern was expressed that the presence of a video camera in the consultation would create a Hawthorne effect (Roethlisberger & Dickson 1939) on research data (Blum 1968 cited in: Pringle & Stewart-Evans 1990); that is, altering participants' natural behaviours and reactions. Levinson & Roter's findings (1993) lent some support to this and Martin & Martin (1984) found that 11% of participants felt that the camera had made them feel nervous and 20% said that it had changed the consultation e.g. they had felt unable to raise more embarrassing matters. However, in Campbell's (1982) study, only 2% reported withholding information because of the camera and just 1% reported having behaved differently because of its presence.

These concerns, cited in the above, refer to a minority of patients and there is in actual fact evidence supporting the internal validity of video recorded data. Alongside the anxieties raised in Campbell's research it was also found that although 5.5% of patients felt uneasy because of the filming, they did not withhold any information and 3.5% thought that the GP was more attentive because of the camera (Campbell 1982). Similarly, although Martin & Martin's (1984) research raised some concerns they also found that most patients were happy with the idea of being videotaped. 95% did not feel that the video recorder had altered the way the doctor treated them and 78% said that they had forgotten about the camera and most were happy with the idea of being videotaped. Likewise, Herzmark (1985) found that 71% of patients had forgotten about being filmed, and over three-quarters felt that the camera had not affected the consultation. Pendleton & Hasler (1983) found that practitioner anxiety about the

presence of the camera wore off after a few consultations. Coleman (2000) also found that the presence of a video camera did not significantly alter patient and clinical behaviour and Howe (1996) that older people were less likely to refuse to participate in video recording. Herzmark (1985) also found that views about the consultation of those who had been filmed did not differ appreciably from those of patients whose consultations had not been recorded. Verhaak (1988) found that performance bias decreased during the course of the consultation and Pringle & Stewart-Evans (1990) found little difference in performance between those who knew they were being recorded and those who knew that they *might* be being recorded. Campion et al (1992) found that patients were willing to talk about emotional matters and Pringle & Stewart-Evans (1990) found that the presence of a video camera did not increase doctors' stress levels or unduly impact on objective measures of their behaviour and Collins (2005) also found this.

Over the last decade or so the practice of videotaping consultations became increasingly common. In October 1996, the submission of video tapes of one's own consultations was a compulsory, and then optional (1998-2008), as part of the MRCGP examination process (the alternative means of assessment during this latter period being participation in a simulated consultation). During this time a number of GP practices installed fixed video cameras in selected consulting rooms in order to facilitate in-house training. Video recording is also now used to monitor the reliability of specially trained role-players participating in patient simulations for the Clinical Skills component of the MRCGP (RCGP 2010b). There is a range of research having utilised video recorders to tape naturally occurring interactions between patients and healthcare professionals (e.g. Rutter & Maguire 1976; Pringle et al 1984; Gask et al 1988; Hays 1990; Premi 1991; Cox & Mulholland 1993; Tylee et al 1993; Field 1995; Tylee et al 1995; Coleman 2000; Spiers 2000; Kaner et al 2007; Dale et al 2008).

The use of video cameras to collect recordings of patients' consultations has become increasingly commonplace over the last few decades. Whilst such material does indeed have its limitations these seem to only affect small numbers of participants. The strengths and limitations of such methodologies will be revisited in the Discussion.

Transcribing dilemmas and theory

There are many ways in which oral data can be transcribed (Spiers 2000) and this section outlines the rationale for the choices made here.

Decisions regarding the conventions to be used and the level of detail to include were guided by the desire to produce a transcript that was not too difficult to read, which only included information that was expected to be useful during analysis, which conveyed a sense of flow between the interactants (Spiers 2000), facilitated interpretation of the utterances and which included some paralinguistic signals. The way in which this information was conveyed is detailed in Box 11. Some of the conventions used were adopted from Jefferson (1984b) and are acknowledged as such in Box 11, as are those derived from guidelines used in previous work (Edgar 1996). The remainder were developed pragmatically for the purposes of this thesis e.g. a range of bracket styles facilitated electronic searches more easily than variations on single (double ((and triple (((parentheses used by Jefferson (1984b). Similarly, Jefferson's (1984b) double obliques // were not used to indicate overlapping speech as this interfered with the functionality of the coding software NVivo and the alternative of brackets seemed better placed for in-text notations. However, following Jefferson's notion of following "usual" punctuation conventions (Jefferson 1984b, see Box 12) the punctuation markers: .?! were used as described in Box 11. In keeping with this notion of "usual" punctuation conventions, *italics* were used to indicate a speaker's added emphasis to a word

(or part of a word). This deliberate deviation from Jefferson’s (1984b) practice of using italics to indicate “unvoiced production” (1984b: 29) avoided confusion with the aforementioned, popular practice of using italics to indicate added emphasis. All remaining notations are described in Box 11.

Box 11 – Transcribing key

Notation	Description
,.?!	Punctuation markers used to indicate “the usual intonation” (Jefferson 1984b: 27) e.g. to reduce ambiguity by grouping words/phrases together, to denote the end of sentence like structures, questions & exclamations.
(.)	Pause of 0.5 seconds (Jefferson 1984b).
(1) etc	Pause of 1 second etc (Jefferson 1984b).
◦	Utterances spoken much more softly than others (Jefferson 1984b).
Underline	Overlapping speech (Edgar 1996)
Italics	Used to denote words where speaker has applied extra emphasis (Edgar 1996)
word	Exact word unclear (Edgar 1996)
***	Inaudible speech (Edgar 1996)
{ }	Mispronunciation by speaker (see below)
< >	The transcriber’s completion of incomplete words
[]	Descriptive details, each preceded by participant’s ID in the hope this would make the descriptions easier to find for the purposes of deleting (for different types of analysis) & coding. Where relevant, non-verbal acts are entered onto a separate line without any spoken text.
Nods	Short, downward nod in the affirmative
Nodding	Continuous, affirmative nodding
Shakes	Single side to side shake of the head in the negative
Shaking	Continuous, side to side shaking of the head in the negative
Shrug	Upward shrug of the shoulders commonly understood to mean “I don’t know”
Gesturing	Non-specific use of hands whilst speaking
Glance	Where gaze is momentarily shifted from one object and then back again
Screen	Computer screen
Types	Also includes use of mouse or keyboard to move around computer screen/windows.
Single spacing	Denotes participants interrupting each other without overlapping speech (explained on p104).
Double spacing	Denotes distinct turn taking between participants (explained on p104).

Backchannelling theory

As with other aspects of dialogue, *backchannels* are a unit of talk that may or may not be included in the production of a transcript. Backchannels (BCs) are a certain type of *minimal utterance* (see Heinz 2003 for a thorough review) - *minimal utterances* being short verbal and non-verbal utterances (Drummond & Hopper 1993 cited in: Heinz 2003) e.g. *I see, yes, OK, aha*, nodding and single word clusters e.g. “*Mmm. Yes. OK.*” (Carter & McCarthy 2006). Backchannelling then is one of a number of terms used to denote minimal utterances whose function is to indicate the listener’s continued interest, attentiveness and desire for the speaker to continue (Roter & Larson 2002; Sandvik et al 2002). They often appear to occur as listeners’ interjections in dialogue and may look like minimal agreement tokens e.g. *mmm, yes*. They contrast with more demonstrative agreement tokens that might, for example, take the form of phrases or clauses, adverbs which act as *intensifiers* or adjectives used to evaluate (Carter & McCarthy 2006). Intensifiers are “lexical items which modify an utterance by grading it, heightening or lowering its intensity (Swan 1995; Carter & McCarthy 2006).

Differentiating BCs from expressions of agreement is potentially problematic. Roter & Larson (2002) interpreted all patients’ minimal utterances as minimal responses (and not BCs) because they believed that this was how the patients’ minimal utterances were most likely to have been intended. Since they do not develop or evidence this argument their practice was not, however, followed here. Jefferson (1984b) marks all minimal utterances as overlapping “BC talk” reflecting the fact that BCs typically overlap the main speaker’s utterances. Conversely, Sandvik et al (2002) and Heath (1992) interpreted minimal utterances as responses only when the utterance was pronounced with added emphasis.

Since BCs form an act of participation, the topic of enquiry for this thesis, it was decided that the transcripts used for analysis should include BCs and that if their production overlapped others' utterances, or if emphasis was added, this should be indicated with the conventions described above.

2) METHODOLOGICAL PROCESSES FOR THIS THESIS

This second part of this chapter details the way in which the data were treated for the present analysis. Included here are details regarding the management of the raw material, electronic storage, transcription and associated dilemmas, coding, reliability testing, the identification of emergent themes and the identification of theoretical saturation. There then follows in part three an outline of the way in which the data were originally collected, and finally demographic details of the participants.

Protecting Participants - Ethical Approval, Consent, Confidentiality, Anonymity

The NHS requires that permission must be granted before its employees and users can be invited to participate in any research therein. Patient confidentiality must be protected at all times. This section outlines how these criteria have been met.

Ethics committee and R&D approval

Permission for the collection of the original dataset was granted by West Midlands MREC (Multi Research Ethics Committee) on 15/8/02 (MREC Ref No: MREC 01/7/89, REC Ref no: 2002/121M). Necessary permissions were also obtained from the local Research and Development (R&D) Consortium (see Appendix III for copies of Ethics approval and extensions). The permission granted by these bodies, and also agreed to by the patients when consenting to the research (see Appendix IV), permitted access to the video data from those academic staff and post graduate students within the Interactive Studies Unit (ISU - formerly known as the Interactive Skills Unit) at the discretion of the ISU's then Senior Lecturer in

Communication Skills (now Professor). This access also included approved transcribers for the university.

Confidentiality and anonymity

The data collected were on videotape, therefore total anonymisation of participants was not possible. However, the following safeguards to limit identification of participants and unauthorised access to the data were employed:

- No information identifying the patients was written on the casing or enclosures.
- All subsequent reference to individual patients was through means of an individual identity number chosen by the researcher. In addition, names referred to during the consultation were not transcribed, but healthcare facilities were.
- The researchers' copies of the completed consent forms were stored separately and securely filed (in a locked cabinet).
- The physical data were stored in a locked drawer/cabinet in a locked office within the Department of Primary Care and General Practice at the University of Birmingham and the electronic transcripts in a password protected folder on the University of Birmingham's computer network.
- The University Data Protection Officer was informed of the steps taken to secure both electronic and hard copy data.
- The data were held by the Professor of Clinical Communication and Director of the ISU (originally identified on the Ethics Application as the ISU's Senior Lecturer in Communication Skills) and were only made accessible to others with his permission.
- Video tapes were scheduled for destruction by September 2006. Transcribing was not complete by this date and the original research team obtained an extension from West

Midlands REC (Research Ethics Committee) to extend this date to September 2007 (see Appendix III).

- In accordance with MREC guidelines the videotapes and their digital copies will be destroyed once the present research is complete, the transcripts will be kept securely for a maximum period of twenty years.

Identity numbers - IDs

Simple identity (ID) numbers were given to participants (1-78). These were differentiated from quantitative values by prefixing them with a capital letter representing the participant's role in the consultation (see Box 12). Patient ID numbers ran from 1 onwards and GP ID numbers from 1-10. The sequence of numbers for GPs and patients in the first instance reflected the sequence of IDs used in the electronic transcripts created by the original researchers. Participant IDs in subsequent transcripts were numbered sequentially as they were transcribed.

Box 12 – Participant IDs

ID	Participant Role
A	Accompanying Person
B	Baby (non-patient)
D	Doctor/GP
P	Patient

Other persons accompanying the patient were given the same number as the patient. If more than one person accompanied the patient their ID was suffixed with a lower case letter (a,b,c etc). Where participants changed their role during the consultation (e.g. someone accompanying the patient who then consulted) they were given a second ID to reflect that role – this was necessary for tasks such as automated analysis of the data. Transcripts/

consultations were labelled with the patient ID. Where consultations involved the management of 2 different patients, each of whom required a consultation of their own, the transcript was labelled with both patients' ID.

Number of Participants

The database used (2003-4) comprises 10 videotapes which in turn contain around 90 video recordings of primary care consultations from 9 different GPs conducted over 10 different sessions (1 GP recorded 2 of his sessions). However, not all of these were used. In the first instance 3 tapes and an additional 8 consultations were excluded prior to transcription, a fourth tape was also excluded during the analytical stage. The reasons for these exclusions are explained next. The break down of participants included in the final total is depicted in Figure 2 on p102.

Excluded Data

Prior to analysis and transcription, 3 of the videotapes were excluded without having been viewed because:

- Poor sound quality (D3 – see p115), the poor sound quality would have made transcription too unreliable.
- One tape (D9's) only contained one consultation limiting options for analysis.
- A third tape comprised a 2nd session from D5. As D5 was the only GP to record 2 sessions, including his 2nd tape would have skewed the data.

Once viewing of the tapes commenced it was identified that 2 of the consultations had already been excluded (P73 & P77 – see list below). 6 further consultations were then excluded by

the author, again, prior to transcription and analysis. Details of these exclusions are listed here:

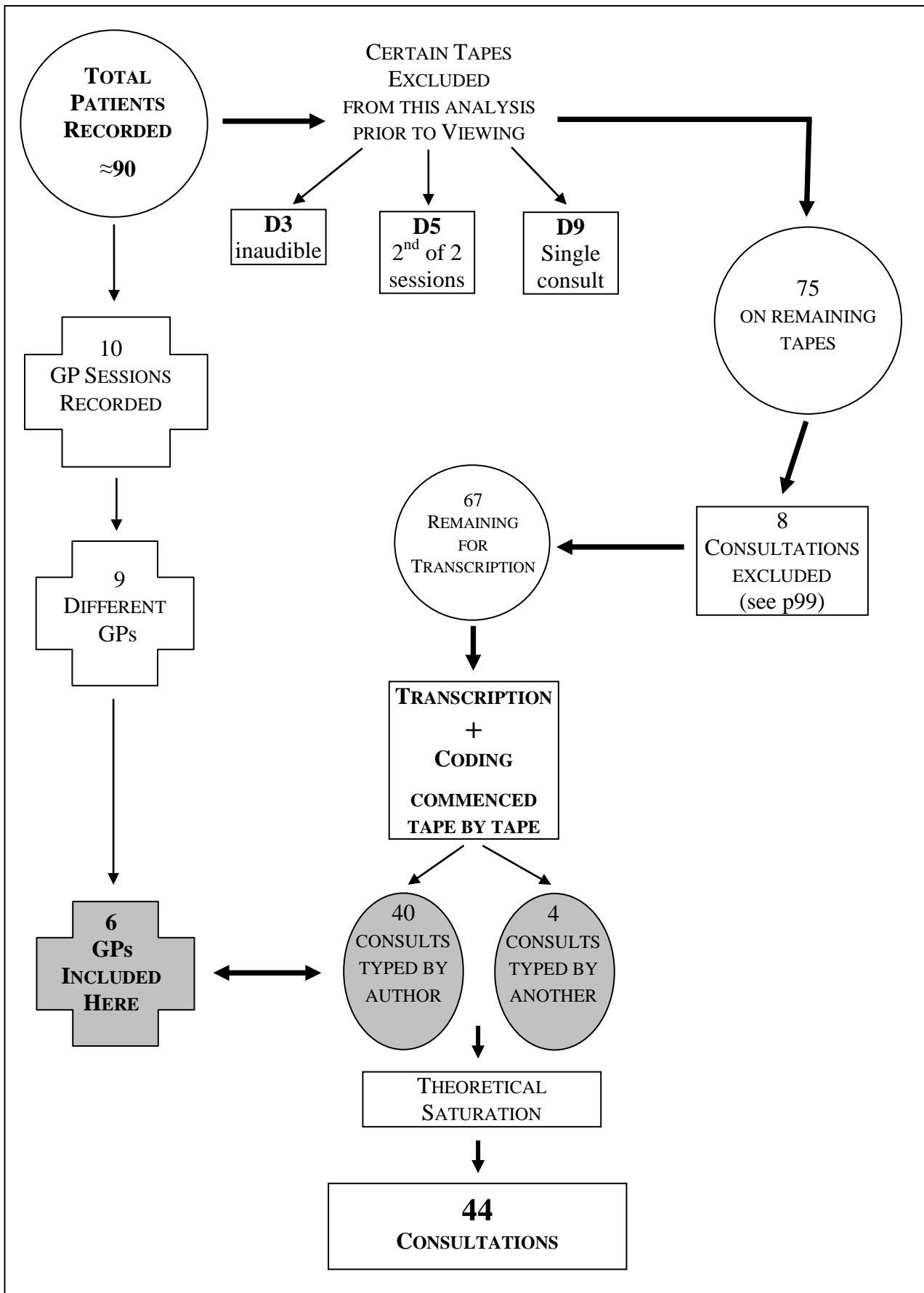
- 1 was inaudible (P5).
- 1 had no visual (P22).
- 1 only consented to the first half of the consultation being recorded (P26) making analysis problematic as there was reference to the unrecorded issue in the first half and the patient's concern regarding this unrecorded topic was evident from the outset.
- 1 was incomplete once transferred to DVD (P67).
- 1 was very complex in that the patient did not display typical cooperative behaviour. He suffered with mental health problems and relied upon his wife to discuss the management of his condition with GP. Although the consultation differed from the majority of the others, it was not deviant in the sense used here (p82) and it was therefore agreed with the supervision team that its inclusion would not add any benefit to the sample (P71).
- 1 was very long (34½ mins) (P72) and again the supervision team agreed that the time needed to transcribe and analyse this case would not have added to the analysis.
- 1 patient withdrew consent after the researcher had left the premises with the agreement that the recording be deleted (P73).
- 1 patient withdrew consent directly after the consultation and the recording was immediately deleted (P77).

Finally, theoretical saturation (see p84) was achieved after having transcribed five and a half of the tapes (all of D1, D2, D4, D5, D6 and half of D7). This led to the subsequent exclusion of:

- D7's remaining 4 consultations
- D8's 13 consultations

Thus, a total of 44 consultations were included in the analysis here. Figure 2 shows a breakdown of the exclusion/inclusion process.

Figure 2 – Number of participants included in the analysis here



Data Storage

The videotapes from the database were digitalised to facilitate storage, access and further transcription (see next).

Transcription Process

27 of the consultations already had transcripts which were reviewed before commencing further transcription. It was found that these transcripts did not include information about hesitations or repetitions, body language was limited to occasional single words describing particular activities e.g. “writing”, and BCs had not been recorded. Since these aspects of communication are considered here to be important tools in the routinised interpretation of language it was decided to re-commence transcription using the above described conventions (see p93). Transana Software (Woods & Fassnacht 2006, 2008) was used to facilitate transcription, enabling the researcher to view and hear the recording as well as the emerging transcript during the transcription process. It also allows the user to insert timing points into the transcript that directly link text to the relevant points in the video.

Transcribers

40 of the 44 consultations included in the analysis were transcribed by the author, whilst 4 of the longer ones (P58, P62, P63&P64, P65) were transcribed (speech only) by an administrative officer. Before commencing transcription or listening to any of the material the administrative officer was asked to check the identity of the participants. None were known to her. The administrative officer only transcribed audible dialogue. Additional detail such as descriptions of visual data were then added whilst also checking the accuracy of the scripts.

Alternative pronunciations & grammatical errors

As is usual in unrehearsed dialogue, alternative pronunciations/dialect usages, mispronunciations and grammatical “errors” often appeared. Those listed in Box 13 were changed during transcription to aid understanding of extracted quotations and to facilitate subsequent text searches. The original utterance was transcribed and then the alternative form inserted in curly brackets { }. The pronunciations in Box 14 were not amended because they only have one meaning and can therefore be included in text searches without getting false returns.

Box 13 – Alternative pronunciations/dialect usages changed in transcripts

The use of *me/meself* to mean *my/myself* - because it would not be possible to detect the different meanings from a simple text search.
“*Sommat*”, “*summat*”, “*innit*” - because of their infrequent occurrence in this dataset.
“*Ain’t*” - because it can be used to mean *isn’t* or *aren’t*.
“*Them*” - when used to mean “*those*” again to aid text searches.

Box 14 – Alternative pronunciations left unchanged in transcripts

‘cos
dunno
‘em (them)
gonna
gotta
wanna
yeah/yup/yah*

* It was very difficult to differentiate “*yep*,” “*yeah*,” “*yah*” and “*yes*” therefore one could not do any reliable comparisons of their usage. This is true of many of the other terms in Box 14 too.

Backchannels and their representation

During the transcription process it was found that there were very few examples of BCs being uttered with additional stress or emphasis. Similarly the majority did not overlap the first

speaker's utterances, instead they appeared to be inserted between the speaker's words. This made it very difficult to differentiate BCs from minimal agreement, a dilemma also noted elsewhere (Aronsson & Sätterlund-Larsson 1987; Roter & Larson 2002; Sandvik et al 2002). Italics were therefore only used to indicate added emphasis where such emphasis could be clearly heard. And, as with Aronsson & Satterlund-Larsson (1987), it was decided to treat each utterance from a new party as a turn, placing it on a new line indicating overlap only when it could be clearly identified. In such instances single spacing was used so as to highlight the fact that the first speaker's dialogue continued. Double spacing was then used to denote distinct turn taking between participants i.e. when the listener waited for the speaker's utterance to be complete before starting to speak.

Reliability testing - transcription

The reliability of the transcriptions as an accurate representation of the participants' utterances was tested by providing 2 nominated inter-raters (IR) with copies of 4 of the consultations' transcripts and video recordings (P1, P2, P12, P10). These 2 inter-raters each had an interest in linguistics and transcription (1 was a supervisor for this thesis (IR1) and the other was a linguistics PhD student IR2). Copies of 3 more consultations (P19, P20, P24) were given to a GP to consider from a clinical perspective (IR3). The inter-raters listened to and watched the video recordings, noting any disagreements that they had with the transcript of the consultation.

IR3 identified one clinical anomaly (which the present researcher agreed with) that could not be resolved from the video recording (P24). IR1 and IR2 identified some discrepancies that they were certain of (see unbracketed numbers in columns 3 & 4 of Box 15) as well as others

that they themselves were unsure of (these are listed in Box 15 in columns 3 & 4 in brackets).

Some of the discrepancies were randomly identified for discussion.

Box 15 – Transcribing reliability

Transcript ID	No. of Discrepancies Identified by Each Inter-Rater				Accuracy of Original Transcript (%)	
	IR1	IR2	IR3	No. shared by IR1 & IR2	IR1	IR2
P1	4 (14)	30 (2)	-	2	99.7 (98.7)	97.8 (97.7)
P2	24 (7)	74	-	8	99 (98.6)	96.8
P10	5 (2)	15	-	1	99.5 (99.3)	98.4
P12	6 (4)	5	-	1	99.6 (99.4)	99.7
P19	-	-	0	-		
P20	-	-	0	-		
P24	-	-	1	-		
					99.7 (99.4)	98.2 (97.7)
						Average
						98.9 (98.5)

IR1 and IR2 questioned the accuracy of 192 (3.1%) utterances and pauses out of approximately 6193 across the 4 transcripts analysed. Only 12 (6.3%) of these 192 queries were shared by both IR1 and IR2 (column 5 of Box 15). On average the transcripts were found to have an accuracy of 98.5-98.9% (last column of Box 15). It was agreed by the supervision team that the transcripts were of good quality, and had been made with careful attention to detail. All additional copies of the video recordings made for the inter-raters were subsequently destroyed.

Coding – Politeness Outputs and Clinical Decisions

The transcripts were then coded using the principles described above and records of the codes generated recorded in a coding diary. The coding itself was recorded using NVivo computer software (QSR 2006, 2008). The coding comprised 3 key parts:

- *Broad brush coding* (Bryman 2001): Used to label broad categories, and also large sections of data containing finer levels of coding (Richards 1999). These provided a map or index of the different aspects of the consultation.
- *Politeness outputs*: Nodes were devised in NVivo which mirrored the politeness outputs listed by Brown and Levinson (1987) (defined on p70 and listed in Appendix I) and the data coded accordingly. A description of the labels used within the analysis here will be presented from p123 of the Results Chapter.
- *Clinical decisions*: These were identified as described above and highlighted within the transcripts using a bold font, and text boxes placed around the dialogue which appeared to directly contribute to the decision. These very visual tools aided contextual analysis.

Some parts of the transcripts were left uncoded, e.g. if they were not essential to understanding context or did not contribute to the decision-making or development of rapport. These sections were however marked as being uncoded so that they could easily be reviewed.

Coding and interpretative reliability

As a precursor to setting up the electronic coding schema, 6 transcripts of various lengths and with varying patient age and gender (P1, P2, P10, P12, P20 & P24) were selected. These were coded as described above and accompanied by detailed notes regarding the categories identified. The resultant coding was discussed with the supervision team and the critiques offered defended. Relevant amendments were made prior to applying the schema to all of the transcripts.

There are a few additional points that can also be made at this stage. As is always the case with language analysis, or indeed as is the case with language in use under any circumstances, there is more than one interpretation that can be made. We were not involved in the conversation, were not even direct observers of it, and even given the additional resource of video, much is likely to have been lost. The complexity of conversation means that we cannot establish with any certainty such things as illocutionary intent or perlocutionary uptake. Neither can we know how intentions shifted or were modified by the words and actions of other participants. However, observing the way in which politeness operates, and by extension therefore discussing interaction using the backdrop and vocabulary of politeness, it is hoped to uncover some illuminating interpretations.

Summarising the Data

Again using constant comparison (Glaser & Strauss 1967), the coded transcripts were read and re-read and a textual, electronic record was then produced of the impressions, and rationale for them, of the politeness strategies and facework management performed in relation to these decisions. These impressions were then compared with the coding stored in NVivo in order to situate the decision-making analysis within the performance of face in the consultation as a whole. This process was systematically repeated for each of the consultations, analysing each individual GP's session before moving onto the next session. At the end of the analysis of each of the GP sessions a summary was produced of the key emergent themes.

Identifying Themes and Theoretical Saturation

It was as the analysis and process of summarising continued that it became clear that common themes were emerging from the GP sessions, that is, findings were being generated that were common to each of the sessions. When there were no longer any new findings or themes being identified it was agreed with the supervision team that *theoretical saturation* for this aspect of the analysis had been reached. This occurred after 44 of the consultations had been analysed (all of D1, D2, D4, D5, D6 & half of D7).

On the basis of the findings up to this point, Phase 2 of the analysis was then commenced and the identification of cases which deviated from the Phase 1 findings. Having identified a selection of such cases which met this criterion, the original case analyses and summaries for each was revisited, and then an in-depth analysis undertaken as will be demonstrated in the Results Chapter. It is the subsequent emergent themes from this second phase of the analysis that form the research findings of this thesis.

3) ORIGINAL DATA COLLECTION

Period of Data Collection

The idea of collecting video recordings of primary care consultations was first conceived by the ISU team in 2000 and ethics approval applied for in 2001. Ethics approval was granted in August 2002 once amendments had been made to the study design. Once R&D approval had also been obtained and GP practices recruited, data were collected between October 2003 – March 2004.

Purpose of the Original Research

The purpose of the team's original research is presented here since it is pertinent to the way in which the participants might have been influenced during data collection. The data were collected for use in two studies:

Study 1 aimed to describe doctor-patient interaction and to establish:

- 1) When and why patients initiate topics for discussion
- 2) How doctors can facilitate patient discussion in the interaction, and consequently involvement in the decision-making process
- 3) Whether or not there was a relationship between patient participation and patient enablement

Study 2 aimed to compare the characteristics of simulated consultations used in training with authentic doctor-patient interaction. Prior to agreeing to participate the GPs were advised that the research was concerned with:

- Improving communication skills;
- Patient participation.

As can be seen, these aims are in keeping with the main topic of inquiry for the present study. It is therefore possible that knowledge of this could have led participants to focus on these aspects of behaviour more than they would do normally, resulting in data collection that was not representative of the participants' usual behaviours. The written information given to GPs can be seen in Appendix V and that given to patients in Appendix VI. In addition, participants were given the opportunity to discuss the research more informally prior to data collection.

Data Collection Sites

The GP Postgraduate Education Unit (West Midlands) sent information about the study and invitations to participate to all of the GP trainers (GP practices used to train junior doctors in general practice) in the West Midlands at the time (84 in 2002).

Recruitment & Consent of Patients

Guidelines from the Caldicott Guardians (DoH 1999) at the time of data collection required that patients must have at least 24 hours to consider whether or not they would like to participate in research prior to any data collection. This was problematic as GP clinic

sessions typically include a mix of patients who have booked their appointments more than 24 hours in advance alongside those who have booked within the last 24 hours. Therefore, in order to meet West Midlands MREC requirements and to make recruitment, consent and data collection more streamlined, it was agreed that the GPs would organise dedicated data collection sessions for patients booking appointments more than 24 hours in advance.

Advertisements were sent to participating practices three weeks prior to the data collection sessions. Patients were given details about the study when making advanced bookings and invited to participate. GPs also advised their regular attendees of these dates. Interested patients were given the opportunity to discuss the study with the researchers.

Consenting patients were sent a covering letter and a copy of the patient information sheet prior to their appointment (see Appendix VI). On arrival for their appointments, participants were reminded of the study and given the opportunity to talk to the researcher. Consent was also obtained from any other persons accompanying the patient. The GPs obtained three copies of the patients' signed consent (see Appendix IV) – one each for the patient, the patient's GP records and the research team.

Patients requiring physical examination during the consultation were offered the option of having the camera lens covered over, a position out of view of the camera whilst the examination was taking place, or the option to pause the videotape until after the examination. It was made clear that the patient could ask for the recording to be discontinued at anytime. Patients were free to withdraw their consent at any point in time during or after the consultation.

Inclusion/exclusion criteria for patients

All patients who gave written, informed consent were included. The groups of patients listed below were identified as vulnerable and special care was taken to ensure that these patient groups were given every assistance to make a free and fully informed decision regarding their willingness to participate in the study:

- Children;
- Adults without capacity;
- Patients who were extremely anxious or upset;
- Patients with special needs;
- Patients with mental illness/psychoses;
- Patients with breast problems;
- Patients with pelvic/perineal problems;
- Patients with contraceptive/reproductive problems.

These vulnerable groups were protected in the following ways:

- GPs seeing members of these groups in the weeks leading up to the videoing were explicit about the dates that filming was to take place in order that alternative arrangements could be made for follow-up appointments.
- Reception staff were made aware of these groups and were asked to be particularly careful about how these groups were invited to participate.

- The researchers or their representatives were also fully aware of these vulnerable groups and actively discouraged the participation of a subject whom they felt might not be able to give free and fully informed consent.
- Where there was doubt as to the validity of consent, GPs were given the final decision as to whether filming was appropriate.

Participants were not required to be speakers of English.

Demographic Data Collection

Patients were asked to complete an anonymised “Patient questionnaire” with the help of their GPs, this included recording demographic and bio-statistical information, and a tool with which to evaluate the consultation (see Appendix VII). Anonymised demographic information about the GPs was also collected (see Appendix VIII).

Sample Size

The original data collectors aimed to collect recordings of 120 consultations. This sample size had been determined from a pilot study of 30 transcripts from audiotape recordings of consultations collected in the ISU between 1992-95 (Skelton & Hobbs 1999). Statistical analysis of the pilot study had shown that at least 120 consultations were needed for the original researchers to obtain statistical significance from their analysis.

Recording the Consultations

The video recordings were made using the researchers' VHS camera mounted on a tripod in the corner of the consulting room. On one occasion (D3) the practice's own recording equipment was used but the sound quality proved to be too poor to make subsequent recordings in this way. Recording equipment was set up before the clinic began and the VHS camera positioned so that both patient and GP were visible. The cameras' own microphones were used to record sound (in the case of the VHS camera this was mounted on top of the camera). GPs were given the option to turn the camera off between patients or to leave it running. GPs had the option of discussing consent with the patient and completing the patient details, or they could leave this to the researcher. A researcher was always on site whilst recording was underway.

4) SAMPLE DESCRIPTION

This final part of the methodology provides details about those who participated in the study. Information about the responses received by the original data collectors provides insight as to the limitations experienced by potential participants in taking part in the study. The demographic details for those patients and GPs in the sub-set used here demonstrate the range of participants included. Demographic details of the remaining patients and GPs not included in the analysis here can be obtained from the ISU.

Responses

GP responses

22 GPs expressed an interest in taking part in the study, some of whom were colleagues of the GP trainers, and therefore not themselves GP trainers (where the GP's status was known this has been noted in Table 2 on p118. Others responded giving reasons for not participating, these included:

- Being too busy;
- Concern that the practice was not set up for research;
- Being a single handed practice (run by only 1 GP);
- Belief that the practice was already doing enough for the university.

Some of these GPs subsequently decided against participating either because of the MREC's insistence that special sessions, with pre-consented patients, be set up or because the study did not attract sufficient remuneration. In addition there was one GP participant who failed to recruit any patients (D10 - see below). Two sets of GPs came from the same practice - D4 &

D6 and D5 & D3. Additional GPs from this latter practice also agreed to participate but the original research team felt that it would skew the data to obtain such a disproportionate amount of data from one practice.

Ultimately, 10 videotapes were recorded from 9 different GPs (1 GP (D5) recorded 2 sessions), see Table 1 below.

Patient responses

There was no way of ascertaining how many patients chose not to participate. However, regarding reasons for declining, it was identified that a key factor in D10's failure to obtain consent from any of the practice's patients was because the patients were largely Somali asylum seekers who were unwilling to sign consent forms because they feared deportation. Only 4 of the 90 or so patients found the idea of having their consultations recorded too distressing after all (P22, P26, P73 and P77 – discussed previously on p121). Additional responses included some patients seated in the waiting room who volunteered to participate on the day of recording. However, they could not be included because of the ethics committee's requirement that recording be limited to dedicated sessions for patients who had provided consent in advance.

Number of Participants

“Participants” refers to all those whose utterances were transcribed, that is, the GPs, their patients, and those accompanying them. 44 patients and 6 GPs from 5 different practices have been included in the qualitative analysis here. 2 of the patients were related and were seen in the same consultation (P63 & P64 - see “Other persons accompanying patients” on p117). In

addition, there were a total of 10 other adults who did not themselves consult (again see “Other persons accompanying patients” on p117).

Table 1 – Overview of participant numbers

Original Dataset	
No. of Patients	≈90
No. of GP Sessions	10
No. of GPs	9
Sub-set Used in this Analysis	
No. of Patients	44
No. of GPs	6

GP Demographics

The GPs’ demographic details are recorded in Table 2. Their ethnic origin was not formally recorded but it is known that D7 had a South African accent and that this is where he did his medical training. 5 of the GPs were based in South Birmingham PCT (D1, D2, D4, D5 & D6) and D7 in Birmingham East & North PCT. All the GPs had close links with the Department of Primary Care Clinical Sciences at the University of Birmingham.

Table 2 – GP demographic data

ID	Gender	Year admitted to GMC register	No of Partners in practice	PCT	Misc
D1	M	1986	5	South Birmingham	
D2	F	1980	?	South Birmingham	
D4	F	1993	6	South Birmingham	Part-time Same practice as D6
D5	F	1978	10	South Birmingham	Trainee trainer Recorded 2 sessions Same practice as D3 (D3 excluded see p99)
D6	M	1992	6	South Birmingham	Same practice as D4
D7	M	1984	3	Birmingham East and North	Trained in South Africa

? – Missing data

Patient Demographics

The patient demographics reported here (see Table 3 on p120) are taken from the archived database and where possible from the original patient questionnaires (see Appendix VII for an example), some details are, however, missing. In particular, GPs were asked to record here the patients' body mass index but only 2 did so.

These data can be summarised as: nearly two thirds of the patients were female (n27), recorded ages ranged from 19 months – 81 years (see Table 3 for full list) with 6 being under the age of 16 (P21, P37, P45, P63, P64 & P70). Where the age of other persons accompanying the patient was provided this has been added to Table 3 and the ID offset to the right, additional information will be given about the persons accompanying patients in Table 4 on p121.

Of the 35 patients whose ethnic origin was recorded, the vast majority (83%) classed themselves as “White: British” (see Table 3 below). Only 2 patients were not native English speakers, their first languages being Polish (P24) and Arabic (P48). The Arabic-speaking patient (P48) was seeking asylum and attended with an interpreter. With the exception of P48, all adult patients demonstrated their ability to read and write by reading and signing their consent forms. Consultation lengths ranged from 3 - 21 minutes (P20-D5 & P62-D2). The issues discussed in the consultations were wide ranging and these are reported in Appendix IX.

Table 3 – Patient demographic data

Patient ID	Age	Gender	Other*	GP ID
P1	16	F		D1
P2	38	M		D1
P3	60	M		D1
P4	78	M		D1
P6	35	F	Mixed	D1
P7	81	M		D1
P8	69	F		D1
P9	30	F		D1
P10	25	F		D2
P11	66	F		D2
P12	74	F		D2
P19	37 or 44	F	Database & early transcript differ	D4
P20	31	F		D5
P21	19m	M		D5
P23	28	M	White other	D5
P24	64	F	White other L1 [†] Polish	D5
P25	22	F	?	D6
P27	47	M	?	D6
P28	?	M	?	D6
P29	?	M	White Irish	D6
P30	57	M		D1
P31	61	F		D1
P32	67	F		D1

Patient ID	Age	Gender	Other*	GP ID
P37	7	F		D7
P38	29	F		D7
P39	64	M	Irish	D7
P44	76	F		D7
P45	6	F		D4
A45	35	F	Mother	D4
P46	?	F	^Afro-Caribbean appearance with strong Caribbean & Birmingham accent	D5
P47	?	F	?	D5
P48	?	M	^L1 Arabic, asylum seeker with translator	D5
P50	77	M		D7
P51	59	M		D4
P52	78	F		D7
P55	38	F		D7
P58	30	F		D2
P62	28	M		D2
P63	6	F		D4
P64	?	F		D4
A63/64	24	F	Mother	D4
P65	60 or 68	M	Database & dialogue differ.	D4
P66	76	F	?	D5
P68	?	M	?	D6
P69	?	M	?	D6
P70	?	F	?	D6

M – male

F – female

? – Missing data

*Other – includes notes and ethnicity and first language where these have been identified as not being “White: British” – the dominant population here.

^Based on visual & aural observations from the video data since accompanying demographic data missing.

†L1 – Refers to speaker’s first/preferred language.

Other persons accompanying patients

There were 9 patients who were accompanied by somebody else; i.e. spouse, parents/other related carers, siblings (both consulting and non-consulting siblings) or translator. All children had adult females who appeared to be relatives with them. Only one child’s father was also present. None of the male patients were accompanied by a female spouse/partner.

Table 4 below details how many people accompanied each patient, their relationship to the patient, and which of the attendees spoke.

All 9 accompanying adults spoke during the consultation. The double appointment (P63 & P64) appears to have been pre-arranged at the time of booking.

Table 4 – Persons accompanying patients

Patient ID	No.	Relationship	Speaker Y/N	Patient Y/N
P21	2	Both parents	Y	N
P1	1	Grandmother	Y	N
P12	1	Husband	Y	N
P37, P45, P63&P64, P70	1	Mother	Y	N
P1, P37	1	Sibling	N	N
P63&P64	1	Sibling	N	Y
P48	1	Translator	Y	N

Excluded patients

The demographic information for those excluded patients whose consent was not withdrawn is listed in Table 5. Their data is presented here to demonstrate their similarity to the included population and that their exclusion has not created any obvious bias.

Table 5 – Demographics of excluded patients

Patient ID	Age	Gender	Other*	GP ID
P05	47	F	Bangladeshi L1 Bangla	D1
P22	30	M		D5
P26	76	M		D6
P67	?	F		D7
P71	?	M		D6
P72	51	F		D2

*Other – includes notes and ethnicity and first language where these have been identified as not being “White: British” – the dominant population here.

CHAPTER 4 - RESULTS

INTRODUCTION TO CHAPTER 4

There are three aspects to this Results Chapter: firstly a description of those politeness outputs used to describe the process of decision-making between doctors and patients; secondly an outline of the common themes identified in Phase 1. It is from these common themes that the Phase 2 deviant cases were identified, and from these that the central findings of this thesis emerged. It will be seen that 8 key themes were identified from this analysis each of which has been grouped into one of 3 categories: *Space*, *Endorsement* and *Confusion*.

Extracts from the data are used throughout to support the analysis and the line numbering in them directly replicates that of the original transcripts. When data from these extracts are referred to in the text, the line numbers where the relevant material can be located are denoted with the prefix “L”. The clinical decision-making points have been emboldened in the extracts in keeping with the original analysis.

Decisions can be arrived at in a number of ways, as already noted; the decision-making process is not necessarily bounded to discrete, consecutive turns (e.g. see Marra 2003 cited in: Lohrova 2011). Rather, the process may comprise various discursive points occurring within different phases of the discourse, throughout the interactional encounter. It is therefore essential that a pragmatic linguistic analysis takes such issues into account. Hence, the present analysis of the data was not limited simply to the excerpts of dialogue reproduced

here; rather, care was taken to interpret the data in the context of the whole of the consultation.

PHASE 1 RESULTS

Phase 1 of the analysis included coding of the politeness outputs used by participants in the consultations; that is, the identification of the way in which participants' politeness outputs contributed to the mechanisms which effect politeness strategies, how they incorporated and effected Brown & Levinson's (1987) view of politeness within their discourse. Of those outputs identified, the ones which will be referred to throughout the in-depth presentation of the subsequent case analyses in Phase 2 are described below. Additional outputs which are only referred to in specific cases will be described when introduced in the main body of the text. There then follows a synopsis of the way in which patients and GPs tended to participate in the decision-making process.

Mechanisms for Politeness

As already explained, the strategies used to perform politeness are enacted through the use of various mechanisms and outputs which Brown & Levinson (1987) describe in intricate detail, uses that one is not necessarily conscious of. There is not the space here to describe each of these, nor would doing so benefit the analysis. Instead, the description of politeness outputs has been limited to those directly referred to in the case analyses presented in this chapter. Some of the outputs identified are only referred to once; where this is the case they are described within the body of the text. Others are referred to more than once, and these are listed here in order to reduce repetition and avoid detracting from the analysis itself.

Negative politeness outputs

The negative politeness outputs used by the participants in the extracts are presented first.

Being oriented toward the protection of negative face, these outputs attend to the individual's need to maintain their own autonomy, to be free from imposition, to act in their preferred way and to maintain their position (e.g. that of expert status) (Brown & Levinson 1987: 61-2).

And, as already explained, these strategies are typically more indirect and more formal than positive strategies, and more likely to increase the social distance between the interactants.

Conventional indirectness

Conventional indirectness refers to conventionalised phrases or sentences whose literal meanings might appear ambiguous, whereas when used in a conventionally recognised context are unambiguous e.g. "Can you pass the salt?" is not an enquiry about the listener's physical abilities, but rather is a mitigated request to pass the salt (Brown & Levinson 1987: 72, 82, 132-44, 213-227).

Deference

Giving *deference* refers here to raising the status of the speaker. This can be achieved in one of two ways, either by using humility to lower the speaker's status, or, by using strategies which elevate the status of the listener (Brown & Levinson 1987: 178-87). This strategy demonstrates awareness of the limitations entailed in trying to influence others, and the rights of others not to be imposed upon.

Gratitude

Gratitude refers to direct and indirect expressions of thanks. Such utterances position the speaker as having incurred a debt (Brown & Levinson 1987: 67, 209-11) and are associated with demonstrating respect for the listener's right not to be imposed upon and the listener's claim to status (e.g. expert). They can be interpreted in a number of ways including as indirect apologies (Brown & Levinson 1987: 187-90) and as a means of giving deference (Brown & Levinson 1987: 67, 178-87). Expressions of gratitude can also function as positive strategies (Brown & Levinson 1987: 126-7) but there are no such examples in the material presented here.

Hedging

Hedging can be summarised as a means of modifying the degree to which a speaker adheres to his/her utterance (Brown & Levinson 1987: 145-6). When used as a politeness strategy hedging enables the speaker to avoid suggesting any presumption that the listener will cooperate. Outputs include lexical items (see p211 for further discussion) as well as hesitating pauses and false starts (revisions or repetitions made by speakers when formulating utterances e.g. p257), prosodic (e.g. fillers like *er*) and kinesic communication (e.g. raised eyebrow) (Brown & Levinson 1987: 57, 94, 145, 172, 187; Holmes 1995: 75; Holmes & Stubbe 2003: 7). Each of these devices has the capacity to convey an air of "tentativeness and possibility" (Hyland 1996: 433) as well as imprecision and uncertainty (Biber et al 2002: 457). In reality, hedges are complex polypragmatic linguistic devices (Hyland 1996) which tend to be instinctive as opposed to pre-meditated (Brown & Levinson 1987: 85) and which can be used to convey both solidarity (a positive politeness strategy described below) and uncertainty. Avoidance of over-interpretation is then paramount; see p211 for further details.

Positive Politeness Outputs

Next, the outputs used which relate to positive politeness are described. These outputs attend to the individual's need to be seen as appealing, to be appreciated and approved of, and for their wants to be viewed as desirable by others (Brown & Levinson 1987: 61-2). Positive politeness strategies tend to be more informal than negative strategies, and are commonly oriented toward developing closer relations between the interactants. The positive strategies described here present the speaker as a co-operator; such an approach has a collaborative element to it. By making oneself and one's ideas sound appealing, the speaker increases his or her chances of obtaining the listener's cooperation (Brown & Levinson 1987; Holmes & Stubbe 2003).

Giving gifts

One's positive face-needs can be managed by the giving of *gifts* which demonstrate that the speaker understands, is interested in and wants to fulfil the listener's needs, in sum, a desire to be cooperative. Such gifts can take the form of tangible goods, e.g. a prescription (p174174), or can satisfy relational needs by offering such things as reassurance (p178), understanding (p194) and cooperation (Brown & Levinson 1987: 128-9).

Inclusive strategies

Inclusive strategies function to demonstrate or claim common ground and in-group membership with the listener. In doing so the speaker indicates solidarity with the listener, reducing social distance and drawing the interactants together as mutual co-operators. Such displays particularly attend to the need to have one's goals and values shared and met (Brown & Levinson 1987: 107, 112-17, 125, 127). The mechanisms used to achieve this include use

of in-group language, inclusive pronouns (p179), informal address forms (p137) and shared remembering (p172).

Decision-Making – Common Themes

The research set out to look at the relationship between politeness and patient participation in decision-making. As previously noted, the Phase 1 analysis demonstrated that generally speaking across the dataset, there was a strong theme of the consultations being oriented towards agreement, a finding which led to the commencement of a new cycle of analysis focussed on deviant cases. Consequently, Phase 1 serves as a central indicator for the way in which other consultations deviated. An overview of this essential component of the Phase 1 findings is presented here, illustrating what has been understood in the present thesis as “typical”, setting the scene for the Phase 2 analysis. This early aspect of the findings, whilst crucial in obtaining an overview of the decision-making norms within this dataset, explores only certain aspects of the research question. So as not to detract from the research’s overall aims, therefore, this section of the report is necessarily short.

This theme of agreement was manifest in different ways within the consultations, typically falling into one of the following categories (examples of which will be given below):

- Patients bringing their ideas to the consultation;
- GPs making the decisions in the form of:
 - Declaratives – statements
 - Closed, yes-no questions - invitations to agree.

Patients' ideas

To elaborate then on the first of these, in Extract 3 below, P39 has booked his appointment because he has *run out of tablets* (L66). P39 does not know whether or not D7 will agree to this request because patients on regular medications are supposed to submit a written request for repeat prescriptions at least 48 hours in advance. They are not meant to use consultation time to make such requests. However, as can be seen at L69, D7 agrees to the request *Oh, OK*.

Extract 3 – GP agrees to patient request for medication (D7-P39)

- | | |
|-----|---|
| 65. | D7: ... Right how can I help today? |
| 66. | P39: [P39 looks at P39] Well, unfortunately [D7 glances at P39] it's just tablets, I've run out of tablets without even noticing. |
| 67. | D7: [D7's tone indicates that this is unusual, ¹ nods] Oh right! |
| 68. | P39: *I've none left* for today [P39 smiles]. |
| 69. | D7: ¹ Oh, OK, [D7 writes on patient's paper notes] which ones, erm, [P39 reaches into pocket for list of medications] are you running out of? |

Another such example can be seen in Extract 4, below. Here D5 has prescribed *antibiotics* (L28) for P20, having done so, he goes on to check whether or not she is *allergic* to them (L30). Although she isn't *No* (L31) she later goes on to explain that *Erythromycin* (L37) makes her *vomit* (L39). In response, D5 offers her *a friendlier version* (L28) to which P20 offers agreement *Ah ha* (L43).

Extract 4 – GP agrees with patient suggestion (D5-P20)

28. D5: ²**I'll give you some [D5 raises eyebrows sympathetically] antibiotics,**
29. P20: [P20 nodding]
30. D5: you're not allergic to anything are you?
31. P20: No. [P20 shakes head]
37. P20: (2) Eryth<romycin>, I can't take erythromycin, it makes me (.)
38. D5: OK
39. P20: vomit
40. D5: [D5 faces P20] We'll try something else then. [D5 glances at screen and gestures with hands] It, it's not that you come out in a rash too? It's just that
41. P20: no [P20 shakes head] [D5 faces screen and types] it makes me feel sick.
42. D5: ³**OK. They've erm, they've produced a friendlier version of it, which erm, doesn't make people feel quite so ill so [D5 glances at P20] we'll try that instead.**
43. P20: Ah ha [P20 nodding]
44. D5: [D5 types] (8) That's great. Work and everything [D5 looks at P20] going alright?

GPs' decision-making

Alternative scenarios within this theme of agreement typically involved patients presenting with a symptom to which the GP responded with a specific course of action, one which the patient agreed to. Patients were rarely given options to choose from. The GPs typically presented their recommendations in the form of directives or invitations to agree, with the former being the most common. These are discussed next.

GPs' declaratives in decision-making

In Extract 5 one can see an example of decisions being presented to the patients as directives, that is, the decision takes the form of a declarative statement. As can be seen from L53, D1 has just finished examining P8's eyes, concluding that she does not have *conjunctivitis* (L55). He uses a declarative to tell P8 that she has *blepharitis* (L61), that he will give her some *sheets to look at* (L63) and *an ointment* (L65). In this scenario P8 did not open by suggesting a diagnosis or any ideas, concerns or expectations about the symptoms or possible treatment

options. As can be seen P8 indicates agreement with D1's diagnosis, apparently echoing D1's *milder* and with the use of the minimal utterance *yes* (L62). She again uses minimal utterances to respond to his subsequent directives *mmm* (L64, 66, 68).

Extract 5 – GP declarative stating decision (L61, L63 & L65) (D1-P8)

53. D1: ... Well they look pretty good today. [P8 replaces glasses] Erm, the things sort of [D1 turns light switch back on] things we're looking for are, [D1, gesturing and looking at P8, sits down] [P8's gaze follows D1] for instance, is there any infection, what
54. P8: right, right [P8 nods]
55. D1: we call conjunctivitis, there's no [D1 shakes head] evidence of that
56. P8: oh right
57. D1: and what you tend to get with that anyway is, er, a lot of persistent irritation, irritability, not pain but sort of itching almost
58. P8: no [P8 shakes head] I haven't got that
59. D1: and quite a big discharge of pussy
60. P8: mmm
61. D1: and lots of redness to the eyes. So, that's, that's fine that's not happened (1).
¹The next, next thing we're really looking is, is the edge of the eyelid because that can become a little bit inflamed, what, what's known as blepharitis and you get very small, bits of debris stuck there and they tend to make the eye water. Erm, [D1 glances towards screen] and I think that's really, probably what's happening to you, given that it's happened before in a, milder form
62. P8: *milder* yes [P8 nods]
63. D1: [D1 pointing and looking at screen] **²I'll give [P8 glances at screen] you some sheets here, [D1 looks back at P8, gesturing] to take away that you can have a look at**
64. P8: mmm, mmm
65. D1: **³and I'm going to give you an ointment to put in your eye,**
66. P8: mmm
67. D1: er basically you pull the eyelid down,
68. P8: mmm [P8 nods]

GPs' use of invitations to agree in decision-making

A common alternative within this theme was the GPs' use of closed, yes-no questions when responding to patients, devices which function as invitations to agree. These utterances again tended to receive an agreeable response from the patient. In the example in Extract 6 P24 is attending for the annual review of her medication. D5 has identified that P24 does not take as much of one of her tablets as her records indicate. He decides to *change* [the] *prescription* (L39) so that it matches what she is actually taking *you're only taking one at night* (L39), a

move that will benefit the practice *so that we've got only one on there for you* (L39) by reflecting more accurately her current usage. The nature of the question *OK, if, if you're only taking one at night, can I change your prescription so that you're only, so that we've got only one on there for you?* fits the model of an invitation to agree not only because of its closed, yes-no form, but also through the boosters which encourage agreement by outlining the benefits of such a decision. P24's response indicates agreement *Yes [nodding] if you want to* (L40).

Extract 6 – Invitations to agree (D5-P24)

- | | |
|-----|---|
| 32. | P24: And I've been, [P24 gesturing] you know, on, [P24 glances at screen] but I, I don't (1) have, I don't have two at night. |
| 33. | D5: [D5 nodding] right |
| 34. | P24: I just have the one, |
| 35. | D5: [D5 nodding] |
| 36. | P24: then if I do feel rough, I have another (.), <u>another one</u> . |
| 37. | D5: <u>OK</u> , OK |
| 38. | P24: But otherwise, I'm not too bad. |
| 39. | D5: [D5 gesturing] ¹ OK, if, if you're only taking one at night, can I change your prescription so that you're only, so that we've got only one on there for you? |
| 40. | P24: Yes [P24 nodding] if you want to. You, [P24 speaks brightly and without concern] yes, |
| 41. | D5: OK? [D5 nodding] |
| | P24: yeah, yeah [P24 is nodding]. |

As previously noted, this aspect of the evidence, that the consultations seemed to be oriented toward agreement, is a characteristic that has already been identified elsewhere within linguistic research (Houtkoop 1986; Heritage & Sefi 1992; Stivers 2005). As a means of managing the data more effectively the decision was therefore made to use this finding to identify specific consultations for a much more detailed level of scrutiny, ones that had more unusual characteristics. In the first instance, analysis therefore turned to consultations where patients expressed, or appeared to express, reluctance to agree. It is in the next section, the

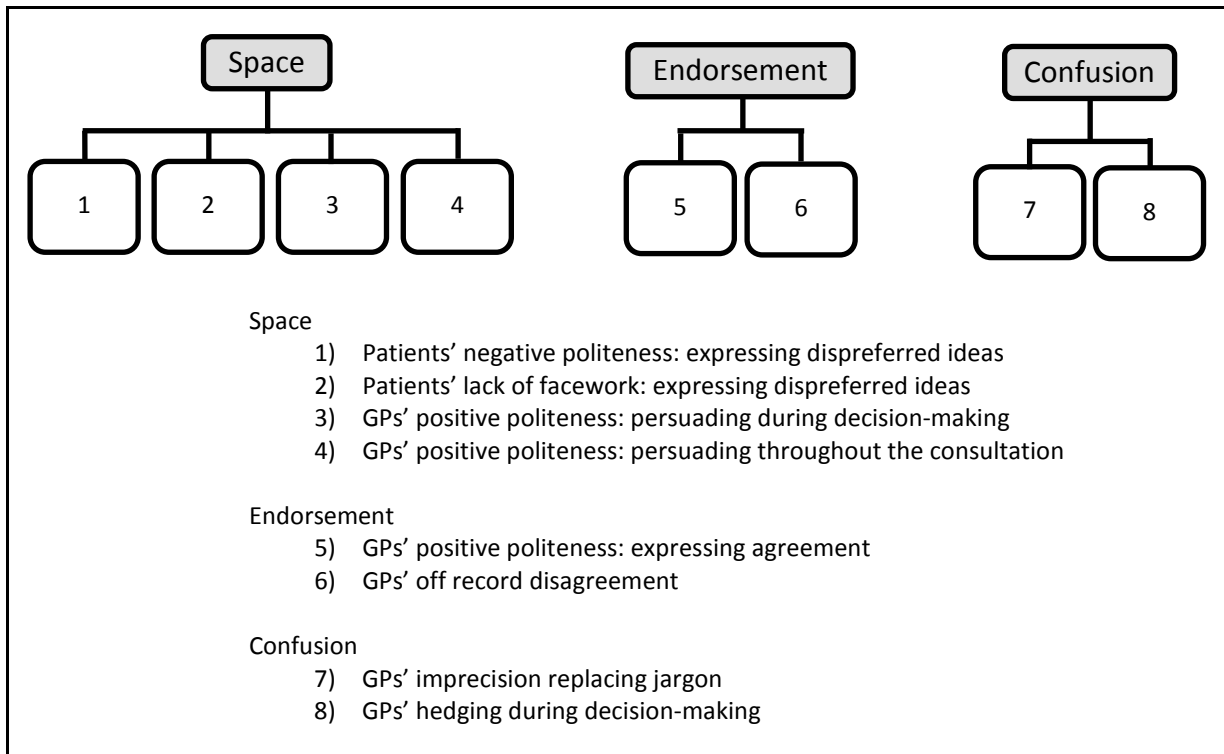
presentation of the Phase 2 findings, that the use of politeness strategies to attend to face-needs during decision-making is examined more thoroughly.

PHASE 2 RESULTS

The chapter now turns to the key findings of this thesis, the presentation of the themes derived, in the first instance, from the deviant case analyses. This analysis begins with a detailed consideration of particular decisions made in 3 of the consultations (P2, P6 & P29) where the doctor and patient have, or appear to have, differing ideas about the best course of action to take. What is important to emphasise here is that the patients are not choosing between options offered by their GPs. Rather, they have opted for, or are considering opting for, alternatives that have not been suggested by their GP. They have dispreferred ideas, ideas and preferences which differ from those expressed by their expert advisor, namely, their GP. Building on these findings, the analysis turns then to specific considerations of politeness within the dataset, topics of enquiry prompted by the deviant cases.

In each instance a detailed discussion of the analysis is offered, with consideration given to the individual politeness outputs and mechanisms for each of the participants and a description of the emergent theme. In the spirit of transparency, and as a means of testing the credibility of the overall analysis, analysis not directly related to the themes has also been included. This not only shows that there are invariably a range of strategies in play, but is also intended to add to the validity of the findings by reducing any concerns that data have been interpreted out of context, or to favour a biased argument.

Figure 3 – The emergent themes and their categories



This analysis, to varying extents, weaves in and out of the 3 overarching categories that group the themes together: *Space*, *Endorsement* and *Confusion*. Their relationship to the various themes is shown in Figure 3. The first category, *Space*, is concerned with issues relating to the interactive space available to, and used by patients to present alternative viewpoints. Expressing viewpoints that differ from dominant medical beliefs might be construed as a source of conflict, or as breaching therapeutic norms, as well as a means of undermining the very decision to seek expert advice. Meier (1995 cited in: Harris 2003) suggests that any challenge to normative behaviour and rules e.g. deviating from the dominant beliefs, constitutes a breach. The issues explored in this category relate both to the way in which patients found the space to introduce dispreferred ideas, their use of politeness strategies to do so, and, the effects of GPs' politeness strategies on the management of the space available to the patients for doing so.

Mindful of Charles et al's (1997) edict that patients' decisions should be endorsed even when opinions within the party differ, the second category *Endorsement* is concerned with differing responses received by patients expressing dispreferred ideas and the way in which the GPs managed the issue of "endorsing" dispreferred decisions. The themes within this category also provide striking examples of the way that what we appear to say and what we actually mean do not always correlate. The final category is concerned with GPs' use of negative politeness in ways that could cause *Confusion*. The penultimate theme here explores a misunderstanding between one of the patients and his GP. This misunderstanding is attributed here to the use of indirectness, an aspect of politeness. Such use of indirectness, and other negative politeness mechanisms, are the familiar strategies that talk of politeness immediately conjures up (Brown & Levinson 1987: 62, 129-30). With the final theme following on from this to explore other ways in which indirect politeness might cause confusion, the limitations and drawbacks of such mitigation in the consultation are highlighted.

The relationship of the Categories to each of the themes is clearly explained as the various cases and their related topics are presented, with some of the cases containing reference to more than one Category. Many of the points to be drawn out in these case studies involve simultaneous reference to stretches of dialogue occurring at different junctures within the consultation. Wherever possible, attempts have been made to focus on one output at a time and to present data analysis chronologically, maintaining the flow of the consultation. However, there are occasions where the need to avoid fragmented, repetitious argument necessitated the inclusion of extracts containing utterances from various parts of the consultation, and others where discussing an utterance more than once could not be avoided.

There are also instances where the unfolding dialogue prompted detailed reflection on earlier utterances, and where the liberty has been taken of repeating such pertinent utterances.

The Case of P2: Patients' negative politeness to express dispreferred ideas & GPs' positive politeness to express agreement

Turning then to the first of the deviant cases, we begin by looking at the way in which P2 identifies and uses *Space* to express his dispreferred idea to his GP, D1. The case involves a decision made outside the consulting room, one which has already been effected despite its divergence from the GP's previous advice. The analysis begins by exploring how the patient finds and manages the space in which to share his decision, in this case, his reliance on negative politeness to do so, hence the emergence of the first theme: *Patients' negative politeness: expressing dispreferred ideas*.

Also included will be an analysis of the GPs' response, and the way in which the decision is endorsed, taking us into the category of *Endorsement* and in this case the theme of: *GPs' positive politeness: expressing agreement*.

P2 is a 37 year old "white British" man who appears to be attending a review appointment booked sometime ago with D1 and who has been having problems over the last few days with his thyroxine dose.

It would seem from the dialogue that P2 has recently (in the last few months as opposed to years) started taking thyroxine. In the last week or so he has experienced unpleasant symptoms, and having read the information leaflet accompanying his medication, has taken it upon himself to alter the dose without consulting his GP. Changing one's treatment plan without specialist advice is a breach of cooperative norms. Such concern could conceivably

be interpreted as doubting D1's ability to fulfil his role as expert, and therefore a threat to the cooperative nature of the interactants' future relationship, hence the reference to it here as a *breach*.

Extract 7 – Diverging from GP advice (D1-P2)

- | | |
|-----|--|
| 1. | D1: Come in [D1 turns to door] Hi [D1 uses P2's first name]. |
| 2. | P2: Morning [D1 grins] Dr1, how are you? [P2 shakes D1's hand] |
| 3. | D1: Fine. [P2 comes into view, glances at the camera]
[Discussion about the camera, data collection & consent] |
| 11. | ... Good, so [D1 looks at P2] how are things? |
| 12. | P2: Er, yeah, not bad, actually, I haven't *managed to* *** ** I think it's about three months |
| 13. | D1: mmm |
| 14. | P2: since I've seen, saw |
| 15. | D1: [D1 nodding] mmm |
| 16. | P2: you since, [P2 tuts, shakes head, corrects self] saw you, seen you, so er, I thought I'd pop in. Er, there is one thing really. You know when, er, you asked me to go up to [D1 nodding] 200mg on the thyroxine, what was it, five or six weeks ago? Or whenever it was. |
| 17. | D1: [D1 nodding] yeah |
| 18. | P2: [D1 looks at P2] Erm, well, I've gone back to 150 |
| 19. | D1: right |
| 20. | P2: because I, about last week, I began to feel a bit sort of flushed with it and, |
| 21. | D1: [D1 nods] right |
| 22. | P2: I've, you read those, [D1 nods] you know, the leaflet that goes with it, |
| 23. | D1: yeah |
| 24. | P2: erm, and I, I was getting a little bit of a, sort of a fluttery [D1 nodding] (.) sort of heart, nothing (.) |
| 25. | D1: right |
| 26. | P2: amazing or anything else like that, and I knew I was coming to see you [D1 nodding] anyway, so I thought, "OK. Well, I'll just (.) drop it." [D1 nodding] I'd got a few 50s left, |
| 27. | D1: yeah, yeah |
| 28. | P2: I don't know if I've done the right thing or the wrong thing [P2 trails off, gestures as if inviting D1's opinion] |

For the sake of context, the analysis begins by exploring the way in which D1 opens the consultation. He begins with positive politeness strategies that promote inclusiveness and the idea that the two share common ground – addressing P2 by his first name (L1, Extract 7) and

grin[ning] (L2). Thus he sets the scene by conveying the idea that he is interested in and willing to cooperate with P2's needs. His response to P2's expression of interest in him *how are you?* (L2) is limited (as it typically is in this data) to phatic communion, as opposed to the sharing of any personal details. The two then deal with the business of consent (for the research). Having moved from phatic greetings to the matter in hand, P2's response to the GP's enquiry *how are things?* (L11) is interpreted as a HAY-type elicitation (Coupland et al 1994), a move to begin the health related discussion necessary for the consultation (L12).

So, the consultation opens with utterances oriented to close relations. However, the power differential between GP and patient becomes more evident as both participants take on their model roles of expert and lay person, beginning with D1's management of the consent needed for filming, followed by a further shift with D1's second enquiry *how are things?* (L11). Whilst on the one hand although this enquiry is framed as an open question – a strategy actively encouraged in healthcare communication as a means of increasing patient participation (Fletcher 1980; Maguire et al 1986; Spencer 2003; Cox 1989 and Wissow et al 1994 both cited in Kurtz et al 2005; Sullivan & Jeremy 2005), on the other hand it places D1 in the dominant position of having determined that this is the point at which they should begin discussing P2's health. Furthermore, as a request token it constitutes a face threatening act, no doubt more so for P2 since he knows that he needs to reveal a breach.

P2 responds to D1's enquiry with the initial evaluation *not bad* (L12), a conventionally indirect response (Brown & Levinson 1987: 132-45). It is the context of the GP surgery that marks it as such. On the one hand P2 legitimates (Parsons 1951; Heath 1992; Pilnick 1998; Heritage 2009) his attendance with his measure of how *bad* things are (as opposed to how good they are) indicating that whilst things could be worse, there are certainly problems, at

the same time his response attends to the convention that phatic exchanges are not intended to elicit detailed responses. In the specific context of P2's consultation this utterance also serves to delay the FTA of going on record, indicative of a tension between P2's need to communicate his actions and the effect that this might have on social relations. These initial utterances seem oriented toward the protection of his own negative face and sense of self.

P2 then goes on to talk about the time elapsed since his last visit *I think it's about three months* (L12). This utterance has properties that attend to both negative and positive face. In the first instance it reinforces the above interpretation by again using indirectness to avoid the FTA. This type of avoidance is seen as an indicator of the degree of threat involved for the speaker in making the revelation (Brown & Levinson 1987: 72, 82). However, its contribution, as a measure of time, to the "history giving" process also acts as another legitimising strategy (Parsons 1951; Heath 1992; Pilnick 1998; Heritage 2009). On the one hand legitimising can be interpreted as a means of adhering to circumscribed, asymmetrical roles, showing deference to D1's position and expertise. On the other, it can be seen as an inclusive strategy whereby P2 cooperates by attending to D1's need for history taking and thus demonstrating his own ability to perform the role proficiently.

P1's first apparent attempt to go on record is then seen at L16, *There is one thing really*, a conventional discourse marker warning the listener that the topic is about to contain unexpected content. This utterance also acts as a device to further delay the revelation of the breach, again protecting P2's own negative face as well as D1's right not to be violated. However, rather than going on to directly perform the FTA, P2 reverts to additional scene setting strategies further avoiding the FTA *you know when...* (L16), strategies which also serve to further legitimise the reason for his attendance.

The interpretation here of P2 being reluctant to commit to revealing his breach is reinforced by his use of hedging (hedgies will also be discussed in greater detail elsewhere (p211)). His dialogue throughout Extract 7 and Extract 10 is littered with hedges e.g. fillers like *Er, yeah*, (L12), repeated false starts e.g. *since I've seen, saw you since, [P2 tuts, shakes head, corrects self] saw you, seen you* (L14-16), minimisers e.g. *I'd pop in* (L16) and uncertainty *about last week* (L20). As one might expect, this also includes the utterance whereby P2 finally performs his FTA *Erm, well, I've gone back to 150* (L18) it being marked with the fillers *Erm, well*. Throughout, P2 modifies the degree to which he is committed to his actions. Doing so mitigates against the suggestion of arrogance regarding their appropriateness and thereby positions himself as deferential to D1 – protecting his own face and the way in which he is perceived by others, as well as D1's territorial claim.

Having performed the FTA (L18), P2 goes on to use reasoning as a means of legitimising his actions. Whilst on the one hand this again attends to the need to fulfil his role as patient, the utterances are also defensive in nature *because I, about last week, I began to feel a bit sort of flushed with it it and, I've, you read those, you know, the leaflet that goes with it, erm, and I, I was getting a little bit of a, sort of a fluttery (.) sort of heart, nothing (.) amazing or anything else like that* (L20, 24-6). This reasoning shifts the blame to external factors, feeling *flushed* (L20) and experiencing *fluttery* sensations in his heart (L24). Shifting culpability in this way functions as a means of dissociating oneself from one's actions, a strategy indicating to the listener that, under the circumstances, the speaker believes that the affront could not have been avoided. This kind of strategy also acts as a means of dissociating oneself from the FTA. Such mechanisms serve to counteract any damage to the listener's (D1's) basic right not to be imposed upon, as well as the listener's claim to expert status. They also act as a means of protecting the speaker's (P2's) own face-wants.

Another, more classic, means of dissociation is seen when P2 further distances himself from responsibility for his behaviour by attributing his actions to the guidance contained in the drug information leaflet accompanying the thyroxine (L22), a strategy which also attends to the need to legitimise his patient role. There are a number of occasions too, where P2 reinforces this shift of responsibility by emphasising the idea that his behaviour was not intended to offend, rather it is in keeping with behavioural norms and based on more universally held views (Brown & Levinson 1987: 122), a notion engendered by his use of the inclusive pronoun *you* which functions not only as a strategy to claim common ground with D1, but also as a means of de-personalising his decisions and thereby dissociating himself from them (L22x2, & Extract 10, 56, 58 on p146). His use of *we* to indicate the authorisation of another, unnamed person, functions similarly - *and we thought* (Extract 10, L64). His strategy of switching to quoting himself also acts as a means of dissociation *so I thought, "OK. Well, I'll just (.) drop it."* (Extract 7, L26). This deictic shift, labelled by Brown & Levinson (1987: 152-3) as a type of point-of-view operation, serves to distance the speaker from his actions, as does P2's use of "past tense hedging" to situate the idea as one belonging to the past *I thought* (Brown & Levinson 1987: 169).

The hesitancy displayed in P2's approach, both in his initial avoidance of performing the FTA and his use of hedging, suggests that he does not presume to have *done the right thing*, and is keen to convey this, a strategy which can also be interpreted as a display of deference toward D1's position as expert, attending to D1's negative face and the territorial claim inherent in his privileged position. The way in which P2 expresses his reasoning following his on record admission (Extract 7, L20, 24-6) whilst on the one hand externalising himself from his actions, can also be interpreted as an indirect means of showing respect for and deference to D1's extensive knowledge; namely his expert ability to identify the relevance of the

information to P2's actions. There is further evidence of such deference to D1 when P2 goes on to say *and I knew I was coming to see you anyway* (L26). This can be seen as indicative of the value invested by P2 in the opportunity to have an expert evaluate his actions today, and thus his respect for D1. This is further intensified with his use of the metapragmatic particle *I knew* (L26) to preface his utterance (Holmes & Stubbe 2003) and his use of the discourse marker *anyway* (L26) to specifically draw attention to the fact that despite his unilateral decision, today's appointment is of great importance to him. *Anyway* also has concessive overtones, conveying the idea that P2 is willing to accept that he may have made the wrong decision. The concluding utterance of P2's on record disclosure *I don't know if I've done the right thing or the wrong thing ... [P2 trails off]* (L28) is a pessimistic admission (Brown & Levinson 1987: 173-8) that his actions may have been inappropriate, necessitating D1's expert evaluation. The hand movement (gesture) accompanying this utterance (L28) conveys the idea of handing the matter over to D1 in P2's closure, again showing deference to his expertise (Brown & Levinson 1987: 227). His use of ellipsis, leaving the utterance hanging in the air also acts as an indirect request for approval *I don't know if I've done the right thing* and a final act of avoidance - avoiding any further risk of violating D1's face, or his own.

The analysis now turns to D1's response. Throughout Extract 7 D1's responses comprised minimal utterances e.g. *mmm* (L13, 15), and *yeah* (L27) and non-verbal responses e.g. *nodding* (L15, 17, 22, 24, 26). Whilst there is no indication of concern or disagreement from these, it is not clear whether or not they were intended as BCs or agreement. Extract 8 lists all of D1's more extended responses regarding the thyroxine.

Extract 8 – Positive politeness to give feedback (D1-P2)

28. P2: I don't know if I've done the right thing or the wrong thing [P2 trails off, gestures as if inviting D1's opinion]
29. D1: [D1 gesturing] No. ²**It sounds like you've done the right thing.**
30. P2: you know, erm.

[D1 & P2 review & discuss recent thyroxine blood levels]

53. D1: So it's just a, I mean it's, it's good that, that you've done that, I think [D1 looks at P2 shaking head] that's the right thing to do [D1 sits back]
54. P2: [P2 glances at D1] Is that OK?
55. D1: [D1 nodding] °yeah°
56. P2: Yeah. I mean I haven't felt any (.) problems in doing so, [D1 shaking head] er, and, you're never quite certain [D1 nodding] because it might just be that I was having a stressful day at work
[P2 continues to express reservations about his decision – see Extract 10]
65. D1: no that's fine

[D1 typing whilst P2 evaluates the benefits of 6 months' thyroxine treatment]

172. P2: I was just, I'm pleased that you've, you're reasonably happy that I, I did take the ***
173. D1: No. I think that's the right decision, definitely. Erm, erm, you know if you're, ⁹**if you're worried about changing things if you wanted to, to ring and leave a message I can ring you back** but those *things*
174. P2: yeah
175. D1: *** *** but I'm sure that what, you did the right thing.

L28-30 occur at the end of P2's 1 minute dialogue regarding the thyroxine (Extract 7). The remaining utterances in Extract 8 occur at other points in the 10 minute consultation where the issue is returned to. One can see that D1's dialogue, in Extract 8, is oriented toward attending to P2's need to be approved of. He seems keen to both reassure P2 that he is quite happy with the decision P2 has made, and to repair any perceived breach. He uses a number of linguistic devices to achieve this. Firstly his responses are not limited to minimal agreement tokens; rather, he uses stronger agreement initiatives (PTO):

It sounds like you've done the right thing (L29)

it's good that, that you've done that, I think that's the right thing to do (L53)

no that's fine (L65)

I think that's the right decision, definitely (L173)

but I'm sure that what, you did the right thing (L175)

He does not limit the expression of his strength of approval to L12-30 (Extract 7) the part of the consultation where this is the main focus of the dialogue; instead he praises D1's actions at various points, throughout the consultation. In addition, the illocutionary force of these utterances is bolstered with the use of:

Repetition e.g. *it's good that, that you've done that, I think that's the right thing to do* (L53)

Metapragmatic particles to narrate his actions i.e. *I think* (L53, 175) signifying that this is not just a supportive response, but that he is actually expressing his own opinion (Holmes & Stubbe 2003).

Intensifiers e.g. *definitely* (L173) and *I'm sure* (L175)

D1 then further attends to P2's needs and wants with the gift of a self-management plan (L173), further boosting his response in a number of ways:

It indicates that it is OK for P2 to make similar decisions in the future.

This is a very personalised gift – permission to consult with D1 over the telephone instead of having to come into the surgery, a practice that was most unusual in 2003 and demonstrates that D1's regard for the patient has not been damaged.

Reinforcing P2's right to make this type of decision by implying that D1 has confidence in P2's ability to do so correctly because he need only ring D1 if he is *worried about changing things*.

In amongst this is also an example of hedging *sounds like* (L29). This is most likely lexical in nature, indicating that a blood test is necessary for unequivocal confirmation, a reminder of D1's clinical remit. Later, after having reassured P2, D1 regains control of the institutional

agenda by explaining the relationship between the blood results, dosages and the way in which oral thyroxine works (see Extract 9). This return to a position of expertise has a reparative function, attending to D1's own territorial needs and his "basic claim to territor[y]" - one of the three key aspects of negative face described by Brown & Levinson (1987: 61).

Extract 9 – Protecting expert position (D1-P2)

[Selected utterances from section of dialogue where D1 & P2 discuss thyroxine levels & dosages]

31. D1: Let's just have a look at the blood test actually,

37. D1: [D1 looking at screen, gesturing ambiguity] I mean 150 is, is fairly standard, 200 is getting to the higher range, 100 would be sort of lowish range of, [D1 glances at P2] of most adults,

43. D1: so, so that's high...

48. P2: [P2 glances at D1] That's the sort of, the demand side of things is it?

53. D1: So it's just a, I mean it's, it's good that, that you've done that, I think that's the right thing to do

The analysis now returns to P2, reflecting on additional aspects of his utterances, but primarily focussing on those made following D1's supportive response. The strategies identified so far indicate that P2 was reluctant to risk offending D1's face by performing the FTA, that he did not want to impinge on D1's right not to be imposed upon by being transgressed or on his claim to expertise. Some of these can also be interpreted as indirect apologies; that is, utterances which convey regret or reluctance for any infringement and act as an attempt to repair any breach (Brown & Levinson 1987: 187-90). These include his previously discussed use of reasoning which suggests that he would not normally dream of infringing on D1 in this manner (L20, 24-6) (Brown & Levinson 1987: 189), his suggestion that his actions may have been inappropriate *I don't know if I've done the right thing or the wrong thing* (L28) and his repeated reference to the uncertainty surrounding his decision and the need to have it verified by D1, seen first in L26 Extract 7 ... *and I knew I was coming to*

see you anyway, so I thought ... and then Is that OK? (L54, Extract 8), you're never quite certain (L56), you don't know (L58), I'm pleased that you've, you're reasonably happy (L172).

Extract 10 – Continued redress (D1-P2)

53. D1: ...that's the right thing to do [D1 sits back]
54. P2: [P2 glances at D1] Is that OK?
55. D1: [D1 nodding] °yeah°
56. P2: Yeah. I mean I haven't felt any (.) problems in doing so, [D1 shaking head] er, and, you're never quite certain [D1 nodding] because it might just be that I was having a stressful day at work
57. D1: yeah
58. P2: you don't know,
59. D1: yeah, yeah
60. P2: erm, but it, it happened [P2 glances at D1] over a period of time,
61. D1: [D1 nodding] right
62. P2: just a few days,
63. D1: yes
64. P2: and we thought, "OK well I'll, I'll just take a little of
65. D1: [D1 shaking head, glances at screen] no that's fine

[D1 & P2 have been discussing the problems diagnosing and managing P2's RA and thyroid problems.]

172. P2: ... I was just, I'm pleased [D1 looks at screen, starts typing] that you've, you're reasonably happy that I, I did take the ***
173. D1: [D1 still typing, shaking head] No. I think that's the right decision, definitely.

One can see in Extract 10 that despite D1's assurances, P2 continues to offer redress for his behaviour. These continued appeals for D1's approval also indicate P2's ongoing deference toward D1. The utterances *Is that OK?* (L54), *you're never quite certain* (L56), ... *it might just be that I was having a stressful day at work...* (L56) – *you don't know* (L58) all tend to make the same point, that P2 knows that, arguably, unlike his GP, he is not qualified to make such judgements and must therefore defer to D1's expertise. This remains evident in P2's final comment on the matter *I'm pleased that you've, you're reasonably happy that I, I did take the **** (L172), an expression of gratitude that still continues to reinforce the importance of D1's expert evaluation and which is still heavily hedged.

Whilst P2's dialogue in Extract 7 and Extract 10 seems primarily oriented towards negative politeness, there are also occasions where he uses positive politeness too, a mix typical in a pragmatic analysis of language. One such example is his use of the inclusive pronoun *you* to replace the universalising pronoun *one*. This type of inclusive strategy is oriented towards indicating that both interactants share an understanding of the situation, examples of which include *you read those* (L22, Extract 7), *you're never quite certain* (L56, above) *you don't know* (L58).

Other examples of his use of inclusive strategies include his use of the metapragmatic particle *I knew* (L26, Extract 7), as opposed to *and because I was coming...* the former being associated with more relaxed, inclusive, interactions (Holmes 1995: 100). His previously mentioned use of direct quoting *so I thought, "OK. Well, I'll just (.) drop it."* (L26) also acts as a means of capturing the listener's attention, drawing them in to what is being said (Brown & Levinson 1987: 106-7). Returning also to his use of ellipsis to close his initial revelation (L28), although already identified above as a potential avoidance strategy, ending an utterance in this open ended way can also be interpreted as inviting camaraderie by suggesting that the two share sufficient understanding for further explanation to be unnecessary (Brown & Levinson 1987: 111-12, 227). His final comment on the matter *I'm pleased that you've, you're reasonably happy that I, I did take the **** (L172, Extract 10) P2, amongst other things, tentatively draws attention to the fact that the two now have a claim to common ground. The remark also attends to D1's need for appreciation.

There is also evidence of P2 attempting to portray himself as a cooperative patient who would not normally infringe on D1's recommendations in this way. Though much downplayed, this strategy acts as a means of protecting his own positive face and need for approval. Presenting

oneself in this way increases the chance of obtaining cooperation from the listener (Brown & Levinson 1987: 58). The examples given here again overlap with other strategies, once more demonstrating how positive and negative strategies can co-exist. They include P2's minimisation of the symptoms *not bad* (L12, Extract 7), *a bit sort of flushed* (L20), *sort of a fluttery* (L24), *nothing amazing* (L24-6); utterances which also serve as a means of explaining why he did not seek more urgent healthcare advice – setting himself as a responsible individual mindful of the need to use NHS resources wisely. His reasoning (L20, 24-6) also indicates a perception of self as someone capable of assimilating new information and deduction, making informed, reasoned decisions as opposed to ill-founded ones, someone acting in cooperation with his healthcare providers. Finally, his attempts to obtain D1's approval (L54, 56, 58, Extract 10) and his admission that there could have been other causes of his symptoms (L56) are also indicative of a desire to be seen as cooperative.

Throughout his dialogue P2 used a mix of negative and positive politeness strategies, demonstrating on the one hand a desire to dissociate himself from actions that might have damaged his relationship with D1, whilst on the other wanting to draw D1 in to approve of him and share his point of view. His predominant orientation, however, seemed to be toward negative face. His use of negative politeness to express a dispreferred idea demonstrated deference and a desire not to impose. Despite D1's assurances that he had actually taken the right course of action P2 continued to perform redressive action (Extract 10). This apprehension again highlights the power differential between such interactants leading to the theme: *Patients' negative politeness: expressing dispreferred ideas*.

The case began with D1 providing *Space* for P2 to present his reasons for attending, space that was used by P2 to reveal his potential breach. The apparent anxiety demonstrated by P2

in Extract 7 and Extract 10 indicates a discomfort with using - no doubt from his perspective having to use - the space for this purpose. However, with our knowledge of the way in which such consultations tend to be organised, one can see that this was an opportune point at which to make such a revelation; certainly there were no examples in the data indicating less threatening ways of creating opportunities for such disclosures.

This suggests that the notion of patients making their own healthcare decisions outside of the consulting room, even in today's culture of shared decision-making, is not perceived by patients as a usual part of general practice. If such actions are not seen as a normal part of healthcare culture, then the level of threat experienced by patients performing them will be significantly increased. The higher the level of threat posed by a speech act, the higher the super-strategy that will be utilised by the speaker (see Box 9 – “Super-strategies” on p68) (Brown & Levinson 1987; Spiers 1998; Holmes & Stubbe 2003). The dependence on negative strategies as opposed to positive ones seen in the case of P2 is indicative of a discomfort and reluctance to share the decision about his own health with D1. The greater the level of threat perceived by individuals, the more likely they are to avoid making such revelations. This in turn has implications for the relationship between doctor and patient and the quality of patient care.

In other words, to make the decision P2 has done and then to make the further move of acknowledging it to the doctor involves the patient in some delicate politeness work. It is well-known that patients often do not take medication as they are advised to do, and that this fact tends to go unseen (Aronsson & Sätterlund-Larsson 1987; Beisecker & Beisecker 1990; Williams 1994; Haynes et al 1996; Marinker 1997; Platt et al 2001; Marinker & Shaw 2003; Marshall et al 2006). P2 offers one perspective on this phenomenon. The cost is high; how

much simpler, many patients might think, just to keep quiet and offer the doctor face-saving agreement.

Another good example of the use of negative facework in this way can be seen in the case of P19 and D4 (Extract 11, below). The analysis is brief and intended simply to highlight just some of the similarities with the case of P2. It would seem that P19 has tonsillitis and is returning, as agreed, for a follow up visit. It emerges that she has an additional, albeit related matter to discuss *and I wanted to show you something ...* (L23). She is now concerned that her symptoms are related to drinking in pubs *those two places* (L25) where outbreaks of *ecoli* (L23) have just been reported in the press *there was an article* (L23). Like P2's situation, this too risks being viewed as a challenge to cooperative norms since it could be interpreted an indication of doubt in D4's expertise. It might be seen as: suggesting that D4 may have missed something, or telling D4 what she as a clinician should be doing i.e. testing for *ecoli*, or implying that she has greater knowledge on the subject than D4. The utterance therefore heralds a higher than usual level of face threat.

Extract 11 – Patients' negative facework: Patients' ideas (D4-P19)

1. P19: Hello there,
2. D4: Hello [D4 said in raised, familiar tone, immediately turns towards screen]
3. P19: That's to give to you [P19 hands research paperwork to D4]
4. D4: Yes. Is that alright with you?
5. P19: That's fine [P19 sits down] yes.
6. D4: OK, great. [P19 places bag on floor] OK [D4 stops writing and turns to screen]
7. P19: yeah
8. D4: Lovely. How you doing?
9. P19: [P19 shaking head] Loads better, than
10. D4: good
11. P19: earlier in the week, [P19 pointing at neck] it's still quite sore (.)
12. D4: yes [D4 nodding]
13. P19: er, the swelling's gone down considerably (.)
14. D4: right [D4 nods]
15. P19: erm, [P19 nodding] obviously the antibiotics are working, [D4 nodding] I mean you can tell that.
16. D4: mmm [D4 nodding]
17. P19: [P19 gesturing] the swelling's going down noticeably everyday
18. D4: yeah, good [D4 nods]
19. P19: but, er without painkillers it's still quite tender
20. D4: is it? [D4 nods hesitantly]
21. P19: [P19 nodding] mmm
22. D4: OK [D5 drawn out, thoughtfully]
23. P19: erm, [P19 reaches into bag on floor] and I wanted to show you something that may or may not [P19 shaking head] be linked, erm, it's just that on Saturday [P19 opens out newspaper article] I was reading in the Mail on Saturday and there was an article that I was, that caught my eye. [P19 holds article out so that D4 can see it] Which was called that, [P19 places article on desk where both look at it] and it seemed to deal with ecoli and
24. D4: right
25. P19: I mean, I promise I won't take up much of your time telling you all this, it's just that those two [D4 leans on elbow on top of newspaper] (1) places
26. D4: mmm
27. P19: (.) out of a *national* survey mentioned by name, both of which I was in on Friday night,
28. D4: oh, right
29. P19: both of which I had a drink with ice in, and I don't know [P19 laughs, D4 smiles], I mean, could it be linked [P19 still laughing and nodding]?
30. D4: Well, [D4 laughs, throws head back laughing more loudly, leans back in chair]

We see delaying tactics similar to those used by P2 – it is not until L23 that P19 begins her

disclosure, somewhat indirectly at first *may or may not be linked* (L23) without at this stage giving any indication as to what it is that might be linked. The dialogue includes apologies indirect: *it was just* (L23) - an attempt to minimise her intrusion, and more direct: *I promise I won't take up much of your time ...* (L25). Deference is also displayed as she indicates her lack of expertise in this area *may or may not be* (L23) and *I don't know ... could it be linked?* What is also interesting to note here is that there is evidence of a fairly relaxed, informal relationship between D4 and P19 as suggested in the first instance by their shared laughter here (L29-30), a theme which will be returned to later on (on pp185 & 203).

Returning to D1's responses, we have seen here the theme *GPs' positive politeness: expressing agreement* as a means of providing *Endorsement*. D1's use of the gifts of praise and reassurance attended to P2's positive face-needs, managing P2's perceived breach. At no point did he indicate any disagreement with P2's decision, or suggest that P2 should have taken another course of action, rather he set up a plan to enable P2 to make similar decisions in the future. It appears then that D1 was wholly supportive of P2 and that P2's decision did not in actual fact contravene best practice. D1 used positive politeness to give feedback. Other examples of this include the cases of P62 and P65 below.

Extract 12 – Positive politeness & feedback: Declining medication (D2-P62)

- | |
|---|
| 11. D2: How are you feeling? |
| 12. P62: Erm (1) I hope you don't mind but [D2 looks at P62] ¹I decided that [P62 glances at D2, shaking head, holding up pharmacy bag of medications] I didn't <u>want to take</u> |
| 13. D2: [D2 nodding] <u>Not to take the tablets.</u> ²That's fair enough. |

In Extract 12 (above) is another example of a patients' dispreferred decision, P62 has decided not to take the medication prescribed for him at his last visit *I didn't want to take* (L12).

However, before he has chance to finish his utterance D2 anticipates what he is trying to say *Not to take the tablets* (L13), aligning with P62. She continues with *That's fair enough*, an utterance which is more demonstrative than a minimal agreement token, showing unmitigated support for P62's decision. Another very different example is seen in Extract 13 (below), one which is perhaps more familiar, the type of response we see more commonly on a day to day basis. P65 is telling D4 that he is *Getting plenty of exercise, doing the right diet!* (L349). D4's response is brief but again demonstrative, *Good!* with added emphasis.

Extract 13 – Positive politeness & feedback: Healthy lifestyles (D4-P65)

<p>349. P65: I got this horrible *thought*, [P65 looks away, gesturing expansively] I'm 60 next year, and, [D4 looks at prescription in her hand] "Oh god, you always saying when you're this age, and oh." [D4 looks at P65 grinning] <i>Getting plenty of exercise, doing the right diet!</i> [P65 looks at D4]</p> <p>350. D4: [D4 nods] <i>Good!</i> Good, we'll get, just get you [D4 hands prescription and blood samples to P65] <u>stopping smoking and we'll be there.</u></p>

The importance of these GPs' responses in the analysis here, and in particular that of D1, will be seen when their force is compared to that of D1's response to P6 next. Also worthy of note is the fact that there is evidence in P2's example of the expert agenda continuing to dominate.

The Case of P6: Patients' lack of facework to express dispreferred ideas & GPs' off record disagreement

This next case, the case of P6, also concerns a patient's dispreferred decision made prior to the consultation. As the analysis will reveal, the *Space* in which P6 discloses her decision and the attention to facework therein is managed very differently to the preceding case. Finding a way of characterising her facework proved quite challenging. As the reader will see, there is little evidence of any reparative facework in her dialogue making it at times appear quite forceful, even confrontational, and yet, it cannot really be described, in the strictest sense, as

bald, on record either. The more neutral description “lack of facework” was therefore settled upon, leading to the theme: *Patients’ lack of facework: expressing dispreferred ideas*.

Once again the case analysis also explores the GP’s response and way in which P6’s decision is *Endorsed*. An important aspect of this part of the analysis is a comparison between the experiences of P6 and P2, particularly since both were seen by the same GP - D1. The analysis of the GP’s response here depicts the theme: *GPs’ off record disagreement*. This label is not intended to imply a value judgement of the GP’s behaviour (D1), but rather, as the following interpretation will endeavour to demonstrate, functions as a means of portraying the interaction observed when analysed from a facework perspective. As with the preceding themes, the term “off record” has been taken from Brown & Levinson’s (1987) theory of politeness. The term “(dis)approval” would have been well placed as one relating again to their facework terms (showing *approval* as a means of attending to face); however, disapproval has evaluative undertones. Furthermore, in the other case studies it is *agreement* that is discussed. In this case we do not see any evidence of D1 agreeing with P6’s decision, hence the decision to choose “disagreement” as a label.

P6 is a 40 year old woman of “mixed” ethnic origin. Her appointment was arranged to evaluate a skin condition exacerbated by work related stress for which she needs a new sick note. In addition, she has that morning received a reminder for her 3 yearly, routine cervical smear which she does not want to have.

It is policy that all women between certain ages should be offered screening for cervical cancer and GP practices receive remuneration for those screened (see p11). Those who do not take up screening receive regular reminders, and when attending the GP’s for other health matters the practice’s electronic records will continue to alert the practitioner that the test needs arranging. A letter from the patient declining the procedure stops the reminders and ensures practices are not penalised.

Extract 14 – Declining best practice (D1-P6)

81. D1: [D1 hands over sick note] That should cover you for all the time you need, OK?
82. P6: Thank you. [P6 speaks without pausing or looking up, fiddles with sick note] I've also had a smear request, and ⁵**I really don't want it.**
83. D1: (2) You've been asked *to go for pap*? [P6 looks at D1]
84. P6: °*Yeah. ⁵**I [P6 shakes head] don't want it.***°
85. D1: Right, [D1 nods slowly, then shakes head enquiringly] erm, do you want to tell me more about that?

Analysis begins with P6's first reference to the matter of the *smear request* (L82, Extract 14).

At no point in the preceding discussion about her skin condition and fitness to work has she indicated that she has additional matters to discuss. This new problem is then suddenly presented once she has obtained her sick note (L81). The topic change is marked *I've also had* (L82), and immediately followed by an on record declaration of her position on the matter, *I really don't want it* (L82). Since the topic marker *I've also had* is the only means of mitigation used, it seems like a somewhat sudden and abrupt utterance. We do not see the hesitation or indirectness observed in the previous case nor is there any attempt at reparative action. The only additional signals to note are paralinguistic ones – her avoidance of eye contact with D1 and fiddling with her sick note (L82). This behaviour is also observed on a couple of other occasions (L86 Extract 15 & L116).

P6 does not offer any mechanisms for D1 to express an alternative opinion, instead emphasising the strength of her resolve with the use of the intensifier *really*, to which she adds additional stress. She seems unconcerned about attending to D1's face-needs. She does however seem concerned about how D1 will react to her decision. This is indicated, for example, by the fact that had she been expecting D1 to offer his approval then we might more likely have seen P6 frame the request in a way that assumed it to be one which was common-

place and unremarkable e.g. *Oh, and by the way, I've decided that I don't want to have my smear, but I'm not sure how to go about formalising it.*

Turning then to D1's response. This is a particularly challenging situation for D1 as he has to manage conflicting priorities between providing best care for P6 (the chance to prevent cancer), policy recommendations and the patient's right to decline recommended treatment. D1's initial response seems quite sensitive *tell me more* (L85), an open question that gives her the opportunity to express her ideas, concerns and expectations. However, this initial response is at the same time devoid of any of the tokens of support offered to P2.

Extract 15 – Reasons for declining smear (D1-P6)

86. P6: Yeah, I don't need one. I'm, I'm really out of all the high risk groups. The last ten years I've slept with three men they've all been circumcised. I don't, I don't, have erm any of that semen. I don't do it, I don't eat any red meat, I don't take the pill, and I don't drink a lot of alcohol and I'm very, very health conscious. I just, I, I'm not interested. From what *I've* read, alternatives on smears, they're as likely to trigger something, I don't like the chemical that's used on the end, I don't like the attitude of the nurses. And they're always very rough and I always feel damaged for about [P6 fiddles with sick note] three or four days after, as do, [P6 shakes head and leans forward] as do every, every other woman

87. D1: [appears to be trying to speak]

88. P6: continues to talk about discomfort.

89. D1: [D1 looks down, gesturing] The, the,

90. P6: my periods are *clockwork*.

91. D1: [D1 does not sound confrontational] There's, there's no chemical on the end of those smear things.

[Succeeding dialogue will be considered in Extract 17]

The consultation lasts 10 ½ minutes, the last 5 ½ minutes being largely dedicated to the matter of the smear. In this part of the consultation P6 speaks determinedly throughout, unlike P2. On the whole she is on record, making her points directly with little, if any, attention to face. Atypically she holds the floor, and, repeatedly flouts cooperative norms by not appearing to acknowledge D1's attempts to speak (e.g. L87 in Extract 15). She seems to want to forestall

any attempt at negotiation and to be unconcerned with facework. From this perspective her orientation appears to be largely focused on the maintenance of her own face-needs.

Box 16 – P6's reasons for not needing a cervical smear

- 1) Not in high risk group (L86, 94, 132)
- 2) Not promiscuous (L86)
- 3) Partners circumcised (L86)
- 4) Practised withdrawal as a means of contraception (L86, 102, 126)
- 5) Doesn't eat red meat (L86, 122)
- 6) Does not use hormonal contraception (L86, 122)
- 7) Has a low alcohol intake (L86)
- 8) Has a healthy diet (L86, 120)
- 9) Cervical smears can trigger cervical cancer (L86, 94)
- 10) Concerned about the chemical on the spatula (L86)
- 11) Dislikes nurses' attitude (L86)
- 12) Nurses are rough (L86, 88, 94)
- 13) Feels uncomfortable for some time afterwards (L86, 94)
- 14) Points 12-13 shared by other women (L86, 88)
- 15) Regular periods (L90)
- 16) Breastfed for years (L96)
- 17) No previous abnormal smears (L100, 114)
- 18) Unlikely to develop abnormal smear at this age (L102, 114)
- 19) Only 5 occasions where her partners haven't withdrawn (L104)
- 20) If you're going to get it, you'll do so regardless (L112, 128)
- 21) No pelvic discomfort (L110)
- 22) Germaine Greer has written extensively on the topic (L116)
- 23) Doesn't use latex contraceptives (L126)
- 24) No family history of cancer (L128)

See cervical screening texts for more information on cause and prevention of cervical cancer (e.g. Vainio et al 2005).

During the course of the ensuing dialogue, P6 produces a total of 24 reasons (see Box 16, above) as grounds for the appropriateness of her decision. She begins recounting them at L86 (Extract 15, above), immediately after expressing her unwavering position and again does not offer D1 any space in which to voice his own thoughts. The citing of and extensiveness of this list suggests that she wants D1 to understand and approve of her decision. Her strategy of being prepared with and listing such evidence, some supported with references e.g. *From what I've read* (L86), bears similarities to the medical practice of presenting evidence. It

could be interpreted as indicative of a desire to cooperate with the clinical process of decision-making, and to draw D1 onto common ground with a shared approach to reasoning. Trying to demonstrate such skills may also function as a means of acknowledging and respecting the way in which experts approach consultations, and as an attempt to reduce the social distance between the two of them.

Extract 16 – D1’s minimal utterances (D1-P6)

- | | |
|------|---|
| 98. | P6: I've, I've had so many in, in years gone by, |
| 99. | D1: yeah |
| 100. | P6: I've never had it, there's never been anything, come up [P6 shakes head] on them, |
| 101. | D1: right [D1 nods slowly] |

During this part of the consultation D1 speaks far less than P6, demonstrating P6’s atypical control of the floor. There are a couple of occasions where he looks as though he is trying to speak (e.g. L87, p156) and on others he tries to interrupt but has to wait for P6 to finish e.g. *The, the* (L89 – other examples include L103, 113, 125, 129) and then there are examples of minimal utterances that one might expect to see (e.g. L99, 101, Extract 16 above). All of his extended responses are contained in the extracts here (about 10 in total). These responses from D1 rely heavily on an institutional agenda. This is seen initially in Extract 17 and will be demonstrated again in Extract 18. In the first example (L91-93) D1’s focus is on correcting P6’s scientific understanding of the procedure *there’s no chemical* (L91) – *the chemical that’s used on the end* was one of her concerns (L86, p156). His adherence to a scientific point of view in this way, allows a deictic shift away from the dilemma he faces between supporting P6 in whatever choice she makes versus his professional duty to practice EBM.

Extract 17 – The chemicals used (D1-P6)

[P6 gives reasons 1-14 for not wanting her smear – see p156 for dialogue]

87. D1: [D1 appears to be trying to speak]
[P6 continues to talk about discomfort – reasons 12-14]

89. D1: [D1 looks down, gesturing] The, the,
90. P6: my periods are *clockwork*.

91. D1: [D1 does not sound confrontational] There's, there's no chemical on the end of those smear things.

92. P6: Isn't there?

93. D1: °No.° It's just a wooden spatula

94. P6: [P6 looks ahead] I don't like it. ... [P6 reiterates discomfort, reiterating reasons 9 & 1, and adding 16]

Another similar example can be seen in the way in which D1 picks up on P6's reference to risk *I'm, I'm really out of all the high risk groups* (L86, p156), *I'm really out of all the high risk groups, out, out of all the high, I know ... what the high risk groups are* (L94-6, Extract 18 below), *I'm out of the high risk groups* (L132) which she brings up on 3 different occasions. D1 responds similarly (L97, 105 & 127, below), although as can be seen from these line numbers these are not necessarily immediate responses. In his responses D1 does acknowledge her low risk status *there are high risk groups you're right* (L97), *I, I accept that you're in a, a low risk group, that puts you in a better situation* (L105-7), *certainly you, would be in a, low risk group ... I agree* (L127), but his explicit praise for this achievement is limited to *that's good* (L105). Overall his responses serve to reinforce his adherence to an institutional agenda by pointing out that even those in *low risk groups still develop problems* (L97, 105-107).

Extract 18 – Risk (D1-P6)

[P6 reiterates discomfort & reason 9]

94. ... I'm [P6 shakes head] really out of all the high risk groups, [P6 gestures away dramatically] out, out of all the high, I know

95. D1: [D1 moves head as if trying to speak]

96. P6: what the high risk groups are. **I've* breast fed for years*

97. D1: [D1 tilts head patiently and gestures] *well, there are*, there are high risk [P6 puffs cheeks and taps hand on desk as if impatient] groups you're right. On the other hand, [D1 raises eyebrows emphatically] people in low risk groups still develop problems, sometimes, OK?

[P6 gives reasons 17 & 18, and reiterates 4 & 2, D1 responds with minimal utterances and attempts to speak]

105. D1: But that's not, necessarily going to mean that you could never develop a problem. I, I accept that you're in a, a low risk group and that's fine, that's [D1 raises eyebrows emphatically] *good*,

106. P6: mmm

107. D1: [D1 looks down] that puts you in a better situation [D1 glances at P6] than a lot of people, I agree. ⁶**Erm, having said that, we would still recommend you,** [D1 looks at P6] **that you have it done.** You don't have to have it done, [D1 glances at screen] you know that often, it's every three years.

108. P6: Well if I see anything, or feel anything, I'll [P6 nods] *surely* let you know. But honestly I don't

109. D1: but that's *sort of too* [D1 gesturing] *late, isn't it?* [D1 nods]

110. P6: **I've got no discomfort**

111. D1: you know, in a, [D1 raising eyebrows and stretching out hands as if inviting agreement] in a way.

112. P6: [P6 sighs deeply] Well in, in *my* opinion that, on that front, if it's too la<te>, people who are prone to it, are prone to it, and that's gonna show up years ago. [P6 slides finger along desk demonstrating the passage of time]

[D1 tries to interrupt, P6 talks about reason 17]

115. D1: [D1 gesturing] that's not [P6 looks at D1] necessarily the case, because er, you know things can change with the cervix

[P6 talks about reason 22, D1 responds with a minimal utterance]

118. P6: [see Extract 22] ... I think I'll intuitively know **when it's affecting me**

119. D1: [D1 looks enquiring, gesturing] *erm, how do you feel* that, that you would be best, sort of protecting yourself against the things that, that we screen for, for instance, then?

[P6 repeats reasons 2-8 adding 23, D1 responds with minimal utterances]

127. D1: certainly you, would be in a, low risk group. I agree with you, OK? On the other hand that, that's not an absolute guarantee, [D1 raises eyebrows as if seeking understanding] OK?

128: P6: No. [P6 shakes head] I understand that. Of course it's not, you know, it, we all know if you're gonna, if you're gonna get it [P6 sits up, looks down and shrugs] (3) if, if you're that, we, [P6 looks at D1 shaking head] we don't have cancer in my family [talks about family's health]

131: D1: *then again not e<very>, not* [D1 gesturing with quizzical tone and expression] every cancer re<lates>, relates to family history, does it?

Turning to P6's utterances in this extract (Extract 18, above), her acknowledgement *Well if I see anything, or feel anything, I'll surely let you know* (L108) is one of the few stretches of talk that could be interpreted as attending to face. If taken literally, it could be understood as an assurance to D1 that she would *surely let [him] know* if she had any symptoms of cervical cancer, suggesting continued respect for him and the healthcare provided by the NHS. Her decision to discuss the matter with D1, rather than just ignore the invitation to book her smear, and her subsequent agreement to sign the necessary paperwork (Extract 20 which will be discussed later) could also be said to support this. As acknowledgements of the way in which one obtains healthcare these actions could also be interpreted as a means of drawing attention to her own face-needs for approval and recognition as a cooperative person who does respect others and recognises their territorial claims and need for approval.

Returning to D1's institutional agenda, there were a number of occasions when D1 could have attended to P6's need for approval by *Endorsing* her detailed acquisition of information in this area and lifestyle choices. However, he did not do so. For example, he could have shown approval for P6's understanding of the reduction in risk associated with circumcision (L86, p156) and avoiding red meat (item no. 5 in Box 16). Circumcision has been shown to reduce the incidence of the types of human papilloma virus most associated with cervical cancer (e.g. Wawer et al 2011) and avoiding red meat has also been indicated as a means of reducing the risk of cancer (e.g. Pan et al 2012). Other revelations about her lifestyle that passed un-noted included her limited sexual activity *The last ten years I've slept with three men* (L86) and alcohol intake *I don't drink a lot of alcohol* (L86), her decision to breast feed **I've* breast fed for years* (L96, p160) and the inclusion of fresh fruit and vegetables in her diet *I'm very, very health conscious* (L86) *I, I eat rigorously I mean really, you know fruit and veg* (L120). Public health campaigns warn against promiscuity and excessive alcohol consumption,

advocating breast feeding and recommending instead healthy lifestyles and diets which include fresh fruit and vegetables. Acknowledging these as beliefs shared by medicine could have acted as a point of common ground in their opinions.

Finally on this point, there were a number of occasions where P6 mentioned how unpleasant and distressing she found the procedure *I don't like the attitude of the nurses. And they're always very rough and I always feel damaged for about three or four days after ...* (L86, p156), *I don't like it* (L94, p159 & p160), *I really don't want, I can't stand it* (L132, Extract 19 below). Again, D1 does not acknowledge this or offer her any of the reassurances seen in the first case between himself and P2.

Extract 19 – Absence of reassurance (D1-P6)

132. P6: ...I really don't want, I can't stand it. You sent me a letter a couple of years ago, and I ignored. But I know that they're gonna keep flooding through me {my} door again. But [P6 shrugs] then you can't stop that `cos you're, r<esponsible>, responsible.

133. D1: Yes, [D1 leans back, gesturing] yeah I mean

134. P6: [P6 briefly frowns, looks fed up] why don't they check men for prostate?

135. D1: Sorry? [D1 twists head as if trying to hear better]

[P6 talks about the anomaly that men are not expected to be screened for prostate cancer]

Extract 20 – Declining in writing (D1-P6)

[P6 is talking about the anomaly that men are not expected to be screened for prostate cancer]

138. P6: [P6 glances at D1] Why don't you send letters out to them? *** *** *** [P6 looks at screen] I know, I, I will, I got one this morning, and for<tunately>, [P6 looks at D1, tone light hearted] fortunately, it came. 'Cos I set me {my} alarm, on me {my} phone, [P6 rocks forward] I couldn't work out why I was [D1 smiles] waking up at 9 o' clock this morning

139. D1: aha, right [D1 laughs]

140. P6: [P6 laughing] and then I remembered I had to come and see you, so that was quite fortunate, and when the letter [D1 rests back] came through. But erm, I [P6 glances at D1] *really* don't want to come in.

141. D1: ⁷**Can you, can you drop us a note to, to tell us that?**

142. P6: Confirm that?

143. D1: Is that [D1 raises eyebrows enquiringly] OK?

144. P6: I'll do that at the desk now.

145. D1: Yeah, fine.

146. P6: That's that then. So all's well.

147. D1: OK. Well, I hope things settle down OK. Erm,

148. P6: *well I hope I find a nice new job*

[D1 talks about research paperwork]

152. P6: Alright then. [P6 starts to leave]

153. D1: OK, come back and see me if you're worried, OK.

154. P6: OK, thank you, thank you for that, see you

155. D1: °bye°

156. P6: have a good day.

[End of consultation]

As the consultation draws to a close there is a brief moment of humour (L138-40, Extract 20), after which D1 decides not to pursue the matter any further. This is manifest at L141 *can you drop us a note to, to tell us that?* Here he once again distances himself from the professional dilemma that this creates by adhering to an institutional agenda.

Extract 21 – Fear of cancer (D1-P6)

[P6 talking earlier about her skin condition]

36. P6: [P6 speaks in quite a flat tone] That was very frightening, few weeks ago, I was really frightened.
37. D1: °Right,° [D1 conveys surprise in tone and expression] frightened of?
38. P6: It turning into some kind of cancer, 'cos it's so thick.
39. D1: [D1 nods slowly] Right, OK. So [D1 looks concerned] is that *always* a worry for you?
40. P6: [P6 stares at D1, tone and manner seem to express surprise] (4) When it's bad, yeah.

Moving briefly back to the first part of the consultation, P6 had earlier expressed how *frighten[ed]* she was by the idea of her skin condition developing into *some kind of cancer* (L38, Extract 21). In the subsequent dialogue about cervical smears, D1 does not draw parallels between her fear of skin cancer and the possibility of protecting her from cervical cancer. Drawing such parallels could have been a means of attending to her positive face-needs for understanding and empathy in relation to these fears. It would also have acted as a means of working within her own framework of belief, indicating a willingness to adopt a common perspective, conveying common ground and attending to her need for cooperation. Such an approach could also have attended to her basic negative face-needs to avoid compromising personal values – her preservation of self and territorial claims.

Reflecting on this consultation, there is no direct evidence of any ill feeling between the interactants in Extract 20 and in principle D1 has not done anything wrong here. He has allowed P6 to make her choice, he has not threatened to remove her from the practice register, nor has he chastised her, instead, he wishes her well *I hope things settle down OK* (L147) and makes it clear that she is still welcome to consult with him at any time *OK, come back and see me if you're worried* (L153). However, the issue of the cervical smear has now become

something that is avoided, after L143 Extract 20, D1 makes no further reference to it. Her well wishes (L147, 153) relate to her skin condition and career change (a decision made to reduce the stress exacerbating her skin condition, discussed earlier in the consultation and mentioned here at L148). From P6's point of view, there were, some occasions where she did in fact seem to be frustrated and dissatisfied, indicated by her seemingly defiant expression (L118, Extract 22) and weary sounding tone that seems keen to convince (L120). Based on this and the preceding analysis it seems likely that she expected to leave feeling dissatisfied. This was indeed the case, on leaving the consultation she told one of the original researchers how angry she was with the way in which she had been treated, and how glad she was that the consultation was being used for research purposes.

Extract 22 – Expressing frustration (D1-P6)

118. P6: And I, I, I really don't believe in it (.) for me. [P6 gestures indicating self and leans away from D1, look is almost defiant] ...

120. P6: [P6 shaking head, tone as if weary and keen to convince D1] [D1 nodding] Well I, I eat rigorously I mean *really*, you know fruit and veg, ...

Unlike P2, P6's approach to revealing her medically contentious decision was very direct, with its presentation as an "argument" (the term being used here to draw attention to P6's evident desire to present herself as a rational person, making a rational judgment). This, combined with the scant mitigation and lack of attention to D1's face-needs give the impression that right from the outset P6 seems to have anticipated that D1 would encourage her to change her viewpoint. This is particularly indicated by the limited mitigation used when choosing the *Space* in which to make her topic shift, the possible indications of nervousness (fiddling with the prescription) and the careful formulation of her argument in advance. Her approach seemed focussed on emphasising her own position and, from the

point of view of facework, protecting her own face-needs – her right to autonomy, not to be imposed upon, to be understood, approved of and respected, and to have others share her wants, i.e. she wanted to have her own wishes respected. From this analysis then we see the second theme within the category of Space: *Patients' lack of facework: expressing dispreferred ideas*.

Turning once more to D1 we have seen that he did not perform the face threatening act of disagreeing with P6. Actually, he does not tell her whether he agrees with her, or not. His decision to invite her to talk more about her feelings on the matter *tell me more* (L85, p155, Extract 14) avoided a scenario that might merely lead to a confrontational polarisation of viewpoints, one which could have brought the dialogue to an abrupt halt. By keeping the dialogue open he created the space and opportunity to better inform P6. Such an approach also attends to P6's negative face-needs for freedom of action, as well as protecting himself from the imposition of further confrontation. And yet, the absence of the kind of endorsement seen in the case of P2, alongside his repeated attempts to try and persuade her to have the procedure strongly suggests that he disagrees with her decision and this is the surmise taken here. Furthermore, his strategy of not explicitly specifying his position has a number of effects which will be demonstrated shortly.

In view of policy guidance regarding smears, one would not have expected D1 to express approval of P6's decision. He therefore faced a dilemma between his duty to support her right to make whatever choices she wanted to (GMC 2006) and his remit to practice EBM. Charles et al (1997) advocate that even where interactants' views differ practitioners can and should still endorse dispreferred decisions. Working within the same positive politeness framework seen in the case of P2, D1 could, for example, have used positive politeness to demonstrate a

desire for solidarity by involving her in a dialogue about his own dilemma. Allowing her to enter his world would have enabled the two of them to converse on common ground, reducing social distance, and asking her to participate in the dilemma itself could have indicated a desire for cooperation and collaboration. Such a move would have opened the matter up for wider discussion instead of concentrating it on a small selection of her remarks. Ultimately, her decision could have been endorsed by expressing an understanding for the fact that P6's personal feelings and beliefs outweighed the scientific evidence.

Maintaining an orientation toward positive face would have provided a means of attending to P6's need to be listened to and respected through the expression of understanding and empathy, conveying the desire to share common ground, cooperate and reduce social distance. As with P2, P6's decision breached the norms of the doctor-patient relationship with the attendant risk of damage to said relationship, and the move therefore attracted a higher than normal level of face threat. D1's indirect approach, one where he did not specify his position explicitly, would have made it difficult for P6 to address his disagreement directly, further adding to the face threat experienced whilst trying to express herself. It is striking that, unlike the case of P2, D1 did not make any reparative moves or offers of support, or even praise where such comments might have been reasonable. D1 did not make any directly aggressive or hostile remarks to P6; however, P6's evaluation of her experience to the researcher indicates that she was unhappy with the response that she received, resulting in an unsatisfactory experience.

Together, the absence of explicit approval or endorsement and any reparative work or praise has been interpreted as disagreement. It is because any such disagreement was implicit rather than explicit that this response has been labelled as *GPs' off record disagreement*. The

example of P6 and D1 was the most striking and demonstrative within this theme. Other less remarkable examples can be seen in the extracts below.

Extract 23 – Off record disagreement: Climate & Asthma (D2-P58)

- | | |
|-----|---|
| 38. | P58: I think it could be due to, obviously the climate and *everything and* the weather as well that, <u>that</u> |
| 39. | D2: <u>mmm</u> |
| 40. | P58: [D2 nodding] hasn't helped either. [P58 laughs] It gets you out of breath a lot, quicker than what you normally would (.) erm, <5427066> |
| 41. | D2: How often are you using your blue inhaler? |

In Extract 23 (above) P58 suggests that her asthma exacerbation *could be due to ... the climate* (L38). Again, D2 does not disagree, but she only offers minimal responses *mmm* (L39) and nodding (L40), changing the subject to her asthma treatment without mitigation *How often ...* (L41). In Extract 24 (below) P46, who has chronic back pain, wonders if it has been caused by the *epidural* (L88) she had in childbirth (L86). Although we do not know how old P46 or her daughter are, the impression is that the epidural was not recent. D5 has already undertaken a number of tests and P46 has attended on a number of occasions regarding this and it would seem that this is the first time she has suggested that this is the underlying cause. Since D5 does not explicitly say “yes”, or indicate in any other way that this may well be the case, the suggestion is that he does not agree with her. However, once again, he does not explicitly disagree.

Extract 24 – Off record disagreement: Epidurals & back pain (D5-P46)

86. P46: But it's nothing I'm, I think [P46 nods] is it, [P46 looks ahead] and I'm not sure, [P46 nods] I have a feeling that because, [P46 looks at D5] [D5 nodding] when I had my daughter
87. D5: yeah
88. P46: and the epidural, [D5 nodding] they gave me *that* in the back, and more than *three* times [D5 nodding] they stick me the back you see.
89. D5: [D5 nodding] OK
90. P46: So I think that's why [P46 gesturing] I got the cramp [D5 nodding] with the leg,
91. D5: OK
92. P46: and the pain and thing, [P46 nodding] you know, in the back.
93. D5: [D5 nodding, opens mouth to try and speak]
94. P46: [P46 shaking head] So I don't know [P46 indicating up and down whole body] what **causing** the, **all this pain**
95. D5: yeah, [D5 gesturing] I was going to say that, that
96. P46: [P46 indicates tingling with fingers] and **got tingles,**
97. D5: [D5 nodding] yeah
98. P46: and all over my body, as well.
99. D5: I think we need to ask somebody clever to have a take at you.

Patients' positive politeness to create space

Next, consideration was given to the question of whether or not patients also used positive politeness to create participatory space. The best examples found involved what we might usually describe as small talk. Small talk, or as Holmes & Stubbe (2003) describe it *social talk*, might be understood by some to mean trivial, not worth taking seriously. However, “talk is inherently multifunctional” and small talk is said to “oil the interpersonal wheels” (Holmes & Stubbe 2003: 88-9,97-8). It is its function as a strategy for reducing formality and establishing solidarity that contributes to positive politeness (Laver 1975 & 1981: cited in Holmes & Stubbe 2003) as well as the way in which such narratives bring accounts alive, making them more vivid, drawing the listener in to a more collaborative relationship (Brown & Levinson 1987: 117-8). Small talk is an equaliser, a means of accessing a “common currency” (Holmes et al 2012: 5) between interactants and humanising the workplace, or in this case the consultation.

Various types of small talk were encountered in the data – off-topic narratives that were only loosely related to the clinical concerns under discussion, if at all, and on-topic ones involving the provision of additional information about the matter in hand that was largely anecdotal and arguably unnecessary for the completion of business, as can be seen in the case of P24.

Extract 25 – Patients' use of positive politeness to create space (D5-P24)

- | |
|---|
| 19. D5: Let me just check, what tablets you're taking.
[Paracetamol & dothiepin listed & confirmed] |
| 23. D5: and we're giving you some cimetidine for your stomach, <u>OK</u> [D5 glances at P24, rubs own stomach] |
| 24. P24: [P24 glances at D5 and nods] |
| [Dothiepin discussed] |
| 57. D5: And do you still get stomach problems? |
| 60. P24: Yes. Though it's, sometimes I think it's when I don't eat properly. You know when you're going visiting |
| 61. D5: [D5 nodding] |
| 62. P24: and you're there for, [P24 laughing] supposed to be there for about an hour [D5 laughs] and you're there for two or three hours. I know I had that bad spasm, of not, you know being violently sick, you know, and I've bent down [P24 demonstrates] and all things <u>like that</u> . |
| 63. D5: <u>OK</u> |

Here, P24 uses *social talk* to embellish her response to D5's enquiry about her *stomach problems* (L57, Extract 25) as part of the review of her antacid medication (L19). She does so by making reference to her social activities:

I think it's when I don't eat properly. You know when you're going visiting ... and you're there for, supposed to be there for about an hour and you're there for two or three hours (L60-2).

She uses this Gricean (Grice 1989) breach to share something of her lifeworld (Mishler 1984). This *social talk* also acts as a levelling strategy oriented toward reducing the social distance

between P24 and D5, creating solidarity. She uses the inclusive *you* - *you know when you're* (L60), *you're there* (L62), associated with drawing the listener into the narrative. In addition, they share a humorous moment (their shared laughter at L62). Strategies such as these serve to convey P24 as appealing – interesting and sharing common values, strategies recognised as ones which increase the probability of subordinates obtaining the listener's cooperation (Brown & Levinson 1987; Holmes & Stubbe 2003).

Another such example is P50's narrative about his post-anaesthesia recovery during a recent in-patient experience. He uses this anecdote to fill the time whilst D7 issues his prescriptions:

When I'd had it done ... they must have given me some, I dunno, some gas up me nose and they brought me back to the bed, and I was a bit wobbly, and er, the nurse, only a young girl, she, she said, "I'll help you." (1) Course, she helped me, but both of us finished on the floor.

The best example found of positive politeness being used to present what might tentatively be called a dispreferred idea is the case of P68. This is P68's second visit regarding the refusal of insurance on the grounds of a past health problem that the insurance company will only discuss with D6. It is because his reason for attending lays outside the conventional norms associated with general practice that it has been tentatively grouped with the notion of patients' "dispreferred" ideas.

Extract 26 – Positive politeness to present patient idea (P68-D6)

1. D6: [D6 getting up looks at P68] Mr P68?
2. P68: Film star! [D6 glances down] [P68 can be heard rustling research paperwork] (2)
3. D6: [D6 raises eyebrows, grins, nods] Oh!
4. P68: It is, yeah [P68 hands research paperwork to D6] (.)
5. D6: [D6 looking at research paperwork sits down] OK. Thanks.
6. P68: [P68 laughs, walks across room]
7. D6: Sit yourself down.
8. [P68 hands something to D6, sits down, watches D6]
9. [D6 puts the item to one side, glances at P68] (4) <2111781>
10. P68: [P68 looks at D6] It was, d'you remember last time I was [D6 looks at screen] here? It was about insurance?
11. D6: About insurance. Yeah. [P68 looks at envelope he has brought from insurance company, removing paperwork from it] You were refused because of [D6 looks at P68] this <***>

As can be seen in Extract 26 P68 greets D6 with jocularly *Film star!* (L2), making reference to the video recording, D6 responds with a grin (L3) and having confirmed his name (L4), P68 laughs. He then uses shared remembering to explain why he is back today *d'you remember last time I was here?* (L10). This strategy of recounting events from previous meetings is an inclusive strategy, attending to the listener's need to be noticed, attended to and to be included. It also acts as a means of drawing the listener in, to share common ground with the speaker, and has been recognised as a means of encouraging the listener toward agreement (Edwards & Potter 1992). As already said, these interpretations and the classification of this example as “dispreferred” are extremely tentative and presented merely in the spirit of transparency. The strategies used by P68 could just as easily be interpreted as negative politeness strategies – his humour as a means of covering his embarrassment at having to take up D6's time with this matter and his shared remembering as a means of introducing the subject indirectly and distancing himself from it by appealing to D6 to

remember and identify the reason for his attendance, delaying the need to go on record as seen with P2.

The Case of P29: GPs' positive politeness: persuading during decision-making

The case of P29 looks at what happens in relation to the *Space* used to also express differing views to that of his GP, this time as a response to his GP's (D6) recommendations during the consultation. The analysis concentrates on the GP's response to this focussing on what happened to the *Space* used by P29 to express himself. It is from this case that the theme of: *GPs' positive politeness: persuading during decision-making* emerged. The facework performed here by D6 also provides an example of the mutuality of facework (Brown & Levinson 1987: 60, 61) - that by maintaining P29's face-needs he also attends to his own face-needs i.e. D6's presentation of himself as someone who cares and listens, attending to his own need to be of appeal to others.

P29 is an older man who used to work on building sites and appears to be “white Irish.”* He is concerned about *burning* pain in his lungs and breathlessness since laying a carpet and believes the pain to be due to *dust on* [his] *lungs*. He is known to have asbestosis. Having finished examining P29, D6 is explaining the probable causes of his pain and his plan of action which includes sending P29 for an ECG, after which he expects to prescribe steroids. P29 appears to be concerned about the prospect of having steroids.

Extract 27 begins with another example of the power differential between GP and patient. Here D6 is using his position as expert to explain the possible diagnoses *inflammation in your lungs* or *your heart* to P29, the necessary tests *ECG* (L173) and recommended treatment *steroids* (L175). Whilst on the one hand this type of general transaction is one that both parties might typically expect, it also demonstrates other ways in which the asymmetrical

* Based on visual & aural observations from the video data since accompanying demographic data is missing.

relationship between doctor and patient is reinforced, increasing the degree of face threat for P29.

Extract 27 – Diagnosis & treatment (D6-P29)

173. D6: Erm, [D6 writes, looks up] (4) [D6 looks at P29] I'm not quite sure what this is really. It might just be an inflammation [D6 gestures] in your lungs, due to the, [D6 nods] wh<at>, wh<at> what you've described of the, the carpet. [D6 glances away] Erm, I, erm, I'd [D6 listing on fingers] like to do *two* things really. **I mean, if I can get the, the nurse to, just do erm, an ECG on you,** [P29 nods] just to make sure that there's nothing wrong with your heart. [D6 shaking head] I don't, it doesn't sound like your heart, but just to be on the safe side.

174. P29: mmm

175. D6: [D6 glances at desk] And then, perhaps have a short course of steroids which er, [D6 gestures] re<duce>, *reduce* inflammation on the lungs. ***Just***

However, one can also see that this is mitigated with some examples of positive politeness on the part of D6. Firstly, D6 offers reassurance *just to make sure that there's nothing wrong with your heart* (L173). Implicit in this exclusion of cardiac problems is the point that the recommended steroids would be preferable to an abnormal ECG, a point further reinforced with repetition *it doesn't sound like your heart* (L173). This is then followed with an explanation that the steroids will *reduce inflammation on the lungs* (L175) – boosting the appeal of the plan by the presentation of the steroids as a gift that will benefit P29. Together, these utterances convey D6 as a cooperator, someone keen to attend to P29's concerns, they also attend to certain aspects of one's positive face – the desire to have one's needs respected and for inclusiveness (Brown & Levinson 1987: 128-9).

D6's utterances are also accompanied by a number of hedges e.g. *I'm not quite sure what this is really. It might just be...* (L173) and false starts e.g. *wh, wh what* (L173). These hedges and false starts could be functioning as a form of redress, a means of trying to appear unimposing. However, given the context (the need for an ECG prior to diagnosis), it seems

just as likely that these hedges are operating as lexical devices indicating the uncertainty surrounding diagnosis (Holmes 1995: 88) (to be further discussed later).

Extract 28 – Patient breach (D6-P29)

- | |
|--|
| 175. D6: [D6 glances at desk] ² And then, perhaps have a short course of steroids which er, [D6 gestures] re<duce>, reduce inflammation on the lungs. *Just* |
| 176. P29: [P29 laughing, makes inaudible comment about the steroids] |
| 177. D6: Sorry? Well, I, I'd only give you them for [D6 shakes head] four days, you know, sort of five a day for four days. Something like that. |
| 178. P29: [P29 doesn't sound entirely convinced] Yeah. |

The exact content of P29's response is inaudible (L176, Extract 28) so cannot be analysed in close detail, however, from D6's response (L177) it has been interpreted as significant since D6's ensuing dialogue seems oriented toward trying to reassure P29 about the steroids (as will be demonstrated in due course), and also with his use of the lexical item *Well* (L177) to punctuate his response. *Well* functions here as a discourse marker since it has no evaluative function as an adverb. As such it is able to perform a number of functions modifying the illocutionary force of the utterance (Swan 1995; Carter & McCarthy 2006). In essence, it has been interpreted here as a mitigated form of *but*, intended to indicate an exception, in this case that although steroids have the potential to cause harm, this is not the expected outcome for D6's proposed course of action. Consequently, P29's interruption has been interpreted as an expression of reluctance towards D6's proposed course of action.

So, once again we see an example of a patient committing a breach of cooperative norms.

This time the intrusion which might be viewed as a challenge is encoded in humour (P29 can be heard laughing - L176), a redressive means of softening any contradictory views regarding the steroids. The use of humour in this context can promote solidarity and rapport, acting as a

means of repairing any breach. Much could be said about the role of humour within politeness (e.g. Sacks 1974; Jefferson 1984a; Brown & Levinson 1987; Holmes 2000; Harris 2001; Harris 2003) but that is not the focus of the analysis here.

Extract 29 – D6's response to P29's breach (D6-P29)

179. D6: I mean, you c<an> [D6 shrugs] (1) I would imagine it would just get better on its own. You don't *have* to have those. But I, I haven't got anything *better* to offer you really.

180. P29: [P29 nods] I, I appreciate that doctor. I do appreciate that.

181. D6: Erm, so I mean you, you can, [P29 picks up Ventolin inhaler] we, we can just wait [P29 looks at D6] and see (.) [P29 puts Ventolin inhaler in pocket]

182. P29: Erm (.) [P29 nods] very good.

183. D6: [D6 gesturing] Or, *or* erm, I w<ould>, I, I can't, there's no *harm* in having a sh<ort>, a *small* course of steroids, it's only, it's only a sh<ort>,

184. P29: *** **

185. D6: [D6 shakes head, gesturing] it's not, it, it's not erm, you know, it's not for a long period. It's just fi<ve>, five a day for four days (.), *it's quite a*

186. P29: [P29 pointing to chest] *** ** hotness (1) the

187. D6: [D6 nods] yeah

188. P29: burning sensation. *Would it get rid of that?*

189. D6: Well, I don't *know*. I'm, I mean [D6 pointing to own chest] if it's,

190. P29: [P29 gesturing, nodding] *hope so*

191. D6: if some<thing>, if, if it's the *inflammation* that's causing that (.) in the lungs, then it *should* do. Yes (1) [P29 nods] Yeah.

192. P29: [P29 nods] Very good *** **

P29 has the ECG and D6 concludes that the pain is most likely due to lung inflammation.

212. D6: ... I think if it is an inflammation the steroids will sort of (.)

213. P29: *do it* [P29 jerks head and raises eyebrows akin to surprise]

214. D6: relieve it, yes. It's only a *short* course you see, so it shouldn't do you any long term harm. There's no, there's no evidence [P29 places research paperwork on desk] that these short courses of steroids do any harm at all.

215. P29: Fine [P29 nods deliberately] doctor,

216. D6: Alright?

217. P29: that, that's great. <922561> [D6 glances at screen] I, I (.) [P29 gesturing] there's some friends of mine in Swansea who's on steroids,

218. D6: Yeah well, if you've got

219. P29: *** **

220. D6: really bad lung disease, [P29 nodding] and you're on it

221. P29: *yeah*

222. D6: all the time, it causes all sorts of complications, but just a

223. P29: yes

224. D6: short sharp, well we give it to kids,

225. P29: *I see, well it can't be bad then*

226. D6: two year olds, three year olds. Just for the short course.

227. P29: Very good [P29 nods].

228. D6: Er, erm. (2) So, er, [D6 looks at screen] so this, so we'll try that then, erm, I mean if it's better, that's fine, erm, ⁴if it's not better, [D6 looks at P29] come back.

229. P29: [P29 nods] <944248>

D6's response remains oriented toward P29's positive face-needs (see Extract 29). He sets out to dispel P29's fears with the gift of reassurance – attending to P29's need for others to share an interest in and to cooperate with his concerns and preferences. These reassurances now direct, in contrast to what we have seen above (L173, Extract 27), stress the brevity and harmlessness of the proposed treatment and the fact that it is considered to be the best treatment available:

only ... for four days (L177, Extract 28) – the illocutionary force of this point is augmented by D6's use of the intensifier *only*, the stress added to *small* (L183, Extract 29) and his repeated reference to the brevity of the course (L183x3, 185x2, 224, 226).

there's no harm (L183) - the illocutionary force of this point is again boosted by the addition of audible stress to the word *harm* (L183) and repetition (L214x2).

Furthermore, D6 points out that steroids are prescribed to children (L224-6), the implication being that one would not offer children harmful treatments.

I haven't got anything better (L179) – P29 is reassured that he is being offered the best treatment available, again audible stress is added to *better*.

there's no evidence (L214) – D6 uses science to further boost his assurances.

As well as these reassurances, D6 also includes an offer of an alternative plan of action *You don't have to have those* (L179) – of watchful waiting as an alternative *we can just wait* (L181). This not only functions as another form of gift giving, but is also suggestive of an interest in and desire to take P29's concerns on board, preserving common ground.

However, D6's reference to this alternative is marked with a *shrug* (L179) and contains much hedging, including a 1 second pause (D6's longest in these extracts). The shrug could be interpreted as a means of reducing emphasis on the previously suggested steroids, or it could indicate that the alternative being suggested is not highly valued. Although the intention here is unclear, the marked hedging, coupled with the fact that this option was initially omitted and is in turn only mentioned at this point (a marked difference to the repetition and boosting noted in relation to the steroids) suggests that this alternative is not highly valued, that it is not the preferred option.

D6's approach also involves a number of inclusive strategies, further reinforcing the notion of sharing P29's interests and concerns, and of sharing common ground with him. Evidence of this is seen in some of his pronoun use. Firstly, the repeated use of the pronoun "I" - *I mean....I would....I haven't* (L179) suggests a degree of personal concern with P29's needs, although this may not have been the illocutionary intent or the perlocutionary uptake. And secondly in his use of the inclusive "we" (L181). This is a clearer example of inclusiveness, one which promotes the idea of the speaker as a facilitator who shares the listener's desire for resolution, involving them in the proposition (Robertson 2004: 99) and invoking the image of a shared action stemming from a shared standpoint. In the absence of any further, explicit, objections from P29 regarding the steroids, D6's decision not to revisit the idea of watchful waiting could also have been interpreted as a means of preserving common ground.

P29's responses are considered next. As D6 begins to share his views P29 makes a couple of non-verbal and minimal verbal responses: a *nod* (Extract 27, L173) and *mmm* (L174). Again, there is insufficient evidence here to determine whether or not these are intended as backchannelling or agreement. The concerns expressed at L176, Extract 28, are a little

lengthier and already commented on above. His initial response to D6's attempts to reassure him looks like agreement *Yeah* (L178, Extract 28) but his tone suggests he is less than fully convinced. It seems that D6 noted this discrepancy too since this is the point at which he suggests the alternative of watchful waiting (L179-81, Extract 29). P29 responds with an expression of gratitude *I, I appreciate that doctor. I do appreciate that* (L180). However, it is not entirely clear as to what he is appreciative of, the offer of an alternative, or the fact that D6 does not have *anything better to offer*. Is he directly agreeing to the steroids? Regardless, the offer of gratitude is indicative of deference and respect for D6, and a means of offering redressive action for his possible breach. P29's next response is to D6's additional comment regarding the possibility of watchful waiting (L181), P29 responds with *very good* (L182). This again looks like agreement, but could equally be functioning as a closer (Carter & McCarthy 2006), a means of closing the discussion, thereby avoiding disagreement. From a politeness perspective, appearing to be in agreement with the interactant by avoiding disagreement promotes cohesiveness and the impression of common ground.

When the steroids are again recommended after the ECG (L212) P29's in-filling *do it* (L213) is indicative of shared understanding and agreement and is followed up with *fine* (L215). This latter response can be used to indicate either agreement or a desire to terminate the discussion (e.g. Carter & McCarthy 2006). D6's *alright?* (L216) might have been an attempt to check P29's intentions, but it is equally oriented to inviting collaboration rather than elucidation. P29 responds to this probing with a stronger agreement initiative *that, that's great* (L217) but then in the same turn goes on to volunteer further evidence of his experience of steroids *some friends of mine in Swansea who's on steroids* (L217). This could be an indirect attempt to discuss his fears further, or, a means of asserting his approval of the steroids by implying that if it's OK for them, then it's OK for him. In response to D6's

additional offers of reassurance (L218-224), P29 concedes that a short course of steroids *can't be bad then* (L225), again nodding and closing with *very good* (L227) which once again could indicate agreement or simply a strategy to avoid disagreement. This close analysis of P29's utterances demonstrates that although his replies looked like agreement initiatives, there is evidence to suggest that this may not have been his intention. It is therefore difficult to be sure how he really felt about the steroids at the end of the consultation.

This case demonstrates the theme: *GPs' positive politeness: persuading during decision-making*, showing how D6's reaction to P29's apparent reluctance to agree with the expected plan of action had persuasive power. The *Space* used by P29 to indicate this was not one that was offered to him, but rather one which he created for himself by interrupting. However, D6's offers of reassurance and an alternative treatment option - redressive strategies with the potential to counteract and repair P29's breach, also had the effect of taking over the *Space* created by P29 in which to participate. D6's strategies were ones oriented towards cooperation and the protection of the listener's (P29) positive face - as opposed to a dominant, paternalistic style of consulting, but they too dominated the discursive *Space* without any apparent attempt being made to redress this.

The persuasive power of positive facework is effected by the way in which it promotes partnership, a collective approach. This collaborative characteristic has the effect of guiding the listener toward sharing the speaker's beliefs, stifling participation that might involve the contribution of new or differing ideas. D6's promotion of the steroids may well have been influenced by a concern with maintaining the institutional and professional goal of "Mak[ing] the care of [the] patient your first concern" and by "Provid[ing] a good standard of practice and care" (GMC 2006: i). Whilst such emphasis on providing the best available treatment is

understandable from a professional perspective, such approaches, as has been demonstrated, have the effect of limiting the number of possibilities under discussion and directing the listener to a particular point of view. This effect could have been counteracted by promoting discussion around alternative viewpoints.

Whether or not P29's concerns were adequately addressed and whether his acquiescence in this state of affairs was genuine or not cannot be determined from the text. However, D6's domination of the discursive space at this point within the consultation, coupled with his presentation of himself as appealing, would have added to the face threat involved in expressing any continuing concerns. D6's approach appeared to have the effect of controlling the conversation and limiting it to the confines of the dominant mode of knowledge. Whether conscious or not, this exemplifies the use of collaborative strategies to promote cooperation (Holmes & Stubbe 2003).

GPs' positive politeness: persuading throughout the consultation

The preceding case analysis, that of P29, looked in detail at positive politeness purely in the context of a specific decision and in just the one case. The key finding from this case analysis highlighted the potential persuasive power of positive politeness. This prompted a new direction to the analysis, one which moved from a focus on deviant cases to the consideration of politeness more generally in the dataset. In the first instance, the data codes were revisited with the findings from P29's case in mind (GPs' positive politeness: persuading during decision-making), and the positive politeness outputs subjected to further scrutiny and consideration. This reconsideration revealed that some GPs not only used noticeably more positive politeness than others, but that they did so throughout the consultation, not just at decision-making points. These GPs were D1, D2, D4 and D5. Positive politeness reduces

social distance, fosters solidarity and engenders cooperation. The point in question here, is that when the consultation is considered from a politeness perspective, that is, as a face threatening act, could the potential persuasive power of positive politeness serve to add to this face threat limiting the access to the *Space* available for patients to participate in?

The theme under scrutiny here is: *GPs' positive politeness: persuading throughout the consultation*. The examples offered draw attention to instances of positive politeness occurring elsewhere within the consultation, that is, at points which do not occur within a specific decision-making context. Whilst these strategies cannot in isolation determine the outcome of the consultation, the analysis presented seeks to demonstrate the potential influence that these types of inclusive strategy can have and the way in which they, in addition to more paternalistic approaches, can impede the *Space* available for patient participation. Unlike the preceding examples, those following have been deliberately taken from a range of consultations generally limited to the afore mentioned GPs, and may tend to be shorter.

Extract 30 – Opening greeting (D5-P23)

[Tape cuts straight to voices of D5 & P23, P23's entrance has not been recorded. There is no record here of them discussing consent suggesting that they may have been chatting prior to the material recorded here.]

1. D5: [D5 is standing at desk] [P23 approaches D5] [D5 introduces self by first and surname without title] nice to meet you, [D5 shakes P23's hand] how you doing?
2. P23: Hiya.
3. D5: Have a [both sit down] [D5 is looking at P23] seat ...

The analysis begins with an extract from an opening greeting, Extract 30. In this example D5 adopts an informal style when welcoming P23, an inclusive strategy oriented toward reducing social distance and reflecting in-group membership. He begins by avoiding the address form

Doctor, drawing attention away from the asymmetry of the relationship. Instead he chooses to share his first name so that both patient and GP know each other's full names, again reducing asymmetry and indicative of a desire to reduce the relative power distance between them (Brown & Levinson 1987: 107-8). His next utterance *nice to meet you* (L1) then attends to the listener's need to be of appeal and interest to others. Of course these utterances also suggest that this is the first time that the two have met, this is, however, unclear since, as will be seen, D5 later asks about P23's boxing, a topic that does not appear to have been raised by P23 himself during the recording (they could however have been chatting about this prior to the camera having been switched on – see note at beginning of Extract 30). Continuing, D5's use of ellipsis in this next utterance *How you doing?* (L1) is another marker of informality with its assumption that the listener will understand its meaning (absence of *are* in *How [are] you doing?*). This reliance on shared mutual knowledge for comprehension is again associated with in-group membership (Brown & Levinson 1987: 111).

Overall then, the tenor here is an informal one, implying intimacy. In instances where the relationship, as is the case here, is not in fact an intimate one, the use of such a tenor is viewed as a “metaphorical extension of intimacy” (Brown & Levinson 1987: 101) implying common ground and a sharing of wants. It conveys a desire to align with and collaborate with the listener, to show solidarity, acting as an inclusive strategy. However, the use of such a strategy in this way requires careful judgement; for its success, the listener must be amenable to such an invitation since misjudging informal relations can also damage as opposed to foster relations (Brown & Levinson 1987). Crucial to the argument here is that the patients' response *Hiya* (L2) suggests that the level of informality has, in this case, been well-judged, and is acceptable to the patient.

Other examples of informal greetings that were recorded include *Hi there*, “Hi” being classified as informal in comparison to the more formal “Good Morning” (Swan 1995) and used, for example, by D1 when greeting P9. Similarly, in Extract 31, when D4 invited P19 (previously introduced on p151) to share her reason for attending, she used a familiar tone to greet her (L2), a tone associated with recognising and being pleased to see the other interactant, and so attending to positive face. D4 then continued in the same vein for her HAY-type elicitation (Coupland et al 1994), the most notable feature of which is her use of ellipsis too *How you doing* (L8) with its reliance on shared mutual knowledge that she means *How [are] you doing*, again indicating in-group membership (Brown & Levinson 1987: 111).

Extract 31 – Invitation to present symptoms (D4-P19)

- | | |
|----|--|
| 1. | P19: Hello there, |
| 2. | D4: Hello [D4 said in raised, familiar tone, immediately turns towards screen]
[D4 & P19 discuss video consent & paperwork] |
| 8. | D4: Lovely. [P19 looks towards D4 leaning on desk] How you doing? [D4 glances at P19 before placing paperwork behind her] |

Within this spirit of inclusiveness there were also examples of the GPs actively involving patients in their consultations. For example, looking at paper or electronic records with the patients (D2-P10, D2-P58) and jotting down information for patients to take away with them (D4-P51). In Extract 32 D2 is showing P12 and A12 the results of P12’s recent 24 hour blood pressure recording.

Extract 32 – Involving the hearer: Blood pressure readings (D2-P12)

49. D2: ... Here, [D2 turns screen so all can view] this, [P12 leans to look at screen] *do* have a look at the graph.
50. [D2 looking at screen]
51. [A12 gets up and walks from other side of room to stand in front of desk looking at screen] (3)
52. D2: That's when you took it off,
53. P12: yeah
54. A12: yeah
55. D2: that'll be 120 that'll be, it's either 140 or 150, there
56. P12: yeah
57. A12: right
58. D2: so there's only *that one*
59. A12: suddenly peaked there
60. D2: there, that one and that one.

In this example, D2 invites P12 and her husband to gather round the screen and look at the graph which depicts the blood pressure readings, emphasising the appeal of her invitation by the additional stress applied to *do* (L49). She explains what the features on the graph represent, linking the evidence with the patients' preceding narrative *That's when you took it off* (L52) - P12 & A12 had previously been recounting how P12 had become tangled in the equipment whilst getting undressed. Sharing the data with P12 in this way removes some of the mystery of the specialised readings and presents it as something accessible to all, making it an inclusive strategy.

Extract 33 – Involving the hearer: Cholesterol risk (D1-P32)

51. D1: So (1) we're, always when you talk about cholesterol here (5) [P32 looks at screen], I'll show you, I'll, [D1 gesturing, pointing at screen] I'll switch to another page in a bit, but, but this, on this page you were 6.2, that was, your *total* cholesterol, as we call it.
52. P32: [P32 nods] Mmm.
53. D1: That's *all* your cholesterol, this one here, which is part of cholesterol, 2.1, that's your *protective* cholesterol. So there's *protective* cholesterol, and, if you like, cholesterol that you *don't* want. [P32 nods] [D1 looks at screen] This is protective, OK. Down here, when you had it done, just over a year ago, the total cholesterol was the same, but the protective cholesterol was *less*, alright?
54. P32: Yes.
55. D1: So, although the total cholesterol is *same*, at 6.2 [D1 looks at P32]
56. P32: [P32 points] protective's gone up hasn't it?
57. D1: [D1 nods, gestures, looks at screen] Yeah, so, so that's, that's *good*, in a sense, [D1 glances at P32] alright?
58. P32: Yes.
59. D1: [D1 typing] If we go to another page on here, to show you (.), sort of, what it means (2). [D1 gesturing] This is a way of, putting together, like I was saying, [D1 holds up 4 fingers] there were 4 main [D1 glances at P32] [P32 nodding] *issues*.

In Extract 33 D1 is trying to explain the complex issue of cholesterol readings and their interpretation which involves comparing and combining a number of different biochemical readings. D1 is looking at and assessing the various readings in P32's electronic records. As he does so, he includes P32 in his data collection and considerations, pointing at the screen and explaining what he is looking at and his evaluation of it.

There were also examples of the GPs showing an ongoing interest in their patients, an interest extending beyond just the matter in hand, for instance through shared remembering (Extract 34 - Extract 36) or by showing interest in a particular aspect of the patient's dialogue that was not essential to the business of the consultation (Extract 37). The GPs predominantly demonstrated shared remembering by making reference to previous consultations e.g. D2

reviewing P11's painful foot *we didn't find a tender spot last time did we?* and in these cases, of course, it was not clear to what extent they were being prompted by the data entries visible to them on the screen. Other similar examples include D4's reference to when she last saw P51 *It's been a while though, hasn't it?*, D1's explanation to P3 about the effects of his excess alcohol intake *as well as damaging, say the liver, ... which, which we were talking about last time*, and D5's enquiry to P20 *How's everything else going? ... What about the eyes?*

Regardless of whether or not these utterances were prompted, they demonstrate an orientation toward positive face. The example in Extract 34 shows recollection of an issue that is unlikely to have been documented – D2's recollection that P12 dislikes being weighed *this is the bit you don't like* (L22). This extract also contains an example of the role of humour in positive politeness (L22-26). D2 boosts this display of interest in P12 by using irony and jocularly to minimise the threat. She does so by adopting an ironic tone, speaking in what sounds like a conspiratorial tone. P12 confirms her dislike of being weighed *Oh my God* (L23), confirming that it is *Very* (L25) *bad* (L24), but shares in D2's jocularly with her own laughter (L23, 25) which D2 then echoes with her amused tone (L26). Humour of this type is by necessity inclusive in nature; it cannot be said to be successful unless it is shared by others. In such cases then, it can act as a means of levelling social distance, emphasised by the fact that it is dependent on shared background knowledge and values, and thus functions as another means of conveying common ground and solidarity (Brown & Levinson 1987: 124).

Extract 34 – Shared remembering: Dislike of being weighed (D2-P12)

22. D2: ... [D2 speaks conspiratorially looking at screen] this is the bit you don't like. "Patient needs (.) to have," it says here, "Patient needs BMI *review*," that's body mass index [P12 looks away, bemused] [D2 typing]. We need to *weigh* you.
23. P12: [P12 looks away] Oh my God [P12 puts hand over side of face, laughs sheepishly].
24. D2: Is that bad? (1)
25. P12: Very [P12 glances at A12, laughing].
26. D2: [D2 with sympathetic amusement] Oh dear.

Another example of such unprompted remembering includes D4's recollection of P65 having tried the unlicensed product zinc for genito-urinary tract problems. P65 has prostate problems and is talking about *herbal products* and *zinc* (L261), which in turn prompts D4's enquiry *You tried the zinc didn't you?* (L262) indicating that she remembers this discussion from a previous meeting.

Extract 35 – Shared remembering: Herbal remedies (D4-P65)

261. ... I went to see me {my} mate yesterday [P65 looks away] he's 75 and he has, he's got a bit of [P65 laughing] prostate trouble so we were talking about that [D4 glances at P65] yesterday. [P65 looks at D4] And he'd sent for some herbal tablets from Germany or something, °**sixteen**° pound *they were.* But they're, they've got zinc in which I know zinc is a, a big factor in the er,
262. D4: [D4 looks at P65] You tried the zinc didn't you?
263. P65: Yeah but I
264. D4: A few years ago.
265. P65: Yeah. ...

And also, of a more social nature, below is another extract from P24 where she and D5 are chatting about a mutual acquaintance with a son in Israel (L2-5, Extract 36).

Extract 36 – Shared remembering: A mutual acquaintance (D5-P24)

- | | |
|----|--|
| 1. | D5: [D5 walking backwards, facing P24] Is she alright? [D5 reaches desk and briefly glances at it] |
| 2. | P24: [P24 looking at D5] She's in Israel now isn't she? |
| 3. | D5: Lucky thing. |
| 4. | P24: Yeah. |
| 5. | D5: 'Cos, 'cos [D5 points toward seat, sitting down, looks at P24 smiling], just have a seat. [P24 glances at seat, sits down] 'Cos she's got a son out there hasn't she? |
| 6. | P24: Yes, [P24 names subject's son], been on the phone to me two or three [P24 turns to put research paperwork on chair beside her but turns back to D5 still holding it] times already. |
| 7. | D5: So is she having a good time? |
| 8. | P24: Yes. [P24 hands research paperwork to D5] |

Such displays of social talk, as seen in the above extracts and previously introduced on p169, convey that the listener's interests are admirable and of shared appeal and that the speaker is interested in an ongoing relationship with the listener. This attends to the listener's need to have their interests noticed and to be of appeal to others. A more specific example of this can be seen with P23, briefly mentioned earlier (p183). D5 shows interest in the relationship between P23's career as a ballet dancer and his extracurricular boxing activities, making his enquiry whilst examining P23 *So how does the boxing and the ballet kind of fit together?* (L35, Extract 37). He extends the conversation with supplementary questions *so do you do any kind of erm, proper boxing or is it just kind of sparring stuff?* (L39). The topic is closed by D5 confirming an active interest in this unusual combination of activities *I was gonna say I can't imagine the erm, the Hippodrome going a bundle* (L43).

Extract 37 – Showing interest: Combining activities (D5-P23)

[Whilst being examined out of camera view]

35. D5: ... So how does the boxing and the ballet kind of fit together?
36. P23: Er, well I had a, lot of knee injuries, sort of knee injury problems
37. D5: *just turn around for me*
38. P23: I started er, doing circuit training and boxing to er, (2) improve my overall strength and fitness. And I have to say it saved my career really
39. D5: so do you do any kind of erm, proper boxing or is it just kind of sparring stuff and kind of boxing ***
40. P23: it's, it's mainly erm, pad and bags
41. D5: OK
42. P23: circuit training. I *do* spar occasionally, but
43. D5: I was gonna say I can't imagine the erm, the Hippodrome going a bundle
44. P23: well exactly, yeah

Other examples like this include the conversation between D5 and P20 about her proposed career move to the prison service in Extract 38 which again displays efforts on D5's part to continue the conversation (L46 & L50), as well as another example of shared humour (L50-51).

Extract 38 – Showing interest: How's work? (D5-P20)

44. D5: ... Work and everything [D5 looks at P20] going alright?
45. P20: Yeah.
46. D5: You're having fun there?
47. P20: No. [P20 faces screen] [printer can be heard]
48. D5: [D5 laughs and returns to screen and typing]
49. P20: Hate the place. [printer stops] I'm try, I'm trying to get into the prison service.
50. D5: [D5 faces P20] [printer starts again] Hopefully [P20 looks at D5] on the other side, [D5 points away whilst laughing] not as [D5 trails off and turns back to screen and typing]
51. P20: oh well, *** [P20 shrugs non-committally and laughs and looks at screen] of course, yeah [D5 looks at P20] as a prison officer [printer stops]

Similarly in Extract 39, D2, having just asked P58 about her work, moves on to ask *how are you otherwise?* (L114). She too prolongs the conversation by asking additional questions, *Why's that?* (L116) and *So where are you going to be moving to?* (L118) emphasising her continued interest.

Extract 39 – Showing interest: Moving house (D2-P58)

[D2 has just asked P58 about work and now moves on]

114. D2: And how are you [P58 glances at D2] otherwise?

115. P58: Erm, not too bad. I'm looking at a new place to live [P58 nodding] for next *winter,* [D2 looks at P58] so hopefully I'll be moving quite soon

116. D2: Oh. Why's that?

117. P58: I've had trouble with a noisy neighbour [D2 nods] for erm, for quite some time. I've been living in my bedroom for 2 years now 'cos I was flooded [D2 nods] about 2 years ago, and [P58 gestures] (.) [D2 looks at screen, types] I lost all my furniture and carpet and I've been living in *damp* (.) [P58 shakes head] *wet* kind of *flat* since.

118. D2: So where are you going to be moving to?

119. P58: [P58 looks at D2, names a local area]

120. D2: Right [D2 nodding looks at P58].

121. P58: The other side of the city 'cos my friends are over there, and [P58 nodding] I've got, sort of like,

122. D2: yeah

123. P58: friends over there. [D2 looks at screen, types] My family's over there [P58 nods] as well.

124. D2: [D2 sounds pleased] Oh I hope things go well for you.

There were also examples of the GPs showing approval to their patients. These included approval of patients' healthy lifestyle choices e.g. D5's *That's fine* in response to P20's account of her alcohol intake being well below the recommended guidelines and D7's more forceful praise *well, that's, that's fantastic [grinning]* when P44 explains that he is keen to start swimming again. There were also expressions of support for patients' ideas e.g. D4's agreement regarding P64 *Yeah, she sounds noisy doesn't she?* - a response to the mother's comment that her young daughter *sounds very wheezy*, and D5's agreement with P66's

suggestion that because of her family history of blood clots, she should commence aspirin *I do think it's probably a good idea if you actually went on it.*

Utterances such as these attend to basic positive face-needs – the need to be appreciated and approved of (Brown & Levinson 1987: 61). In the example given in Extract 40, D1 and P32 are still talking about her cholesterol risk. D1 has just advised her to have a low fat diet, in response P32 amusedly explains how she has already gone a step further, and actually *cut* [fat] *out* of her diet (L88). D1 responds by showing interest in her efforts (L89) and then approval of them *good, good* (L95) boosted with the more demonstrative response *Well that's certainly the thing to do* (L97-99). This display of approval is further boosted by his sharing in her laughter (L89).

Extract 40 – Showing approval: Healthy diet (D1-P32)

88. P32: ... I've cut, actually, I've cut it out [P32 grinning] altogether at the moment.

89. D1: [D1 grinning] Have you? [D1 laughs]

[P32 discusses weight gain]

94. P32: ... I, so I've started erm (.), it's [P32 shaking head] not a *diet*, I've just started eating (.) cutting a lot of fat things out,

95. D1: [D1 nodding] good, good

96. P32: that I, I used to have.

97. D1: [D1 gesturing] Well that's certainly the

98. P32: *at home*

99. D1: thing to do,

Similarly, in Extract 41 below, D4 has just explained that 6 year old P45 should have a flu vaccination (L197-9). The conversation has been between D4 and the young girls' mother (A45), D4 now turns to P45 to include her with a grin (L200). She offers reassurance *It's only a tiny, tiny* (L201), at which point P45 asserts *I'm not worried* (L203). D4 shows her approval by again grinning *You don't mind? OK, no worries then* (L204).

Extract 41 – Showing approval: Child’s injection (D4-P45)

197. D4: ... So it might well be worth
198. A45: [A45 nodding] OK
199. D4: getting her, [A45 looks at P45] vaccinated.
200. A45: [A45 nodding] OK [P45 looks at desk] [D4 looks at P45, grins] [P45 looks at D4]

201. D4: It's only a [D4 looks at hand and demonstrates] tiny, °tiny ***° [D4 grins, looks at A45]
203. P45: [D4 looks at P45] I'm not worried. [P45 claps hands on desk]

204. D4: [D4 looks at A45, grinning] [A45 looks away, looks amazed] You don't mind? [D4 gestures, sits back] [A45 leans head on hand, looking at wall] OK, no worries then.

As well as approval, there were also examples of the GPs showing understanding, conveying that they comprehended or grasped what the patient had been saying. This strategy both attends to the listener’s need to be noticed – for others to recognise his or her wants and needs (Brown & Levinson 1987:103-4), and fulfils the listener’s wants for gifts of, amongst other things, understanding (Brown & Levinson 1987: 129).

Extract 42 – Understanding: Bereavement (D2-P62) (110 words)

141. D2: ... I want to say (2) we talked about your, your brother [D2 looks at P62] didn't we last time?
142. P62: yeah, yeah. [P62 gesturing] Yeah, sorry about erm, [P62 smiles, shaking head] getting upset but [D2 shakes head] erm, just touched a nerve like so
143. D2: [D2 nodding] Of course it did,
144. P62: yeah, yeah
145. D2: [P62 nodding] of course it did. [D2 nods] I would feel exactly the same,
146. P62: yeah
147. D2: and, and er (.) and I, [D2 looks down, shaking head] and I would have done *exactly* the same.

148. P62: Yeah.

Returning to the case of P62, whose brother committed suicide, an example of fulfilling the need, or want, for understanding is given in Extract 42 where D2 demonstrates her understanding of P62’s grief. P62 apologises for *getting upset* (L142) *last time* (L141), explaining *just touched a nerve* (L142). D2’s response is more demonstrative than a minimal

utterance *Of course it did* (L143), boosted by her use of *of course* which attends to his wants to be accepted and to be seen as being on common ground with others, and further boosted by her added emphasis to *course* and subsequent repetition at L145. She elaborates on these sentiments of understanding wants and sharing common ground by saying *I would feel exactly the same* (L145) with further repetition and added emphasis *I would have done exactly the same* (L147). Here, not only is D2 fulfilling P62's need to be understood, she is also sharing a moment of common ground.

The example of P66 also demonstrates attempts to alleviate anxiety and worry. Briefly mentioned earlier (p192) P66 has just been to visit her sister who receives total care in a nursing home and has since been diagnosed with MRSA. She has seen a TV programme about MRSA, has developed various symptoms since and is worried that if she has her varicose veins operated on next week it may get in her wounds with serious consequences. D5 demonstrates his understanding of her various concerns by enquiring *So, so I guess what you're saying is that you're worried about the MRSA is it? *Is that the biggest thing you're worried about?**.

Extract 43 – Understanding: Abandoning quit attempt (D4-P65)

313. P65: [P65 looks at D4] Now, the smoking.

[P65 talks about his unsuccessful quit attempt & use of NRT]

329. P65: but *Sunday*, [D4 looks down signing prescription] when this played up, [D4 laughs] [P65 shakes head, looks at desk] it all went down the river, because (.) [D4 puts pen down, looks at P65 grinning] I (1), I used to find before (2) that [P65 nodding] if I had a cig<arete>, couple of cigarettes it would

330. D4: Mmm, [D4 gesturing] because you'd relax.

331. P65: [P65 glances at D4] *because of the tension see.*

332. D4: yeah

Extract 43 revisits another patient, P65 and the relationship between smoking and his prostatitis. P65 finds that smoking is a useful tool in the management of the pain that he experiences when his prostatitis flares, explaining that this is why he abandoned his last quit attempt *when this played up it all went down the river* (L329). Despite the fact that he does not explicitly state why it helps, D4 demonstrates what Tannen (1992) has called “listenership” (showing active listening) indicating alignment with P65 as well as understanding by pre-empting his explanation *mmm, because you’d relax* (L330). Similarly, D7’s anticipation of how *bad* P38’s depression has been is another way of showing such alignment:

P38: *cos this [P38 shakes head] time round it's [D7 nods] been, oh it's been horrific.*

D7: **been* bad, yeah*

The outputs described thus far have been oriented around social interaction (social talk), informality and intimacy. However, these are not pre-requisites of positive politeness as can be seen from the next two outputs: the use of tag questions and the universalisation of the speaker’s point of view. These do not have the same, what we might call, informal qualities as have been seen in a number of the preceding extracts.

Extract 44 contains an invitation to agree, constructed here by D4 with the tag *have you?* (L172) changing her statement into a question. Tags can be used as a conventionally polite means of modifying the imposition of an utterance, negative politeness (Brown & Levinson 1987: 135-6 & 147). However, as is the case here, they can also be used to draw the listener in. This has the effect of inviting compliance through the presupposition of agreement

(Brown & Levinson 1987: 107, 119 & 127). As has already been noted, it was common to see the GPs presenting decisions about treatment plans and evaluations in this way.

Extract 44 – Tag questions: Agreement that treatment is needed (D4-P65)

172. D4: [D4 sounds encouraging] You've actually not had any episodes now for two and a half years so [D4 looks at P65] (1), you've not done bad have you? [D4 looks at screen typing]

173. P65: [P65 looks away, doesn't sound convinced] Nah.

D4's invitation to agree, uttered as an evaluation of P65's condition (the afore mentioned, recurrent prostatitis) *you've not done bad have you?* (L172) seems oriented toward boosting P65's ego, demonstrating that she notices and is keen to attend to his wants and needs. It is not clear however, how successful this invitation is since P65's minimal response *Nah* sounded unconvincing (L177).

A similar example can be seen with D6 (Extract 45) as he seeks to encourage P27 to accept a referral to a counsellor. P27 seems to be saying that he *needs to let it* [out] (L80), to talk to someone about things, D6's response aligns with this need pointing out that *that's what counsellor's are for really isn't it?* (L81), boosting the appeal of this option and encouraging agreement. Although P27's response seems ambiguous, when D6 asks him directly if he can make the referral he replies **°please yeah°**.

Extract 45 – Tag questions: Accept counselling (D6-P27)

80. P27: and I think it's come to a point now where, I can't stand it any longer. I need to let it ***

81. D6: [D6 nods] yeah well, that's right, well that's when, that's, that's what counsellor's are for really isn't it?

82. P27: yeah [P27 nods, but his tone is ambiguous it acknowledges what D6 has said, but agreement is unclear]

And in the last extract concerned with tags (Extract 46), D1 invites P4 to agree *OK?* that she will come back if her pain gets any worse (L111-3).

Extract 46 – Tag questions: Return if worse (D1-P4)

111. D1: Well as long as your neck's reasonably well *supported*, in some way, then, do the best you can with that. But that's why you're getting that. So we, we're probably not gonna influence that at all at the moment

112. P4: no

113. D1: but what, what you need to keep an eye on, and I'm sure you'll come back and tell me, is that if it becomes, for instance, more than something that you, you *get right* through the day, *OK?*

Moving on then to universalising. The term is used here to differentiate one of 4 different types of “point-of-view” operations described by Brown & Levinson (1987: 122), that which refers to the way in which speakers’ presuppositions are encoded into utterances.

Universalising is the presentation of ideas in a way that implies an assumption that the listener should share them - not just because these are the speaker’s views, but because the views are widely held. Disagreement in such contexts is therefore highly face threatening since doing so would not only breach the expectation of listener agreement, requiring a dispreferred response, but also because it positions those with alternative viewpoints, who lack sufficient supporting evidence, as being less knowledgeable than others. This persuasive strategy boosts the utterance’s validity, thereby adding to the arguments for agreeing to the speaker’s point of view, and in doing so encourages the listener to remain on common ground with the speaker, showing solidarity.

In Extract 47, D1 generalises whilst referring to P1’s anatomy. P1 is a 16 year old accompanied by her grandmother, she has had lumbar back pain since playing with a friend in the garden. In Extract 47 D1 has just finished examining P1 and is explaining the diagnosis to her.

Extract 47 – Universalising (D1-P1)

106. D1: Good, Okay, come down [D1 speaks in gentle, fatherly tone]. Alright, I mean when this sort of thing happens, I mean you can imagine if, if it had happened on your leg you, you'd have a big bruise and you can imagine that, that, erm ¹**near the spine bones here there are lots of muscles there and they all get bruised by this sort of problem** ²**and that can take several weeks to go away**
107. P1: [nods slightly]
108. D1: so the pain may last for another week or so even. Okay? ³**But the pain isn't dangerous, it doesn't mean anything terrible has happened to the bones,**
109. P1: [P1 nods slightly]
121. D1: [D1 turns to P1] ⁴**It's important if you do have a back problem to try and carry on as much as you can as normal, alright?**
122. P1: [P1 nods]

The first example of universalising is D1's use of the article *the* when referring to body parts *the spine* (L106) and *the bones* (L108) rather than particularising with personal pronouns e.g. *your spine* and *your bones*. This is also seen in his use of *get* in *they all get bruised* (L106) instead of *are* to say *they are all bruised*, when saying *that can* (L106) instead of *it may*, and then *this sort of problem* rather than *the pressure of your friend's knee*. D1 then again generalises when instructing P1 about recuperation *if you* (L121 – which in this context has been interpreted with *you* as synonymous with the non-specific pronoun *one*) and then by appealing to an externally held value *It's important* (L121) as opposed to saying *with your*, or *you should*. The alternative phrases suggested would have directed the utterances specifically to P1's situation rather than generalising.

The analysis now turns to the closing parts of the consultation and practices like summarising, the discussion of follow up and fittingly ends with leave taking. The examples highlight, once again, more informal features of positive politeness.

Extract 48 exemplifies the process of summarising coupled, once again, with inclusive humour. Here, D2 can be seen summarising a consultation that has addressed three different

issues - acne (L110), chest infection (L112), and renal function as affected by diabetes (L114-16). Earlier in the consultation D2 discovered that P10 had totally misunderstood the role of her *Ramipril*, for which she needed a repeat prescription, something which D2 had made light of at the time. Now she is adding 2 different antibiotics to the prescription. The summarising style used here is dominated by humour which P10 appears to share (P10's corresponding laughter is noted at L113 & 116). Once again, D2's strategy seems oriented toward making light of her actions; in this case the fact that she has to hand over 3 different prescriptions which P10 might find confusing, and she does so again using irony and teasing. This is achieved by ironically exaggerating her intonation and stress in a way comparable to the introduction of something groundbreaking and exciting when in actual fact it is quite mundane. She accompanies the irony with a teasing tone that invites the listener to share in the humour of her utterances (L112, 114 & 116), breaking into a grin as she comes to the end of the list (L116).

Extract 48 – Summarising (D2-P10)

110. D2: ... [D2 picks up prescription] So, oxytetracycline, [D2 looks at P10] that comes in a great big bottle so you'll *know* it's for your complexion because, it's, it's for you know, a month or two [P10 nodding] [D2 shaking head, hands first prescription to P10, signs second prescription] (1) OK.
111. P10: [P10 nods] OK, thank you [P10 looking at and pulling paperwork closer].
112. D2: OK. Co-amoxiclav, *for* your chest [D2 speaks triumphantly, and teasingly whilst signing and handing over second prescription].
113. P10: [P10 picks up first prescription] Thank you [P10 laughs, picking up folding and looking at second prescription].
114. D2: [D2 signs third prescription] *Ramipril* [D2 spoken triumphantly, and teasingly handing over prescription]
115. P10: °For me {my} kidneys.°
116. D2: For your kidneys! [P10 laughing, puts second prescription down nodding] Whatever it's going to do to them. [D2 glances at P10 grinning] [P10 still grinning nods, watches D2] And erm, appointment for the diabetic clinic [D2 spoken triumphantly, and teasingly whilst folding and handing over third prescription].

Next, is an example from D6 and P69, Extract 49. In this extract, D6's agreement to limited follow up for P69, i.e. that he does not have to see a doctor for each of his repeat prescriptions (L85-6), functions as a gift, attending to P69's wants and desires. Later, on the same matter, D6 also uses humour *Just to make sure you're not growing an extra head, or something* (L115-6), although this move does not appear as successful as D2s' above, since there is no evidence of P69 sharing in the joke. Indeed, P69 responds by seeking clarification of the conditions under which he would need to have his condition reviewed (L118).

Extract 49 – Follow up (D6-P69)

85. P69: ... The other thing is, do I have to keep coming in to see a doctor every time
86. D6: ²**No.**
87. P69: I want some more? No? I can get them on a repeat
88. D6: I think you can get them on repeat, I'll put them on a repeat for you.
89. P69: OK then. Fine.
90. D6: Erm, (2)
91. P69: [P69 looks at screen] It seems to be (.) wasting your time just to come in (.) to get a prescription. (1)
-
115. D6: OK the<n>. ³**Erm (1), I basically need, [D6 looks at P69] we can have a rule that we see you every sort of 3rd prescription. Just to make sure you're**
116. P69: [P69 nodding] Yeah ***
117. D6: not growing an extra head, or something [D6 looks at desk].
118. P69: [P69 gesturing] Unless I [D6 looks at P69] (1) because I did *go*

As the analysis for this theme draws to a close, leave-taking is considered more directly returning once again to P19. In Extract 50 D4 has just finished completing a swab request form for P19 – D4 has agreed to take a throat swab to rule out any microorganisms associated with poor hygiene. In the extract her use of the inclusive pronoun *we* (L163) to refer to their joint efforts to *ca[tch] the collection* portrays the two as collaborators. This notion of the two as collaborators is reinforced with another example of humour, this time collaborative in nature as both share in the laughter and joking about the need to avoid the pub in question (L163-170). The dialogue then moves on, once again to the question of follow up, revisiting one of the positive politeness outputs seen between, for example, D6 and P29 - reassurance. D4's assurances that P19's symptoms *will ... settle* (L183), that she *do[es]n't need to come back routinely* (L179) but is however welcome to *just come straight back* (L187) act as gifts of reassurance, optimism and cooperation attending to emotional and practical wants – that she need only attend when necessary. D4 closes the consultation with an invitation to agree with her plan *does that sound alright?* (L191).

Extract 50 – Leave taking: Humour & reassurance (D4-P19)

163. D4: and if you could just hand it in for me at the desk [P19 nods] on your way out we will hopefully have caught the collection this evening, [D4 laughs] [P19 smiles] so that's ideal [D4 continues completing swab request] (16) but maybe not in the same pubs tonight is that right? [D4 glances up at P19]

164. P19: [P19 looks at D4 with serious, probably mock, look on face] Oh absolutely, *yeah*, no way [P19 laughs loudly] and the other thing that occurred to me was I occasionally have a glass of iced [D4 looks at P19, smiling, whilst placing swab in sample bag] tap, tap [P19 points emphatically] water

[P19 talks again about the article, the perils of ice buckets and the benefits of bottled water whilst D4 completes the sample.]

179. D4: [D4 returns sample requests off screen] you don't need to come back routinely

180. P19: mmmm [P19 nodding]

181. D4: unless it's not settled

182. P19: OK [P19 looks at D4]

183. D4: erm, I very much think it will have settled

184. P19: yeah [P19 nodding]

185. D4: looking at it today

186. P19: yeah [P19 nodding]

187. D4: but any worries, just come straight back [D4 can just be seen looking at P19, nodding]

188. P19: lovely [P19 starts to turn away from D4 and starts walking out]

189. D4: and I'll have another look

190. P19: yes, yeah

191. D4: [D4 looks at screen] does that sound alright?

192. P19: *fine* thanks very much indeed

193. D4: [D4 looks at P19] OK

194. P19: bye

195. D4: bye

The final extract depicting leave taking finishes by once again highlighting humour and informality. P46's consultation did not yield the much needed diagnostic explanation for her pain. As a result, she cannot be signed off as being permanently unfit for work, something which P46 is keen to effect. Despite this she can be seen grinning in L127-8. In closing the consultation D5 addresses her by name. This is quite an unusual practice. Therefore, despite the fact that he uses formal address *Mrs P46* (L126), this attention to detail, this demonstration that he still remembers her by name, could be interpreted as a means of personalising the consultation and leave taking, suggesting a personal interest in her and

attending to her need to be noticed. This is further reinforced with the utterance *Nice to see you* (L128) which is also indicative of approval and followed by *take it easy* (L130) whose register indicates a desire to claim common ground.

Extract 51 – Leave taking: Humour & personalisation (D5-P46)

- | | |
|------|--|
| 125. | P46: ... [D5 looks at P46, passing prescription to her] OK |
| 126. | D5: OK <u>Mrs P46</u> |
| 127. | P46: [P46 taking prescription leans forward to stand up] <u>Thanks again</u> for your help [P46 giggles] |
| 128. | D5: [P46 grinning] [D5 reaches to shake P46's hand] Nice to see you. |
| 129. | P46: [P46 shakes D5's hand] alright [P46 stands up] |
| 130. | D5: [D5 grinning] take it easy |
| 131. | P46: [P46 looks ahead] OK |
| 132. | D5: [D5 nods] alright [D5 glances at screen] |
| 133. | P46: [P46 walks towards screen] <u>alright</u> |
| 134. | D5: [D5 looks at screen] <u>bye bye</u> |
| 135. | P46: then |

Positive politeness strategies promote solidarity and agreement. They orientate the listener toward feeling included, making collaboration and cooperation attractive prospects. This theme has shown that the use of positive politeness strategies were not limited to decision-making points but rather were features that could be utilised and found throughout the consultation. Whilst such strategies and their effects promote solidarity and collaboration, they also create an environment oriented toward cooperation and agreement (Edwards & Potter 1992; Holmes & Stubbe 2003), and have a persuasive power that speakers may or may not be aware of. They are strategies which occupy discursive *Space* and may inhibit patients from expressing dispreferred ideas.

In this type of environment, not responding cooperatively risks damaging the collaborative relationship and the associated feelings of solidarity, making it very difficult for the listener to

make dispreferred responses. Such moves also risk offending the speaker with subsequent loss of approval (for that linguistic move at least), damaging the aspect of positive face seeking such approval. In situations where one has little or no regard for the speaker this may not be problematic; however, if the speaker has presented themselves as appealing then the costs of potentially damaging the relationship are much higher.

The key question here is what effect did the GPs' use of positive politeness have? Positive politeness is an indirect means of exerting collaborative power to promote cooperation (Holmes & Stubbe 2003). In a culture where doctors have historically had a dominant, paternalistic decision-making role (e.g. Elwyn et al 1999; Mead & Bower 2000) and where eliciting ICE does not appear to be a routine part of practice, could the GPs' use of positive politeness have the effect of limiting the space available to patients to present alternative viewpoints? The theme *GPs' positive politeness: persuading throughout the consultation* highlights the possibility that GPs' use of positive politeness might create a persuasive atmosphere that may constrain certain types of patient participation.

GPs' imprecision replacing jargon

Having considered the use of positive politeness across the dataset as a whole the analysis now turns to the use of negative politeness strategies. *GPs' imprecision replacing jargon* is the first theme in the category of *Confusion*. This theme considers the way in which modification is used to replace jargon, with examples of the effects of doing so from the data.

There is a tension for the GP between the need to remain on-record in order to maximise linguistic effectiveness and to avoid offence by using jargon. The suggestion is made here that jargon has the potential to be offensive because putting listeners into a position where

they have to admit that their knowledge is inferior to that of the speaker risks face-loss. Furthermore, in such cases, if the patient does not understand and subsequently chooses not to admit this it might inhibit future relations. Avoiding the use of medical terminology that might be unfamiliar to patients and opting instead to use more vague lay descriptions was a means of managing such dilemmas for the GPs in this dataset, and indeed, the avoidance of medical jargon in consultations has been found elsewhere (Skelton et al 2002). However, as shall be demonstrated, this was not without its own problems, at times causing *Confusion*. The theme centres around the case of P4, but draws on other cases too (P29 & P58) in order to expand the scope of the analysis.

P4 is an 84 year old man of “white British” origin. He begins his consultation with D1 by sharing concerns about shoulder and arm pain, going on to request a repeat prescription and finally mentioning a rash on his back. It is the treatment for this latter problem that is examined here.

In this first scenario D1 has just finished examining P4 and presents his treatment decision - a prescription for *some cream* (L159, Extract 52). Naturally he will have to name the cream exactly on the prescription; however, he chooses to avoid such jargon when explaining the treatment to P4, using instead generalisable, non-specific terms.

Extract 52 – Imprecise terminology: Some cream (D1-P4)

P4 describes the history & associated symptoms whilst D1 examines the rash.

159. D1: ... **I'll give you some cream to put on it.**

Continued in Extract 54.

Conversely, in a consultation between D6-P28, when P28 was giving an account relating to medication, the expectations were very different. As can be seen in Extract 53, D6 expected P28 to be able to tell him the exact name of the medication being referred to (L140). D6's

enquiry could be said to be conventionally polite, in that its structure is that of a conventional enquiry. However, the argument thus far has been that GPs avoid the use of jargon in order to protect patients' face-needs, ergo, expecting them to reproduce such jargon is a highly face threatening act and from a politeness perspective therefore demands appropriate mitigation. Such mitigation is not seen here. This type of scenario was also seen with other GPs.

Extract 53 – Need for patient precision (D6-P28)

- | |
|---|
| 135. P28: ... I have had some tablets ... |
| 137. P28: That I used to have for me thumb ... |
| 140. D6: Yeah, what were they? [D6 looks down at paper patient notes] |

Returning to P4's prescription for *some cream*. As can be seen in Extract 54, P4 now seems concerned about the prospect of D1 prescribing *some cream ... aqueous* that he had had once before (L160). It seems that he would prefer to have the same one that he has had for some *patches* on his *legs* (L164) and which was very effective in *clear[ing] it ... up* (L166). He doesn't make a direct request to D1 for this latter cream, for example by requesting "Can I have ...", rather he begins indirectly with an account of previous events (L160), with D1 responding that *we'll step it up a bit* (L161). In making his indirect request, P4 does actually anticipate D1's need for the exact name of the cream that he is referring to and presents this at the beginning of his account (L160). However, naming the cream forces him into the face threatening situation of demonstrating his discomfort with pronouncing the unfamiliar name *aq, aqueous* (L160).

Extract 54 – Imprecise terminology: A different cream (D1-P4)

See Extract 52 for preceding dialogue.

160. P4: I, I had some cream, [D1 looks at screen] what is it aq<ueous>, aqueous [P4 struggles with the pronunciation]?

161. D1: Yes, erm, we'll step it up a bit.

162. P4: Yeah.

163. D1: We'll step it up a bit.

164. P4: See, I've got some cream for, for on me {my} legs, 'cos I have little patches come on me {my} legs sometimes, °and what, I don't know what the°

165. D1: you've got Betnovate-C for your legs.

166. P4: That's it, ah well now that's cleared, that cleared it *right* up,

169. D1: OK, [D1 looks at screen and types, gesturing in between] this is [P4 looks at D1] very similar in the sense that, in the other, the, [P4 leans on desk] the basic part of it, Betnovate, [P4 stands up adjusting trousers and t-shirt] is the same

170. P4: yeah

171. D1: it is Betnovate on its own (.) OK? [D1 turns to look at P4]

172. P4: yeah

D1's response *we'll step it up a bit* continues to rely on indirectness (L161). Despite this assurance, P4 continues with his account (L164) and is forced into the face threatening position of admitting that he *do[es]n't know what the* cream for his legs was called (L164). D1 gives an unmitigated, direct response *you've got Betnovate-C for your legs* (L166) which appears to be bald on record and devoid of any attention to face, but which does of course attends to P4's wants for cooperation and to be understood.

D1 then has to go on to explain that he intends to prescribe a different *Betnovate* cream (L169, 171). Although he is now using more specific terminology, *Betnovate* as opposed to *some cream*, he does not explain that the only difference between the two *Betnovate*

prescriptions is that the previous one, *Betnovate-C*, contained an antimicrobial agent.

Nevertheless, P4 does not express any concern with this (L172).

Extract 55 – Imprecise terminology: Brand names (D6-P29)

157. D6: Are you still taking the erm, pantoprazole [pantoprazole: proton pump inhibitor which inhibits production of gastric acid. Used in the management of gastric ulcers.] [D6 looks at P29] [P29 looks at D6] for the (.) [D6 points to own chest] oesophagus.
158. P29: [P29 shakes head, looks at desk] No doctor. I take erm, (.) erm [P29 sits down] (.), P<rotium>, Pro<tium>,
159. D6: Protium [Protium is the brand name for pantoprazole]?
160. P29: P<rotium>, [P29 holds up finger, looks at D6] Protium!
161. D6: [D6 nods, looks at peak flow meter] That's pantoprazole. [P29 looks at peak flow meter] [D6 leans forward with peak flow meter]
162. P29: That's it is it? Sorry. [P29 grins]
163. D6: That's the fancy name for it, yeah. ⌘<583445> [D6 gestures indicating that P29 should stand up] Er, can you stand up, and [P29 stands up] you know, [D6 looks at P29] have you used one of these before?

Another example, again with D6, exemplifies, once more, both of these issues. In Extract 55 D6 specifically asks whether or not P29 is still taking his *pantoprazole* (L157), referring to the drug by its generic name and not a lay description like “your indigestion tablets”. Once again we see the expectation in the enquiry that P29 should be familiar with the drug name. There is momentary confusion as P29 tries to explain that he is taking a different drug *Protium* (L158-60). It transpires that this is the brand name for pantoprazole and that the two are indeed talking about the same thing.

Extract 56 – Imprecise terminology: Inhalers (D2-P58)

28. D2: [D2 looks at P58] Do you erm (2), do you have a brown inhaler? [brown, red, white and orange inhalers contain steroids]
29. P58: No. I have a red, a blue and a green one, Serevent er, [P58 looks down] Serevent er, Flixotide {Flixatide}, no [D2 looks at screen] Serevent, [P58 glances at D2] salbutamol, and erm, Flixotide {Flixatide} [P58 looks at D2] (2).
30. D2: OK.
31. P58: [P58 looks at screen shaking head] I've never had a brown one.
32. D2: Yeah, OK. [D2 looks at P58 nodding] [P58 looks at D2] So the Flixatide is the same as the brown one,

A slightly different example can be seen in Extract 56 where D2 assumes, incorrectly, that P58 is unfamiliar with the name of her inhalers, simply asking whether or not P58 has *a brown inhaler* (L28). D2 wants to know whether or not P58 has an inhaler containing steroids, but this is not what she asks and in this case she could easily have been left misinformed by P58's answer. P58, no doubt unaware of the colour coding for inhalers, rightly replies *No* (L29). But we can see from her follow up to this that she does have a *red* one, and that she knows the name of the inhalers (L29). She does in actual fact have one containing a steroid, the red Flixatide (L32).

There is the risk then that *GPs' imprecision replacing jargon*, rather than putting patients at ease, can actually disempower them and cause *Confusion*. Whilst indirectness might protect certain aspects of face, it can also be problematic, since choosing not to particularise can cause confusion. If, for example, P4 had been told straight away that he was being prescribed Betnovate cream the dialogue between L160-L172 might not have been necessary, saving D1 time on a consultation that lasted just over 11 minutes. 3 of the scenarios presented here: P4, P28 and P29 demonstrate the expectation that patients be able to give specific details

regarding their medical history. However, if patients are never introduced to the necessary terminology how can they recount it?

Not having access to the same discourse as healthcare professionals has already been identified as a disadvantageous factor in the power differential between doctors and patients (Cheek 2004, previously discussed on p39). Explaining and introducing relevant specialist terms could help to reduce the asymmetry of patients' relationships with their healthcare providers.

GPs' hedging during decision-making

The final theme *GPs' hedging during decision-making* also considers findings across the dataset as a whole. This particular theme was identified by virtue of the frequency with which it occurred, a finding which, although previously identified in some socio-linguistic research (e.g. Aronsson & Sätterlund-Larsson 1987; Robertson et al 2011), appears to have been given little attention in the healthcare communication literature. Although, strictly speaking, it cannot therefore be classed as novel, it is included here for two reasons. Firstly, it is an integral component of the *Confusion* category here. Secondly, it functions as a means of presenting a transparent representation of the data by demonstrating the GPs' use of negative as well as positive politeness.

To explain further, two of the themes under the umbrella of *Space* highlighted the way in which the GPs' strategies were oriented toward positive face. However, during the coding phase it initially seemed that the GPs were predominantly oriented toward negative face, the reason being that there were a considerable number of lexical items coded as hedging devices. In particular, it was their normative use within the GPs' delivery of clinical decisions

throughout the dataset that stood out and from which this particular theme originated.

Although hedging has already been introduced in this chapter, the introduction was brief (p125). This section provides an opportunity to delve a little further, considering first some of the more familiar aspects of hedging, and then touching on some of its complexities.

Hedges have varying functions. The usage perhaps most well known is that of conveying uncertainty – the idea that one is not entirely sure of the precise accuracy of the utterance being made. Examples of such hedges can be seen in Extract 57 where D1 is talking to P1 about her prognosis. P1 has bruised the muscles in her back and D1 cannot be sure how long it will take for the pain to resolve. In L106 D1 uses *can* to express his uncertainty as to how many weeks the pain will last for, modifying his degree of commitment to his utterance.

Extract 57 – Hedging (D1-P1)

- | | |
|------|--|
| 106. | D1: ... ² and that can take several weeks to go away |
| 107. | P1: [nods slightly] |
| 108. | D1: so the pain may last for another week or so even. |

Hedges can, however, also function as mechanisms for politeness, occurring with particular frequency as a means of attending to negative face where they are a “primary and fundamental” means of “disarming” threat in routine interaction (Brown & Levinson 1987: 146). When used as such they function as *downtoners*, exploiting the notion of imprecision as a means of modifying an utterance’s illocutionary force. This in turn has the effect of minimising the appearance of any imposition on the listener (Holmes 1984; Brown & Levinson 1987: 145-72). They attend to face by on the one hand mitigating against any assumption that the listener shares the speaker’s viewpoint, whilst on the other emphasising the notion of cooperation (Brown & Levinson 1987: 164). Hedges are wide ranging. They are not limited to lexical items commonly used to convey uncertainty (like those referred to in

Extract 57), but rather include, for example, utterances used to mark topic changes (Brown & Levinson 1987: 145-172) and can equally constitute any lexical items that need not be uttered but which have the effect of reducing force (Holmes & Stubbe 2003: 36). To this end they can be used to convey certainty in a way that does not appear presumptuous or overbearing. They soften otherwise bald utterances, making commands or instructions less intrusive, attending to the listener's face by showing respect for their right not to be imposed upon.

It must be added though, that as previously mentioned (p125), hedges can also attend to positive as well as negative face. In the context of positive politeness, one sees hedges being used with a more direct emphasis on promoting solidarity and cooperation, largely through the use of strategies oriented toward avoiding disagreement (Brown & Levinson 1987: 116-17). In model examples they can be differentiated from negative hedges by the way in which their inclusion softens the idea of presumption whilst at the same time boosting the utterance's illocutionary force and directing the listener toward agreement with the speaker. Utterances oriented in this way typically contain intensifiers which boost the appeal of the speaker's point of view (Brown & Levinson 1987: 116). However, as will be demonstrated below, differentiation can be problematic.

As already indicated (p125), hedging devices are polypragmatic, capable of performing a range of functions not only in different contexts, but also simultaneously (Hyland 1996), as will be seen in the next case. To add to the interpretative dilemma, it is also recognised that their usage tends not to be pre-meditated (Brown & Levinson 1987: 85) – speakers may not even be conscious of their own intentions. The case then of P37 is used next to explore an example of clinical hedging and the dilemmas created by their polypragmatic nature.

P37 is an 8 year old “white British” girl who attends with a female adult (A37) who appears to be her mother. P37 has had a cold, but within the last 24 hours has also developed “agon[ising]” throat pain, difficulty swallowing and redness in her throat – the reasons for consulting. Both P37 and A37 have had these problems before. They are consulting with D7.

Extract 58 – Scene setting for Extract 59 (D7-A37)

11. A37: ... She's been full of cold, but, we can cope with that, [D7 nods] but now, she's, [D7 glances at A37] finding, it *very* hard to swallow [A37 looks at P37].
16. A37: [A37 looks at D7] I wanna just [D7 looks at A37] nip it in the bud if I can before (.)
22. A37: [A37 looks at D7] She had some Calpol [paracetamol suspension for children]

Extract 58 contextualises the decision presented in Extract 59. Whilst presenting the history, A37 explains that she is not concerned with the cold (L11); instead, in view of their previous experiences with throat pain and difficulty swallowing, she wants to *nip it in the bud ... before* (L16). She is not asking merely for a diagnosis, or advice; she wants something to resolve the symptoms over and above the painkiller (Calpol) that she is already using (L22). Since other painkillers can be purchased over the counter, without a doctor's prescription, it seems likely that she wants a prescription for antibiotics.

Extract 59 – Hedging treatment decisions (D7-P37)

37. D7: ... ⁴**probably worth us considering putting her on some antibiotics**, [A37 nods] just to clear that up (.) you know. [D7 shrugs] It's not gonna do much for the cold, [D7 looks at A37, points to nose] but at least [D7 nods]
38. A37: no, it'll ease that [A37 glances at P37]
39. D7: it'll help with the sore [D7 looks at P37] throat, yeah, probably [D7 smiles at P37] (1).

to be continued in Extract 60

Having examined P37's throat, D7 introduces the idea of *antibiotics* (L37). His utterance *probably worth us considering putting her on some antibiotics* (L37) is not framed as a

definitive decision, i.e. a proposal that he is wholly committed to. Rather, it looks like a suggestion, an idea which has been modified with the use of a number of hedging devices:

- probably* a Quality hedge indicating that D7 is not yet entirely sure if this would be the right course of action (Brown & Levinson 1987: 164)
- worth* an intensifier modifying the benefits of such actions (Brown & Levinson 1987: 147)
- considering* a Relevance hedge questioning the appropriateness of the action at this particular point in time (Brown & Levinson 1987: 169)

The idea that D7 is not wholly committed to the antibiotics is again reinforced at L39 with his use once again of *probably*. Why does D7 use these hedges? Is he presenting the antibiotics as one of a number of options? Is he concerned that A37 may object to the prescribing of antibiotics? Does he need to gather more information today before committing to this action? Is he proposing the antibiotics as an option for the future if the symptoms remain unresolved? Is he protecting himself from litigation by conveying the scientific notion that there is a degree of uncertainty with differential diagnoses (weighing the probability of one disease against another)? Or, is he merely using the hedges as downtoners? Each of these possibilities are now examined in turn.

Extract 60 – Evidence of uncertainty (D7-P37)

continued from Extract 59

40. A37: [A37 looks at P37] And the cold she can cope with, no problem
41. D7: yeah, you can cope [D7 looks at desk] with that, [P37 glances at D7] OK [D7 laughs]. [D7 looks towards P37 & A37] Is she allergic to any antibiotics [P37 looks at D7] (.) [D7 looks at screen] that you're
42. A37: she's not at all
43. D7: aware of? No. [P37 watches D7, swings leg, looks around] [D7 types] [P37 & A37 watch D7] (15) And you've still got enough Calpol [D7 glances at A37] to carry on with (.)?

D7 & A37 discuss Calpol and its merits.

53. [D7 hands prescription to A37]

Looking at the succeeding dialogue (Extract 60) there is no further evidence to support the idea that the hedges provide for the presentation of additional options, as D7 does not make any alternative treatment suggestions. Given the preceding analysis of A37's reason for attending (p214) it seems unlikely that she would have objected to the antibiotics. Her desire to *nip it in the bud* Extract 58 suggests a desire to obtain something other than Calpol (p214). D7 does not go on to explore the components of ICE any further or to enquire about A37's feelings towards antibiotics; instead, having established that P37 is not allergic to antibiotics (L41) he starts typing (L43). Whilst doing so he and A37 chat about Calpol, and then, without any further reference to the antibiotics, D7 hands over a prescription for them (L53). Turning then to the issue of clinical certainty, from a scientific perspective absolutes are rare, deductions being made instead with varying degrees of (un)certainly. This is particularly so in the case of differential diagnoses where diagnoses are made by weighing up the probability of one disease against another. Coupled with this, doctors today have to be increasingly mindful of the possibility of litigation if they are perceived as having made, for example, an erroneous diagnosis. D7's hedging could therefore have been driven by an uncertainty about the diagnosis and consequently the best treatment option, and/or a learned practice oriented towards protecting himself from any potential litigation. Another possibility is that the hedge

merely functioned as an unconscious politeness device, a downtoner to soften his utterance, making it less intrusive than an instruction or command.

So, what can be concluded from this? Although some of the possibilities presented seem to have been excluded, others still remain. D7's hedges may have been intended as deliberate lexical items to express uncertainty or as politeness strategies. As passive observers, not only are *we* unable to determine with certainty what D7 intended, *he* may not have known either since such means of expression form part of routinised language use. Patients face the same interpretative dilemma. Is the hedge just a means of expression, or is there some doubt about the treatment? Their commonplace nature may result in their passing unnoticed and unquestioned by the patient at the time of utterance. But, one can see how such strategies might lead to subsequent uncertainty for the patient.

Similarly problematic is D2's use of the metapragmatic particle *I think* (L21, Extract 61). This hedge could be intended as a means of expressing uncertainty and/or a politeness strategy. To further complicate matters this example could also be interpreted as a positive politeness strategy with *I think* functioning to boost the weightiness of the utterance by putting the force of the GP's expert and personal opinion behind it. Robertson et al (2011) have reported this means of constructing talk, one which replicates the thinking process, as a rhetorically powerful and persuasive device.

Extract 61 – Uncertainty hedges or persuasive devices (D2-P10)

2. P10: ... the last couple of months I just keep breaking out in spots
4. P10: and I wanna know what I can use,
5. D2: mmm, [D2 looks at P10]
6. P10: [P10 looks down, listing on fingers] I've tried Clearasil, TCP, I've left my make up off (2) erm, [D2 looks at screen, typing] and it just [P10 looks at D2] will not clear up,
13. D2: [D2 glances at P2 completing research paperwork, then screen] No, we've got to do something about it then haven't we really?
19. D2: Erm, right, OK. [P10 glances at screen] Erm have you ever been on erm [D2 looks at P10] oxytetracycline tablets, antibiotic tablets for your complexion?
20. P10: [P10 shakes head] No [P10 bemusedly].
21. D2: [D2 nods] **I think that's what you need**, [D2 speaks in a whisper as if addressing a child] erm,
22. P10: is it, is it a (.)
23. D2: [D2 nods] it's an antibiotic. And you take it...

Other examples of hedging during decision-making include:

- D1-P31: *I don't think you'll have fractured the coccyx*
- D4-P64's mother: *What I think would probably be sensible, OK is a couple of things. I think it would probably be reasonable to give her [A63 glances at P64, nodding] some antibiotics*
- D5-P21's mother: *He's, he's got a, a little bit of erm kind of, wax in his ear*
- D6-P70's mother: *Erm, it's probably just erm, er, [A70 nodding] you know a tummy bug that she's got.*
- D6-P28: *Can I [D6 gesturing] suggest you have a few anti-inflammatory, tablets*
- D7-P55: *I think we'll give you some of [P55 nodding] the Fusithalamic eye drops*
- D7-P39: *might be worth, taking two [instead of one of your painkillers] to see if that'll give a better response.*

Decision-making is a means of problem solving (Koester 2006). Expert advice is sought, for example, when the assurances and confidence needed are outside of the individuals' control or expertise. There is then an expectation of certainty about the advice sought. However, since bald, unmitigated utterances can appear highly face threatening, it is commonplace to use conventional indirectness as a means of mitigation. Hedges are a key component of such indirectness. They are devices which breach Grice's maxims (Grice 1989), whilst simultaneously promoting the Cooperative Principle (Grice 1975 cited in: Wardhaugh 2006: 287). There are a number of potential problems with their use in relation to clinical decision-making in the current context.

Since hedges not only form part of routinised language (Malmkjær 1991; Tsui 1994; Spiers 1998), but are also commonly used to convey several meanings at the same time (Hyland 1996) it is likely that the speakers themselves are unclear as to whether or not they intend to convey uncertainty or merely to mitigate their utterance. These factors apply to listeners' interpretations also. Hedges and hesitations make utterances sound as if the speaker is still constructing his/her thoughts, mitigating what might otherwise appear to be an order or instruction. This in turn can have an inclusive effect, promoting solidarity (positive politeness) (Robertson et al 2011). This collaborative effect has also been noted elsewhere, arising from the constraints which such politeness devices place on doctor-patient communication (Aronsson & Sätterlund-Larsson 1987). Hedges are a recognised mechanism for reducing the probability of disagreement. They encourage cooperation (Brown & Levinson 1987). From this perspective, one can see that they too have persuasive qualities.

With these factors in mind, it is possible that patients will respond with routinised, preferred responses without first giving them much, if any, forethought. Such responses may not reflect

their actual views on the matter and could therefore lead to subsequent feelings of dissatisfaction at a later date, particularly if reflecting on the uncertainty conveyed – since there is potential here for concerns to arise later on regarding the prospect of alternative scenarios.

GPs' hedging during decision-making highlights the persuasive power that negative politeness also has, and draws attention to the way in which such hedging can cause *Confusion*. There is then a challenge to find ways of softening directives without sacrificing clarity. This conundrum exemplifies the value of incorporating Linguistics into communication skills programmes: the data here indicates a reliance on conventional politeness to soften directives, an understanding of Brown & Levinson's (1987) *Face* would draw attention both to the multi-functional nature of hedges and therefore their potential to cause confusion, as well as to other ways of doing politeness.

CHAPTER SUMMARY

This chapter used an analysis of GPs' and patients' politeness strategies to identify themes relating to their participation in decision-making within the consultation. Overall, 8 themes were identified under the 3 key headings of *Space*, *Endorsement* and *Confusion*. A brief overview is given here.

Space

The category *Space* contained 4 themes relating to the way in which participants used politeness strategies to create and manage space for participation:

- *Patients' negative politeness: expressing dispreferred ideas*
The use of negative politeness when creating space to share dispreferred decisions indicated a discomfort with doing so.
- *Patients' lack of facework: expressing dispreferred ideas*
The absence of facework when sharing dispreferred decisions suggested an expectation of resistance.
- *GPs' positive politeness: persuading during decision-making*
The use of positive politeness in response to patients' reluctance to agree promoted a collaborative environment oriented toward cooperation.
- *GPs' positive politeness: persuading throughout the consultation*
Positive politeness was a dominant feature of GPs' discursive strategies reinforcing collaboration and cooperation.

Endorsement

The next category, *Endorsement* compared contrasting examples of GPs' feedback to decisions made by patients which ran counter to GP advice and contained 2 themes:

- *GPs' positive politeness: expressing agreement*
GPs' use of positive politeness when endorsing patient decisions conveyed strong agreement.
- *GPs' off record disagreement*
GPs' lack of reparative work and attention to face when responding to patients' decisions can be interpreted as implicit or off record disagreement, creating a barrier to patient participation.

Confusion

The final 2 themes identified areas of possible *Confusion* caused by the way in which decisions were modified:

- *GPs' imprecision replacing jargon*
Imprecision in relation to decision-making caused confusion.
- *GPs' hedging during decision-making*
Diagnostic hedging has the potential to cause similar confusion.

Together these findings highlight: the continued dominance of the GP in the consultation, the persuasive power of language, the level of threat faced by patients who have dispreferred ideas, and more detail regarding the way in which consultations seem to be oriented toward agreement. These findings will be further discussed in the next chapter.

CHAPTER 5 – DISCUSSION

INTRODUCTION TO CHAPTER 5

The findings here inform our understanding of the way in which facework can enhance or hinder patient participation in primary care consultations. Having identified that the consultations were typically oriented towards agreement and that this replicated previous findings (Houtkoop 1986; Heritage & Sefi 1992; Stivers 2005) the analysis of the use of politeness strategies to attend to face during decision-making turned to cases where patients instead were apparently reluctant to follow a recommended course of action. The themes subsequently identified in this analysis and previously summarised in Figure 3 are reconsidered below within the various Categories of *Space*, *Endorsement* and *Confusion*. There then follows a further, brief, discussion as to the relationship of these categories to the existing literature and their unique contribution to the field.

Space - Patients' Use of Politeness

The interpretative analysis opened with an exploration of the *Space* used by some of the patients to share dispreferred ideas, concerns, expectations and preferences which differed from clinical advice, and the role of politeness strategies within the associated dialogue. The analysis of such deviant cases began with examples of decisions that patients had made outside the consulting room and the way in which patients created space to make such contributions. The first patient, P2, showed a heavy reliance on negative politeness to

mitigate this face threatening act whereas P6 seemed to focus on protecting her own face-needs.

As already said, there is an expectation that the patients' right to consult will be upheld with the presentation of a legitimate claim (Parsons 1951; Heath 1992; Pilnick 1998; Heritage 2009). Adherence to this social norm in turn limits patient choices as to which aspect(s) of "face" they present (Robins & Wolf 1988; Spiers 1998). The use of negative politeness strategies here alongside the examples of absent facework indicate concern about the prospect of proffering dispreferred information and the way in which such decisions might be received, pointing toward a culture oriented toward agreement.

Patients' use of negative politeness is informative because of its association, amongst other things, with speakers who consider themselves to be of unequal status with fellow interactants (Brown & Levinson 1987; Spiers 1998; Holmes & Stubbe 2003). Such asymmetry not only adds to the potential level of face threat experienced by patients, but is also at odds with GPs' apparent attempts to create a more egalitarian relationship with their use of positive politeness. This use of negative politeness by patients also poses the risk that its associated indirectness could result in practitioners misinterpreting hedging strategies as a means of minimising the importance of their utterances (Spiers 1998). As a result, comments that are of high importance to the patient but which also constitute a high level of threat might inadvertently be dismissed as irrelevant.

Having identified ways in which negative politeness was used to manage Space the data were revisited to explore patients' use of positive politeness for this purpose. There was little evidence of positive politeness being used for this objective. The limited examples that were

found were either ambiguous in their orientation or seemed to centre around the use of small talk. From a politeness perspective, small talk, or narrative (Sacks 1974 cited in: Heritage 2009), functions as a means of increasing the likelihood of subordinates obtaining listener cooperation (Brown & Levinson 1987; Holmes & Stubbe 2003). Its use by patients has also been observed to function as a device for maintaining a degree of control (Sacks 1974 cited in: Heritage 2009) and a means of legitimising the patient's need for attention (Bliesener & Siegrist 1981). There is the suggestion then that encouraging patients' small talk may facilitate increased participation. The challenge of incorporating this into practice whilst maintaining strict time schedules will be revisited later.

Space - GPs' Use of Positive Politeness

The case of P29 focussed on what happened to the *Space* created by the patient to share what appeared to be a dispreferred idea. The findings highlighted how positive politeness could be used to re-occupy the space created for patient participation, forming a collaborative environment in which to make decisions. As a result of this finding, the use of positive politeness strategies by GPs was then explored more generally within the data. The advantages and disadvantages of the collaborative effects of positive politeness are now discussed.

For doctors to use mitigating strategies in the form of positive politeness to promote egalitarian relations and to portray themselves as friendly, caring and considerate, as opposed to what Fairclough, for example, described as "oppressive" strategies (1995 cited in Holmes & Stubbe 2003: 5) seems to be a judicious way of promoting patient participation. Indeed, given positive politeness' orientation toward the portrayal of self as appealing and the need to be approved of, it must surely be an important component of rapport building, which in turn is

an essential aspect of GPs' interpersonal skills (RCGP 2010a). Indeed, looking at the feedback published on the GMC's website, from GPs who contributed to the recent Good Medical Practice (GMP) review, some of the characteristics reported are ones which closely align with strategies attending to positive face e.g. being "kind", "involv[ing] the patient, empathis[ing] and acting as a "companion" (GMC 2012).

Examining the role of positive politeness strategies within decision-making reveals ways in which the collaborative nature of such strategies could actually inhibit patient involvement by fostering a desire to please and thereby the desire to proffer preferred responses, increasing the face threat associated with dispreferred responses. Thus, whilst the characteristics listed above in the GMP review (GMC 2012) might seem to be straightforward and admirable markers of good practice, findings under this theme suggest that the situation may need more balanced consideration. This is particularly pertinent when considering, for example, the recommendations of Robins & Wolf's (1988) politeness research. They too concluded that "mutual cooperation" (Robins & Wolf 1988: 219) can be promoted by GPs' use of positive politeness strategies. However, the research here suggests that their conclusion that "mutual cooperation" can be equated with "mutual participation" (Robins & Wolf 1988: 220) may be problematic, particularly in cases where patients' preferences differ from those of their GPs; a culture orientated towards cooperation and agreement may actually inhibit patient participation.

To elaborate, in the first instance, in the example of P29, D6's use of positive politeness appeared to control the conversation, limiting the dialogue to the confines of the dominant mode of knowledge. Such a strategy reinforces the notion of a culture where the GP holds discursive control, a characteristic that potentially inhibits patients from volunteering ideas,

concerns, expectations and preferences that differ from those of the GP (Robertson 2004). Secondly, positive politeness' concern with fostering close relations and thereby cooperation (Holmes & Stubbe 2003) creates an environment where the appeal of the speaker inclines the listener toward maintaining harmonious relations. To offer a dispreferred response to such a person, particularly someone offering to meet one's needs would be an act of even greater face threat. Furthermore, compliance with expert advice can be seen as a necessary means of justifying the decision to seek professional help (Parsons 1951; Heath 1992; Pilnick 1998; Heritage 2009) and is believed by some to be necessary for the maintenance of cooperative relations and thereby access to convenient and timely healthcare (Lester et al 2006). These mounting factors add to the conditioning during early language acquisition and socialisation to offer preferred responses (Pomerantz 1978; Pomerantz 1984; Malmkjær 1991; Ervin-Tripp 1976: 52 cited in: Tsui 1994; Spiers 1998).

On this basis, any patient who, unbeknown to the GP is reluctant to agree, has to contend with a significant level of face threat in order to express alternative preferences. The uncooperative nature of dispreferred responses threatens face (Goffman 1967), breaching the most basic tenets of Grice's Cooperative Principle (1975) as well as Brown & Levinson's (1987) principles of positive politeness – the need to be complimentary and gracious to others and to meet their wants. Whereas, adhering to social norms by behaving in ways deemed cooperative promotes social relations and the success of future social encounters.

Positive politeness engenders cooperation and collaboration. When used by experts and those in positions of authority such strategies have the effect exerting collaborative power (Spencer-Oatey 2000b; Holmes & Stubbe 2003). The use of positive politeness in consultations has the potential to create an environment oriented toward agreement, inhibiting patient participation

in the absence of space for participation being explicitly offered. This research therefore not only supports previous evidence of health encounters being oriented towards agreement (Houtkoop 1986; Heritage & Sefi 1992; Stivers 2005), but also strengthens it by highlighting specific linguistic strategies that produce this orientation towards agreement, and that can be found throughout the consultation. This is further reinforced by the nature of the data which having been collected in primary care entailed a broader spectrum of encounters than the afore-mentioned studies (Stivers' (2005) analysis being limited to antibiotic prescribing, Heritage & Sefi's (1992) to health visitors' interactions with first time mothers and Houtkoop's (1986) to the process of summarising).

In the same way that directive, paternalistic styles of consulting have been recognised as fostering a passive style of consultation that do not encourage patient participation (Elwyn et al 1999), the potential for positive politeness strategies to inhibit dispreferred ideas, concerns and expectations being shared also needs to be understood. This will be discussed further in "Clinical Applications to Practice and Training".

Endorsement

The second category, *Endorsement*, groups together themes concerned with the responses received by patients making dispreferred decisions by comparing and contrasting the cases of P2 and P6, both of whom were seen by D1. In P2's case it emerged that his decision was in actual fact in keeping with clinical guidelines and in response, D1 was observed using positive politeness to reassure him and to redress any damage to face. However, in contrast, P6's dispreferred decision did not fit clinical guidelines and was met with a response from D1 that could not be said to attend to positive or negative face, or to demonstrate any reparative work.

One of the basic tenets of Charles et al's (1997) concept of SDM is that patients' decisions should be respected whatever they are. This emphasis on respecting patients' views, irrespective of whether or not the doctor agrees with them, can also be found in the GMC's guide to *Good Medical Practice*:

"You must treat your patients with respect whatever their life choices and beliefs."

(GMC 2006: 10)

Charles et al (1997) go on to explain that even when viewpoints differ, one can still reach a shared decision by endorsing the decision made. Although D1 accepted P6's decision and did not explicitly tell her that he disagreed with her, he did not say anything that demonstrated respect for it or endorsed it.

D1 was not overtly or explicitly rude, aggressive or abusive, but was he *impolite*? Within politeness theory, impoliteness has been described as behaviour that is face-aggravating (Bousfield & Locher 2008; Culpeper 2009) and as failure to "utilise politeness strategies where they would be expected" with the effect that "the utterance can only be plausibly interpreted as intentionally and negatively confrontational" (Lakoff 1989:103, cited in Culpeper 2009). By not commending the positive aspects of P6's behaviour or knowledge, D1's orientation could be interpreted as face-aggravating, as could the absence of the type of reparative facework seen in the case of P2, an omission whose effects would have been exacerbated by the fact that this was a particularly face threatening situation. This face threat would have been further heightened by the linguistic challenge posed by the need to frame and construct an argument in response to D1's indirect, veiled disagreement. D1's response did not demonstrate support for the fact that individuals' personal values and priorities may

weight the pros and cons of treatment outcomes differently to those of their healthcare professionals.

This is an example of how attitudes can still be detected even when not explicitly expressed. Although D1 displayed some model communication skills, his disagreement with P6's decision was still perceptible. Not demonstrating any attempt to view the situation from her perspective, opting instead to reiterate his own viewpoint, reinforced his position as expert. Once again these findings point towards a culture oriented toward agreement. Responses which reinforce the fear that healthcare professionals may not be sympathetic to alternative viewpoints will only perpetuate patient anxiety about participation.

Confusion

The final category, *Confusion*, contains themes which explored the high incidence of hedging and indirectness, negative politeness strategies, used by the GPs at clinical decision-making points. The discussion begins by considering doctors' use of *jargon*. Skelton & Hobbs' (1999) finding that there was little jargon in primary care consultations left them asking why patients do not understand doctors' explanations. From the data analysed here, it would seem that points which might once have been occupied by jargon now contain indirect outputs as a means of modifying the propositions being made.

Jargon has its advantages and disadvantages. On the one hand using clinical terms in the consultation can exclude patients (Gwyn & Elwyn 1999), reinforcing the GP's expert position and thereby the hierarchical differences between them, particularly if the terms are not explained. However, use of specialist terms can also have an inclusive effect by making patients feel included in the professional discourse (Gwyn & Elwyn 1999) and affording them

a better platform from which to share the expertise gained from living with the condition, and sharing more equally in the dialogue (Chew-Graham et al 2008). The inclusion then of such terms, with appropriate explanations, would not only reduce the risk of misunderstandings, like those seen here when jargon was replaced with hedging and indirectness, but would also provide patients with the vocabulary needed to impart details about their healthcare more accurately to other practitioners.

Hedging diagnostic decisions is also problematic because of its potential both to limit patient participation, and to cause confusion. Generally speaking, there was little indication as to whether or not the hedges used by GPs during decision-making were intended to indicate clinical uncertainty, or merely included as a function of polite speech - either as downtoners to soften an otherwise bald utterance or as mitigation aimed at promoting agreement and thereby solidarity and cooperation. Hedges, however interpreted, can not only cause confusion (Hyland 1996), they are also essentially oriented towards promoting agreement and can function as a compelling means of persuasion (Brown & Levinson 1987; Robertson et al 2011). Given that interpreting hedges during data analysis was problematic for the researcher, patients are just as likely to experience problems, if not more so as lay persons, although they are likely to be unaware of such dilemmas. Their usage in relation to clinical decision-making is potentially problematic and may further inhibit the expression of alternative viewpoints.

What does the concept of *Space*, as used within this thesis contribute? The notion of discursive space is well described within the linguistic literature, so in this sense reference to the space needed for dialogic intercourse is not new. However, the notion of *Space* developed here is new since it is not intended as a general reference to patients' contributions, or indeed

to the creation, or apparent creation, of opportunities for patients to participate. Rather, it refers here to *the right moment*, drawing attention to the ways in which patients participated by using what they perceived at the time to be the most appropriate opportunity to present their own, potentially dispreferred ideas. Three different types of participatory opportunity were identified in the results presented here – P2’s insertion in response to a HAY?-type elicitation (Coupland et al 1992), P29’s interruption in response to proposed treatment, and P6’s “by the way” (Middleton et al 2006 cited in: Collins et al 2007) type add-on at what had appeared to be the end of the consultation. This concept of *Space* encompasses the idea that contributions like the expression of dispreferred ideas are very hard to make; that by their very nature, there is not an obvious point in the consultation at which to share them. Although it might be said that patients are given the opportunity to set the agenda in response to a HAY?-type elicitation (Coupland et al 1992), such enquiries usually result in the presentation of patients’ symptoms, not dispreferred ideas. Patients may then be left with the dilemma that whilst this does not feel like “the right moment” it may well be the only moment that does not require either an unwelcome interruption or an unwelcome topic shift. The concept of *Space* then uses politeness theory in a new and novel way to add to our understanding of the way in which the management of cooperative norms can be problematic in such asymmetrical relationships, highlighting both the challenges inherent in finding *the right moment* to participate, and also the daunting nature of such a move, a move which may prove too intimidating for the speaker to even make in the first place.

As a concept (Keirns & Goold 2009) and specific term (Charles et al 1997) used in relation to SDM, *Endorsement* is clearly not new. However, in these examples (Charles et al 1997; Keirns & Goold 2009) the concept is referred to specifically in relation to the management of disagreement. Having considered here the management of disagreement from a politeness

perspective and more specifically in relation to face, one can see that endorsement and the associated management of face-needs has an important role throughout the consultation, that it can be pivotal in the development of a trusting relationship with the practitioner and thereby promoting patient participation. The practitioner, when faced with the dilemma of supporting a patient's dispreferred preference can look for a range of ways and opportunities to express such things as approval and empathy, to be complimentary, to bolster the patient's ego, show cooperation and to convey common ground. Thus, a new meaning is brought here to the concept of *Endorsement*, one which stems from the perspective of politeness theory and facework. Here, *Endorsement* refers to the meeting of positive face needs: to be understood, to have one's wants met and to be seen as appealing.

There are many ways of doing indirectness, not least of which is hedging. The effects of hedging in the consultation have been discussed by others, highlighting how patients' hedging can be misleading (Spiers 1998) and how practitioners' usage can serve to boost compliance by softening directives (Aronsson & Sätterlund-Larsson 1987; Brown & Levinson 1987; Robertson et al 2011). However, the way in which this research highlights the potential for indirectness to cause confusion does seem to be a new and novel finding, one which does not seem to have been highlighted in the politeness literature to date. This finding also contributes to the literature on patient participation by identifying the way in which GPs' indirectness can create a linguistic challenge for patients as they attempt to manage the tension between adhering to cooperative norms versus risking a breach by offering a dispreferred contribution.

Relationship with Existing Literature

Papers relating to the findings here have frequently been referred to throughout the preceding text. Nevertheless, it is worth drawing attention once again to those findings here which are echoed in the existing literature. Examples of these include the unreliability of trying to differentiate minimal responses from BCs (Aronsson & Sätterlund-Larsson 1987; Sandvik et al 2002), decision-making between doctors and patients being oriented toward patient agreement with doctors' recommendations (Houtkoop 1986; Heritage & Sefi 1992; Stivers 2005; Robertson et al 2011), GPs' use of hedging and indirectness as problematic (Aronsson & Sätterlund-Larsson 1987; Robertson et al 2011), the role of positive politeness strategies such as shared remembering as a means of directing the listener toward agreement (Edwards & Potter 1992), patients' need to legitimise requests/reasons as "doctorable" (Heritage 2009: 10) and the minimal use of jargon by GPs (Skelton & Hobbs 1999).

Mainstream literature and tools in clinical communication skills such as the Calgary-Cambridge Guide (Silverman et al 1998) assess processes, evaluating communication skills on the basis of certain tasks having been performed and the achievement of specific objectives. The difficulty with this kind of process-outcome evaluation is that it risks encouraging a homogenised approach towards patients, rather than allowing for the fact that not all patients are comfortable with the same level of involvement, and, it inevitably reinforces the GPs' position as driver.

This thesis argues that a study of the politeness literature offers real insights into the conduct of GP-patient interaction, and that these insights invite a reconsideration of how to achieve egalitarian, cooperative consultations. In essence, there is a potential tension between the effects of the GPs' attention to face and the patient's desire to please that such strategies may

engender. Crudely put, the switch from the doctor-as-authority figure to the doctor-as-participant figure may to some extent mean only that instead of the patient thinking “The doctor’s such an important person I’m afraid to disagree”, to “The doctor’s such a nice person I don’t want to disagree”. This line of argument can be set out with reference to Brown & Levinson’s (1987) exposition of facework and contextualised within it, as has been attempted here through a subtle and careful analysis of facework and the possible effects of language use on others. The findings have thought provoking implications for our understanding of patient-centeredness. Relying on a model that emphasises things such as egalitarianism and the fostering of cooperative relations only takes us part of the way toward increasing patient participation. The tension between showing respect for patients’ choices, whatever they are, and the remit to promote best practice can be bridged by showing attention to face.

Strengths and Limitations

There are a number of frameworks already available for the analysis of doctor-patient communication and patient participation (e.g. Roter & Larson 2002; Edwards et al 2003; Buckingham & Adams 2006). However, none of the existing tools include a framework for the analysis of Brown & Levinson’s (1987) politeness theory; therefore an alternative approach had to be taken. The strengths and limitations of the methods used are explored here.

Representativeness of the study sample

Recruitment sought to be as inclusive as possible, within the constraints of the individuals’ ability to give informed, considered consent (anyone meeting the inclusion criteria was invited to join). However, the participants were inevitably self-selecting and as Champion et al

(1992) point out, the fact that individuals had to choose to participate in the research could mean that the results here are skewed and not representative of a wider population. We do not know what factors influenced patients in their decision to participate or whether or not this in any way biased the results. We do know, however, that patients with emotional problems did not automatically exclude themselves from the study (e.g. P6, P24, P30, P31 and P47) and this supports Champion et al's (1992) findings. We know very little about what motivated doctors to participate or to decline in this study. In general, it has been suggested that 41% of GPs have no interest in research, and that lack of time and lack of funding are two major barriers (Jowett et al 2000). (Of course, these findings too are gathered from a self-selecting group of GPs). The group represented here are particularly select, all being from GP training practices, forming a select group rather than representing a broad spectrum of GPs.

Bias

It is important to note that there are a number of ways in which the data collected and its interpretation could have been biased. Firstly, the GPs may have modified their consulting styles because of the aims of the original research (p110). Although these were not explicitly stated in the written information given to GPs (Appendix V), the title of the original Study 1, "Patient Participation Strategies in GP Consultations" clearly echoes the aims of the present research. Even if the GPs did not read this information closely, or did not remember doing so, they may well have discussed the study aims with the researchers. This, combined with their experience as members of a training practice, might have resulted in a dataset with many exemplary examples of ways in which to elicit patient participation and shared decision making, examples which might not have been typical of GP practice generally. As has been demonstrated, this did not, in actual fact, appear to be the case. However, the particular focus on the use of positive politeness arising from the data that was collected may have been

skewed by the GPs' concerns with demonstrating rapport as per MRCGP requirements (RCGP 2010a). It may be that positive politeness is not usually used to the same extent in wider GP samples.

Turning next to the data analysis itself, the interpretative method used has the potential to produce skewed findings due to researcher bias (Layton 1997; Bryman 2001). Being conducted by a nurse, not a GP, and by a lone researcher rather than a team means that the analysis cannot be said to accurately replicate the GP's view of the consultation (or that of the patient's) and that there may have been personal bias from experience of previous doctor-patient encounters that clouded the researcher's objectivity. An important means of identifying any such bias is to share one's interpretations and conclusions with others. In this case the research process was supervised by two other academics, a linguist and a GP and the findings discussed and critiqued during regular supervision meetings. The interpretations have also been considered by a number of other academics with varying backgrounds (another linguist, an expert in the use of qualitative methodologies and a nurse lecturer) and presented at linguistic conferences. Notably, these opportunities for debate resulted in reconsideration of the way in which to label and characterise the themes relating to P6, informing the analysis and interpretations. In addition to previously mentioned measures to limit such bias (the use of literature to support the interpretations made, as well as the use of assorted examples from the extracts and consultations to substantiate the author's conclusions) care was taken during the analysis to consider whether or not alternative interpretations and explanations were available and whether or not they could be substantiated.

Clearly, experience of practising as a trained GP would have brought additional insights to the analysis. There could, for example, have been certain nuances used by the GPs for particular

purposes that have not been identified here or particular guidelines and policies framing the GPs' practice that have not been given consideration. Concerns in this area were, to an extent, offset by the fact that there was a GP advisor who readily offered insights to the data and critiques of the interpretative analysis. There is of course, also the argument that objectivity can be inhibited if one is too close to the data and/or its participants. New insights can be missed by inadvertently glossing actions as routinised, everyday occurrences that can only be performed in a particular way. Instead, the researcher had experience as a registered nurse and patient, bringing to the analysis both an understanding of many of the medical aspects of the data and the capacity to reflect on experiences both as a healthcare provider interacting with patients and as a patient consulting with a GP. This meant, for example, that the idea of having to adjust thyroxine dosages was familiar (e.g. the case of P2). Also, experiences as a patient meant that it was possible to reflect on utterances and consider how I myself might have interpreted them in such a situation, and how such utterances might have made me feel.

Doctor-patient relationship

Context is an important aspect of interpretative analysis and it has been argued that knowledge about any existing relationship between GP and patient is necessary for such analysis (Hak 1999). However, the data collected here contained little, if any, information about the ongoing relationship between the doctors and their patients. It would have been very helpful to have known to what extent the GPs had in the past tried to elicit these patients' ICE and to involve them in choosing between different options. Knowledge of prior consultations may also have brought insights into what GPs had previously said on the matters discussed here, contributions that the patients may have forgotten and vice versa. Such insights though would still have had their limitations since even if it had been known,

for example, that this was P99's fourth visit about his knee or the first time that P98 and D11 had met, we still would not know, without asking, how this relationship affected the way in which the interactants felt toward each other and/or how this in turn affected their communication style.

Alternative methodologies

The methods used here relied upon subjective interpretation of the data, albeit well substantiated with theoretical argument. We do not know how the participants themselves intended their various utterances to be interpreted, or what interpretations they themselves made when listening to each other. Alternative methods would have given participants the opportunity to discuss their consultations, like *think aloud* methods (Van Den Haak et al 2003; Bugge & Jones 2007) also known as: free recall (Adams et al 2008), patient comments (Arborelius et al 1992), explicit commentary (Thomas 1995) and post consultation interviews (Aronsson & Sätterlund-Larsson 1987; Sheehan et al 2005). Such studies though, have their limitations too, both in terms of practicable design and reliability. For example, inviting participants (both GPs and patients) to discuss their consultations in private, straight after would have greatly imposed upon the participants' time and also GP schedules, further reducing recruitment (e.g. 22 out of 68 GPs originally volunteered to participate in the collection of data for this study, the number reducing to around 12 after the requirement that recording be limited to dedicated sessions).

It is also important to be aware that the reliability of such data cannot be assumed. Although such reflections might add to the richness of data collected, it is known that the accuracy of recall is limited (e.g. Ward & Sanson-Fisher 1996), more so if interviews are not conducted immediately. Re-playing recorded material might help, but this too is problematic. There are

logistical problems e.g. the practicalities of access to equipment to replay recorded material whilst at the same time needing equipment to record the next consultation. And there are still issues with reliability because responses during discourse are immediate and may occur subconsciously (e.g. Brown & Levinson 1987; Ervin-Tripp 1976 cited in: Tsui 1994; Malmkjær 1991; Thomas 1995; Hyland 1996; Spiers 1998), whereas the recollections themselves may only occur as a result of prompting and may be a revision of the original reactions, and, of course as Peräkylä & Ruusuvuori (2007) point out, such methods only reveal what the interviewee decides to tell us.

Despite these limitations, however, the example of P6 illustrates just one of the ways in which such data can enrich analysis. In the case of P29 the conclusion was drawn that it was unclear as to whether or not he had left satisfied with the decision to have a short course of steroids, there being evidence to support either conclusion. In contrast, without access to P6's brief, post consultation feedback (that she had been most dissatisfied with the consultation and was therefore really glad that it would be used to inform future training) it would not have been possible to identify the impact of D1's lack of attention to positive face and off record disagreement. This in itself indicates a potential alternative to some of the above suggestions, showing how even brief, unguided feedback can be exceptionally powerful.

As already highlighted, the interpretivist assumption of qualitative methodologies is that there is no single, objective truth, rather there exist a range of constructed truths (Berger & Luckmann 1967). An interpretivist enquiry does not rely on intuition alone, but is backed up by additional evidence from within the data in combination with accepted theoretical insights (Thomas 1995). Adopting a qualitative approach, as Spiers (1998) points out, enables one to

identify, explore and manage the complexity of conversational interactions. CA is a powerful tool for revealing insights that can be applied to real world practice.

Clinical Applications to Practice and Training

Getting communication wrong can dehumanise, depersonalise and ignore or discount the needs of the client (Spiers 1998). Encouraging patient participation is a means of reducing the risk of miscommunication. However, despite a range of recommendations being available to help practitioners phrase invitations to participate, doing so continues to be problematic (Neighbour 1987; Robins & Wolf 1988; Elwyn et al 1999; Gwyn & Elwyn 1999; McWilliam et al 2000; Stevenson et al 2000; Cheek 2004; Collins et al 2005; Kurtz et al 2005; Richards 2005 cited in: Gafaranga & Britten 2007; Jones & Collins 2007; RCGP 2009). Raising healthcare professionals' awareness of the interactional dynamics within consultations is likely an important way forward (Richards 2005 cited in: Gafaranga & Britten 2007; Jones & Collins 2007).

As an essential component of good communication (Brown & Levinson 1987), introducing the notion of facework to healthcare practitioners as a framework for reflection and training could provide a valuable tool with which to make some of the nuances of language and their impact clearer and more tangible. It is arguable that the difficulties healthcare professionals face when they learn about, talk about or reflect on communication is that they have limited resources available to them. They lack a vocabulary to reflect with, and a structure to hang their perceptions on. Discussion about a doctor's eye-contact or body language can only take you so far.

An introduction into the way in which the collegiality of positive politeness can increase the appeal of one's propositions, enticing cooperation and orientating the consultation to agreement rather than participation, might further elucidate the persuasive power of language and its potentially coercive effects. Regarding negative politeness, since the use of mechanisms such as conventional indirectness and hedging are ingrained into everyday speech, making practitioners aware of the potential confusion that such strategies can cause might help to minimise any negative effects. Training could also highlight the benefits of including and explaining technical terms so that patients are equipped with the necessary terminology to convey essential information to others.

Alongside this, an awareness that threatening information might be framed so tentatively that its indirectness can mask it could better equip practitioners to identify and probe apparently inconsequential comments. Understanding the notion of face threat may also serve to make the hierarchical nature of the doctor-patient relationship more perceptible, thereby affording practitioners the opportunity to redirect their discursive style so as to help create opportunities for patients to participate more actively. In this same vein, such insights into patients' face threat might alert practitioners to the challenges faced by patients fearing reprisal, if they fail to adhere to the socially accepted norm of agreement.

Facework also provides tools for managing the type of disagreement seen between D1 and P6. One idea to explore is the potential for practitioners who tend to work within a positive politeness framework that encourages collegiality, to draw on this by sharing something of themselves and simply expressing that they have concerns e.g. "I'm worried that your decision will bring you to harm and that conflicts with my duties as a doctor, so I'm not sure how best to support you." Such an utterance is non-judgmental and an indirect and yet

unambiguous means of inviting the patient to help the GP manage his or her dilemmas. The notion of SDM (Charles et al 1997) and GMC guidelines (GMC 2006) recognise that there will be occasions where GPs will have to accept that patients' priorities conflict with best medical practice. One way of managing this might be to ensure that the patient has been given all the information they need, in a way that they can understand (GMC 2006) and then check whether or not the patient has fully grasped the implications of their decision by exploring how they plan to manage any negative consequences.

Facework provides a framework within which to see how dissatisfaction can be caused despite the avoidance of explicitly offensive utterances, and how the absence of facework can be cause dissatisfaction. Not verbalising support points to unspoken disagreement, maybe even disapproval. This veiled approach makes any challenge difficult for the listener, requiring greater effort from them to construct a response – a significant challenge when already managing raised levels of face threat. Patients who fear the disapproval that can be associated with disagreement are less likely to be honest about their intentions to their GPs and may even defer attending in future.

GPs already work under conflicting pressures. The recommendations here are not intended to add to these. They are intended to support GPs in the quest to offer patients the best service by developing communication skills that could lead to a more positive doctor-patient experience, echoing current policy (DoH 2010). Including the insights described above in communication training might bring greater clarity and understanding as to how one's utterances can influence face threat and thereby patient participation. Subtle changes in communication style might further promote concordance and increase patient satisfaction.

Recommendations for Future Research

There is much scope here for further research. There are no reports in the literature that any of the applications recommended above have been incorporated into healthcare practitioners' communications skills training elsewhere. Exploration in this area and implementation as part of a well designed trial would allow for more specific recommendations to be made. Studies collecting patients' feedback would also be useful, and would add some validity to the findings here, despite the previously described limitations.

Another area for investigation could be that of the relationship between positive politeness and rapport building. As already indicated, developing rapport is a component of the MRCGP assessment (RCGP 2010a). Examining what is meant by rapport, its relationship with positive politeness and how it is taught would provide an opportunity to see what similar theoretical frameworks could bring to analysis and training e.g. rapport management (Spencer-Oatey 2000a) and Communication Accommodation Theory (Giles et al 1991, cited in: Holmes & Stubbe 2003). A closer inspection of other politeness theorists' work might also be useful in order to see if other approaches might better consider some of the issues raised here. An important area in which these findings can then be applied would be the exploration of training needs for international medical graduates (IMGs).

IMGs face a variety of challenges over and above those faced by UK educated doctors (e.g. see Slowther et al 2009 for a summary of issues). Within the West Midlands for example, 67% (n = 58/86) of doctors referred to a specialist support unit in 2009-10 (ISU, give website) were International Medical Graduates (Skelton & Whetstone 2012), though as the authors remark, this concept is itself complex. Common to these doctors is the fact that they do not share the same communicative competence as native English speakers. Since the evidence

indicates that these doctors do not lack clinical competence or the ability to elicit adequate information for effective diagnoses, it is therefore thought that much of the associated concerns stem from difficulty with other, more subtle aspects of communication i.e. the pragmatic use of language. Further research in this area focussing on the ability to manage facework flexibly, i.e. to recognise the necessary variation in individual needs for attention to positive and negative face has the potential to be most instructive.

Issues around patient participation are at the heart of the Francis report (Francis 2013). Having demonstrated here that patients may find difficulty in creating space at what they perceive to be the right moment to present dispreferred ideas there is a need to explore how practitioners could facilitate such contributions. Research focussing on this would begin by revisiting the literature in order to explore further whether or not this question has been considered by others and in particular pragmatic theory regarding the locutionary effect of different forms of enquiry. For example in what way might asking “What would you like to discuss?” instead of “How are you?” generate different responses? These findings could then be used to design an interventional study.

A new and exciting avenue of research is now afforded by the proposed GMP which suggests that doctors should be “polite” (GMC 2012: 3, 13) to their patients. There are a number of research opportunities here: exploring with the GMC the origins of this particular proposal; the development of further guidance as to what is meant by being polite, i.e. exploring to what extent, if any, this edict extends beyond the realms of conventional politeness; and, training in managing both the requirement to develop rapport whilst being polite. Highlighting the potential tension between lay understandings of the performance of these two communicative practices, developing rapport and being polite, brings the relevance of facework to the fore of

healthcare communication, providing an ideal opportunity to introduce practitioners to politeness theory when delivering communication training.

There are also grounds for further exploring the role of narrative in consultations. Glimpses of a patient's lifeworld are a way of uncovering their concerns (Barry et al 2001 cited in: Collins et al 2007). Research in this area would need to begin by establishing what else is known about the role of patients' narratives in the consultation (e.g. Coupland et al 1994; Hurwitz et al 2008). Future studies could then examine how such narratives might be maximised in the consultation. The amount of self that patients shared with their GPs (that is, information about self that was not essential to the consultation) far outweighed that which the GPs shared with the patients. Is this important? What benefits might there be in practitioners sharing more of their own narratives? How could these ideas be incorporated in a timely manner, and without making practitioners feel exposed? Would concerns about lengthier consultations be outweighed by the time and money saved in the long run?

Turning to the notion of agreement, within a shared decision-making model of participation, "simply agree[ing]" is not classed as participation (Charles et al 1997: 688) and yet the findings here and elsewhere (Houtkoop 1986; Heritage & Sefi 1992; Stivers 2005) have demonstrated evidence of a bias towards agreement in healthcare professionals' discourse. Although these studies have been cited in some recent linguistic literature (Heritage & Maynard 2006; Collins et al 2007), this bias does not seem to have made it to the fore of communication teaching within healthcare, for example, there is no mention of the issue in clinical guidelines (e.g. RCGP 2008; RCGP 2010a) or key communication skills' text books (e.g. Kurtz et al 2005). Perhaps a study with a stronger focus on preferred and dispreferred responses would be a useful beginning in raising awareness of this bias.

CHAPTER 6 - CONCLUSION

This thesis was written at the time of the release and subsequent passing of the Coalition Government's plans to radically revise NHS care (DoH 2010). It draws on the recommendations that: increased patient involvement leads to better outcomes, that patients should have more choice and be given more information, that care should be more patient-centred and patients more involved in decisions about themselves, that anecdotal evidence from patients will have a bigger role in evaluation and that in the future provider payments should be dependent upon the performance of the objectives in the bill. This thesis highlights ways in which patient satisfaction and provider performance in relation to doctor-patient communication might be improved.

From a linguistic perspective, creating a cooperative environment within the consultation promotes congenial relations and collaboration. However, the way in which suggestions are necessarily framed in order to achieve this kind of environment does not create opportunities for alternative ideas to be expressed.

Institutions develop their own cultural norms and goals, enabling both service providers and users to make sense of the establishment's ways of working, and to develop a coherent approach to the tasks required (Harris 2003). However, they carry particular ideologies which by their dominant nature have a powerful, controlling influence over the beliefs and behaviours of others. Thus, adopting an approach that invites cooperation sets a precedent for agreement - one which is promoted by an expectation that patients will accept the expert

practitioners' beliefs and recommendations i.e. the dominant way of thinking which in turn reinforces the dominant ideology. Patients whose previous experience and social competence make them aware of the preferred responses expected in typical doctor-patient interactions are under pressure to maintain congenial relations. The consequence of fostering this kind of approach is that alternative viewpoints are then relegated to the threatening position of being dispreferred (Fairclough 1992 cited in: Harris 2003).

Analysis of the way in which patients created and managed the space used to express decisions which contravened GP advice lends support to the suggestion that offering dispreferred responses to GP decisions constitutes a breach of cultural norms. This is further supported by the contrasting feedback received by patients for such decisions. If increased patient participation is to be truly valued in the consultation then practitioners may benefit from endeavouring to move away from this culture of agreement. Explicitly inviting patients to volunteer their own ideas, concerns and expectations and avoiding invitations to agree are just some of the strategies that might profit such a move. Also useful would be an awareness of face, face threat and its management. Understanding the potential correlation between threat and indirectness may facilitate more effective probing. For example, responding to the query *Do I have to take these pills?* with agreement or disagreement would merely attend to the locutionary force of the enquiry. However, functionally, the illocutionary force intended might be much more complex, for example, it might have been intended as an indirect attempt to open up a dialogue regarding concerns about the medication more generally. Focussing on, and exploring such concerns would increase the opportunities available to the patient for participation and begin to indicate that such viewpoints were welcome.

An understanding of politeness strategies would facilitate reflection on why we say what we say, i.e. why we structure our utterances in the way that we do, raising awareness of the range of functions and effects of speech. From the evidence presented here these would also include the potential effects of ambiguity in relation to decision-making resulting from the use of indirectness and hedging, and also the importance of small talk's role in helping some patients to find a way of participating. Appreciation of this latter point may make practitioners more aware of such talk to act as a medium for presenting additional information that might otherwise remain unvoiced.

This research contributes to the work of politeness theory by offering a unique example of the way in which politeness strategies have been observed in a group of British, primary care consultations and highlights areas in which the teaching of such theories could be introduced. Its interest in face threat and the way in which positive politeness can increase this provides a platform for better communicating the problems inherent in invitations to agree and consultation styles oriented toward cooperation. To fully understand the implications of these findings for clinical practice further research is needed. An important starting point might be to explore how practitioners can maximise positive politeness as a means of rapport building to promote participation without creating an environment oriented toward agreement.

APPENDIX I – DEFINITION OF POLITENESS TERMS

This appendix is intended as a reference guide to help the reader maintain his/her understanding of politeness theory whilst reading this thesis. It begins with a summary of “face” (Box 17), 2nd order politeness (Box 18), face threat and Brown & Levinson’s (1987) 5 super-strategies (Box 19).

Box 17 – Face

Face: The aspect of our self that we serve to protect from offence and which can only be maintained through interaction with others. It has two aspects, negative and positive (see Box 18 & Box 19 below for summaries and p62 for further detail).

Box 18 – Politeness (2nd order)

Politeness: An umbrella term for the intuitive way in which individuals use language to attend to face (Holmes 1995) – that is, the need for both inclusion and privacy (Brown & Levinson 1987), largely achieved through both the active expression of positive concern for the feelings of others and the use of non-imposing means of communication (see p53 for greater detail).

Box 19 – 5 Super-strategies

- 1) Bald, on record
- 2) Positive politeness
- 3) Negative politeness
- 4) Off record
- 5) Not doing the FTA

See p66 for further details regarding the super-strategies.

Box 17 – Face threat

Face Threat: Things which threaten, or risk threatening one’s face-needs, such threats are likely to offend/embarrass.

Next, each of the super-strategies is taken in turn and the pertinent points in relation to face, performance and outputs are summarised.

Outputs

Outputs are the utterances used to achieve the various aspects of politeness (see p66). The various types are listed in the Figures following.

Brown & Levinson's Figures

The figures created by Brown & Levinson (1987) listing the outputs for the mitigated strategies (positive, negative and indirect politeness) are reproduced respectively, under the relevant headings below. The figures comprise 4 columns which Brown & Levinson (1987) differentiate with specific labels within the text, but not within the figures themselves so I have added these:

- The super-strategies are presented on the left-hand side (this is what the speaker hopes to achieve)
- Following are the *mechanisms* needed to achieve the super-strategy
- Then the means that will enable them to *achieve* these mechanisms
- Finally, the *outputs* provide further detail as to the type of utterances through which these mechanisms can be achieved.

Bald, On record

This strategy is the most direct, and involves the use of utterances that are explicit, and are made without any attention to face i.e. without any mitigation or modification and are therefore direct e.g. *deep breaths* (see p251).

Positive Politeness

Positive politeness involves being direct but utilises mitigation which attends to one’s positive face-needs (see Box 18).

Box 18 – Positive face

Positive face-needs:

- To be seen as appealing by others
- To be appreciated and approved of
- For their wants to be desirable by others

(Brown & Levinson 1987: 61-2)

The outputs identified by Brown and Levinson (1987) for this strategy are shown in Figure 4.

Figure 4 – Positive politeness

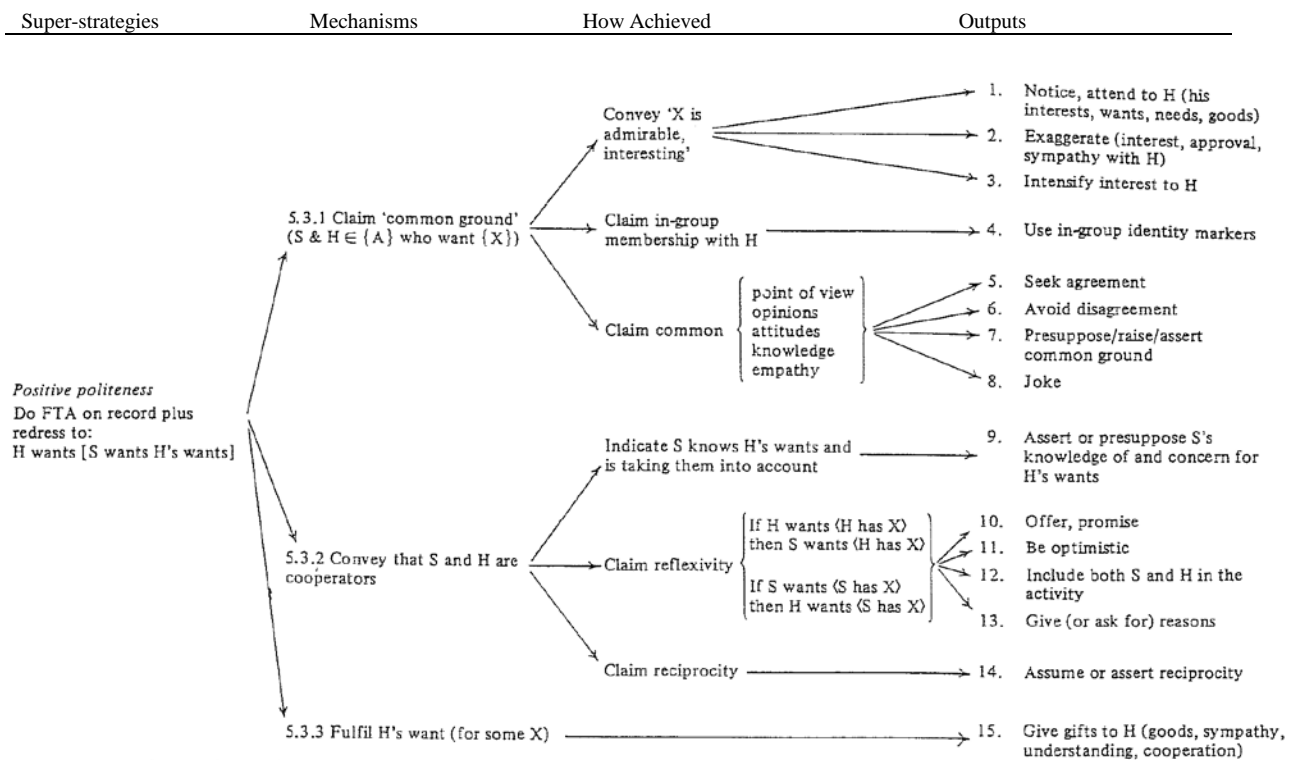


Fig. 3. Chart of strategies: Positive politeness

Copied from Brown & Levinson (1987: 102)

Negative Politeness

Negative politeness is less direct than positive and involves much more mitigation in order to attend to one's negative face-needs (see Box 19).

Box 19 – Negative face

Summary of Negative face-needs

- Territorial claims (e.g. to that of expert status)
- Preservation of self
- Right to non-distraction/imposition
- The right to freedom of action

(Brown & Levinson 1987: 61-2)

The outputs identified by Brown and Levinson (1987) for this strategy are shown in Figure 5.

Figure 5 – Negative politeness

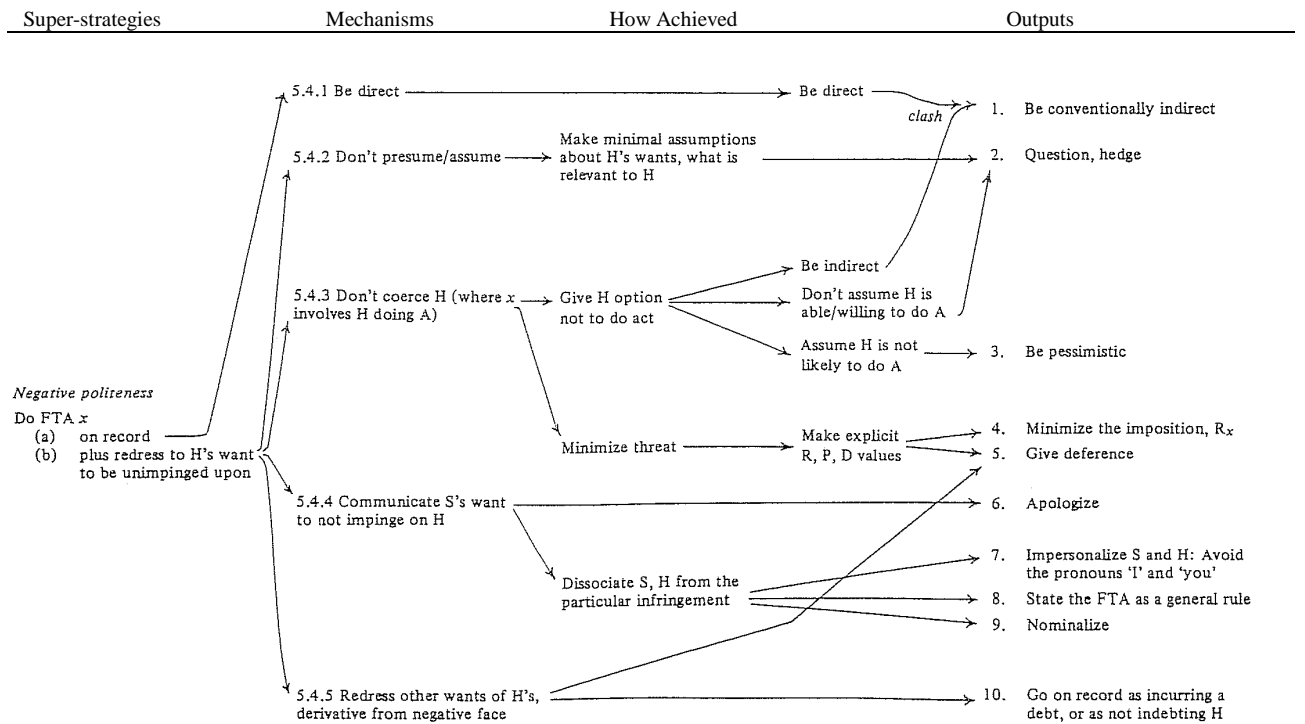


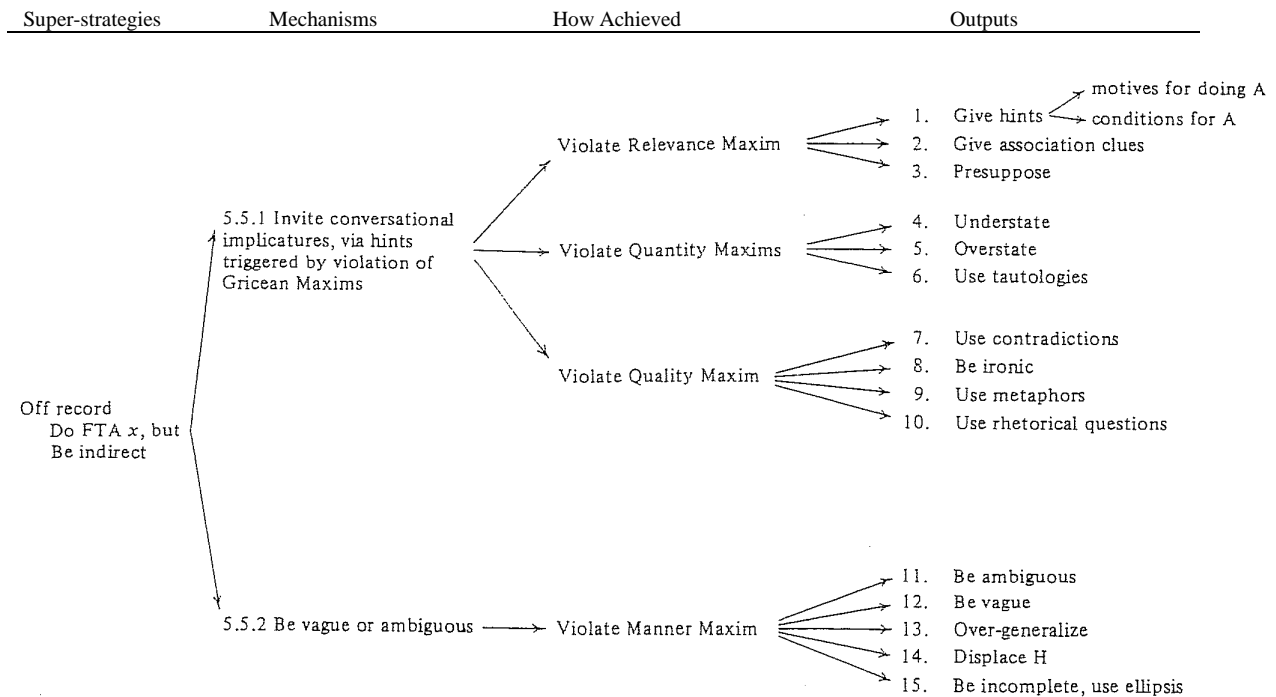
Fig. 4. Chart of strategies: Negative politeness

Copied from Brown & Levinson (1987: 131)

Off record

Off record politeness is the most indirect of the strategies where an utterance is actually made (see “Not doing the FTA” next). Utterances are not made explicitly, instead the listener is left to interpret the speaker’s intentions. Avoidance and mitigation are the main strategies used. The outputs identified by Brown and Levinson (1987) for this strategy are shown in Figure 6 (see also p68).

Figure 6 – Off record politeness



Copied from Brown & Levinson (1987: 214)

Not Doing the FTA

Finally, the most indirect of the strategies actually involves not making the utterance at all (Brown & Levinson 1987). The speaker considers the act to be too threatening to attempt (see p254).

APPENDIX II - GLOSSARY

The purpose of this glossary is to provide succinct explanations for terms as they have been used within this thesis. The content is not necessarily definitive since the meaning(s) attributed to some of the terms can vary quite significantly from one user to another as well as from one context to another.

The course of study for this thesis was conducted from within the medical sciences for examination by healthcare professionals, therefore the focus has been on the inclusion of linguistic terms that occur regularly within the thesis and which it is thought that healthcare professionals are least likely to be familiar with.

With regards to medical terminology, the names of drugs used as common household remedies have not been explained. Drugs used less commonly are explained within the text of the transcripts in which they occur, likewise clinical conditions and diagnoses. It is recommended that any reader unfamiliar with or unsure of any unexplained medical terms refers to a web-based resource for further information e.g.:

www.patient.co.uk
www.clinicalevidence.bmj.com
www.nhs.uk

Adjacency pairs (p48)

A sequence of utterances that are related to each other e.g. a greeting pair where two people greet and respond to each other.

Backchannelling (BCs) (p94)

Minimal utterances interjected whilst another is speaking to indicate continued interest, attentiveness and a desire for the speaker to continue, e.g. *I see, yes, OK, aha* and nodding, including single word clusters e.g. “*Mmm. Yes. OK.*”

Bald, on record - see p66 and p251.

Breach (p64)

Failure to prevent threats to face and utterances causing offence, attempts might then be made to repair the breach.

Declarative (p48)

Utterances with a *subject-verb-object* (SVO) order. Prototypically these are statements e.g.:
These are for the pain.

However, they can also be used to form questions and instructions.

Deictic

Deixis is the construction of an utterance whose interpretation is relative to the context in which it is uttered, factors which are implicit but not expressed explicitly. Examples of such contextual items include the way in which: the speaker's identity is indicated or the time and place relevant to the utterance. Brown & Levinson refer to these as point-of-view operations (1987: 118-22, 204-6) and highlight how speakers can exploit aspects of deictic anchorage like the mode of reporting to re-position their viewpoint (e.g. see Extract 62 below). In the case of Extract 62 P2's shift from summarising (L18-26) to quoting (L26) when reporting his actions serves to distance the speaker from his actions, as does P2's use of "past tense hedging" to situate the idea as one belonging to the past *I thought* (Brown & Levinson 1987: 169).

Extract 62 – Deixis (D1-P2)

- | | |
|-----|--|
| 18. | P2: [D1 looks at P2] Erm, well, I've gone back to 150 |
| 19. | D1: right |
| 20. | P2: because I, about last week, I began to feel a bit sort of flushed with it and, |
| 21. | D1: [D1 nods] right |
| 22. | P2: I've, you read those, [D1 nods] you know, the leaflet that goes with it, |
| 23. | D1: yeah |
| 24. | P2: erm, and I, I was getting a little bit of a, sort of a fluttery [D1 nodding] (.) sort of heart, nothing (.) |
| 25. | D1: right |
| 26. | P2: amazing or anything else like that, and I knew I was coming to see you [D1 nodding] anyway, so I thought, "OK. Well, I'll just (.) drop it." [D1 nodding] I'd got a few 50s left |

Dispreferred/Preferred (p49)

Types of responses – builds on the notion that a listener's response can be classed as satisfactory (preferred) or unsatisfactory (dispreferred). Preferred responses refer to those types of response which adhere to the social norms associated with the preceding pair part. Dispreferred responses breach the associated social norms.

Ellipsis

The omission of words from an utterance (Swan 1995) the omission is inferable from the context (SIL 2004b), e.g. D5's omission of the word *are* in *How are you doing* (L1) in Extract 63.

Extract 63 – Ellipsis (D5-P23)

- | | |
|----|--|
| 1. | D5: [D5 is standing at desk] [P23 approaches D5] [D5 introduces self by first and surname without title] nice to meet you, [D5 shakes P23's hand] how you doing? |
|----|--|

Face – see p62 and p250.

Face threatening act (FTA) – see p64 and p250.

Facework (p62)

Linguistic strategies which protect, maintain and enhance face, satisfying face-needs and reducing the risk of threat.

False starts

The phrase “false starts” is used here to refer to revisions or repetitions made by speakers when formulating utterances e.g. in Extract 64 there are a number of examples of D6 using repetitions in the production of his utterance: *wh<at>*, *wh<at>* *what* where the *what* is only completed on the third attempt, similarly *Erm, I, erm, I'd*.

Extract 64 – False starts (D6-P29)

173. D6: Erm, [D6 writes, looks up] (4) [D6 looks at P29] I'm not quite sure what this is really. It might just be an inflammation [D6 gestures] in your lungs, due to the, [D6 nods] *wh<at>*, *wh<at>* what you've described of the, the carpet. [D6 glances away] Erm, I, erm, I'd [D6 listing on fingers] like to do *two* things really.

HAY?-type elicitations

“How are you” type enquiries oriented toward moving onto health related matters (Coupland et al 1994), see for an example Extract 65. Here, D7 follows his initial greeting *Hello Mrs P52* (L1) with *How are you today?* (L3) which is not interpreted by P52 as an invitation to explain her reason for attending, but rather as an example of phatic communion *Oh, not so bad thank you* (L4). This contrasts with the example in Extract 66 where P12 interprets D2's *How are you?* (L1) as an invitation to turn to health related matters. In the case of P52, it is not until D7 later enquires *how can I help today?* (L9, Extract 65) that they make this move.

Extract 65 – Phatic Greetings and HAY?-type elicitations (D7-P52)

1. D7: [D7 looking down at paper patient notes] Come in please [D7 peers towards door]. [Door opens] (2) Hello Mrs P52. [D7 starts to get up, smiling]
2. P52: [P52 comes into view, shutting door] Hello.
3. D7: How are you today? [D7 sits down]
4. P51: Oh, [P52 walks towards D7] not so bad thank you. [P52 hands D7 research paperwork]
5. D7: That's good. Thank you.
9. D7: ... Right, how can I help *today?* [D7 glances at P52]
10. P52: Well I think you've just, I've just got to top up me tablets.
11. D7: [P52 looks at D7] [D7 looks at screen, types] ¹**Tablets is it today?**

Extract 66 – HAY?-type elicitations (D2-P12)

1. D2: [D2 sits down looking at screen] Right (3) [P12 sits down putting research paperwork on desk, looks ahead]. Let's just try and sort [P12 glances at screen] this out and get you up on the, [P12 looks at D2] [D2 speaks with a hint of excitement] oh, here we go. (2) [D2 looks at P12] How are you?
2. P12: Very, very unwell.

Hedging (p125 and p211)

A means of modifying the degree to which a speaker adheres to his/her utterance (Brown & Levinson 1987: 145-6) e.g. use of *kind of, sort of, probably, actually, really*, false starts and hesitations.

Hesitations

Hesitations (e.g. *erm, er*), pauses and false starts (e.g. *I, I was, er I am...*) can function as a means of hedging.

ICE (p23)

ICE is a mnemonic devised by Neighbour (1987: 43) as an “aide-memoire” for practitioners seeking to actively elicit patients’ *ideas, concerns* and *expectations* (see Box 20).

Box 20 – Neighbour’s aide-memoire “ICE”

I deas C oncerns E xpectations

Inclusive pronouns (p179)

Inclusive pronouns (e.g. *we, us* and *let’s*) used by the speaker when referring to activities which depend upon the speaker’s input. For example, *I think what we should do is ...* in Extract 67.

Extract 67 – Inclusive pronouns (D4-P45)

158. D4: ³ Erm, I think what we should do [A45 nods] is keep with the orange [inhaler] one on four puffs,

Inclusive strategies (p126)

Strategies which claim in-group membership, demonstrating a desire for solidarity (output 4 Brown & Levinson 1987). Includes the reduction of social difference and claims to common ground. Strategies include use of in-group language, inclusive pronouns, informal address and shared remembering.

Intensifiers (p94)

Intensifiers are lexical items which modify an utterance by grading it, heightening or lowering its intensity (Swan 1995; Carter & McCarthy 2006), for example D1’s use of *particularly* in Extract 68 below.

Extract 68 – Intensifiers (D1-P1)

112. D1: The reason [the pain] comes round is that particularly in the lower back the nerves that come out in that area tend to come around forwards, right?

Lexical items

Words or word forms, the units of speech or text used to communicate, including items like fillers, that is *ah, er, erm* etc.

Metapragmatic particles

Utterances which narrate the activity being performed e.g. *I think* in Extract 69.

Extract 69 – Metapragmatic particles as boosters (D2-P10)

21. D2: [D2 nods] ¹**I think that's what you need, erm,**

Minimal response (p94)

Minimal utterances intended to convey agreement or disagreement e.g. *Yes, No*.

Minimal utterances (p94)

Short verbal and non-verbal utterances e.g. *I see, yes, OK, aha* and nodding, including single word clusters e.g. “*Mmm. Yes. OK.*”

Negative face – see p62 and p253.

Negative politeness - see p66 and p253.

Non-minimal responses (p94)

Responses which are more demonstrative & complex than minimal utterances using adjectives and adverbs and other linguistic devices boosting the impact of the response e.g. *Yes, I totally agree*.

Not performing the FTA – see p66 and p254.

Off record politeness strategy – see p66 and p254.

Outputs – see p70 and p250.

Patient participation (p23)

Reference, in this thesis, to patient participation in the consultation refers to the inclusion of patients' ideas, concerns, expectations and preferences in clinical decisions.

PCM (p30)

Patient-centred medicine - a medical model where the practitioner tries to view the patient and their concerns from the patient's perspective (e.g. Rosenstock 1966; Becker & Maiman 1975; McWhinney 1989) when consulting.

Phatic communion

Polite greetings which are not intended to be taken literally e.g. *How are you?* as a greeting, instead of an enquiry regarding health.

Politeness strategies – see p66 and Appendix I.

Positive face - see p62 and p252.

Positive politeness - see p66 and p252.

Redressive action (p66)

Ways of mitigating/softening the force/impact of an utterance so that it doesn't sound too authoritative or direct.

Shared decision-making (SDM) (pp18-46)

The active encouragement of patient involvement in decisions about their healthcare at their preferred level of involvement. These shared decisions should incorporate the patient's ideas, concerns and expectations relating to their health, information which should be actively elicited if not already volunteered. Choices should be discussed with the patient, including the option of doing nothing and where patient and practitioner cannot agree, the patient's choice should be actively respected rather than merely accepted (see pp18-46 for discussion).

Tag questions (p196)

Lexical items tagged/added onto the end of statements changing them into questions, for example *doesn't it?* in Extract 70.

Extract 70 – Tag questions (D2-P58)

12. D2: ¹ Right, so in fact it <i>sounds</i> as if you're on the mend doesn't it?

Utterances

Things people say or utter. Refers to both single units of speech (words) as well as longer narratives.

APPENDIX III - ETHICS APPROVALS

Following are copies of responses received from West Midlands MREC in relation to this dataset. It should also be noted that since September 2011 seeking such extensions no longer needs to put to the MREC Chair formally. Rather the MREC now require that where the duration of the study needs extending reasons be given in the annual progress report provided to the MREC by the PI or other nominated persons.

APPENDIX IV - CONSENT FORM

Following is a copy of the “Consent Form” signed by participating patients during the original data collection period 2003-4.

University of Birmingham consent form

Patient identifier

03/01/

Patient/parental agreement to investigation or treatment

(procedures where consciousness not impaired)

CONSENT FOR YOUR CONSULTATION TO BE VIDEO-TAPED

(You can ask for the tape to be stopped at any time during the consultation, or the cap to be placed on the lens)

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

Signed: Name (PRINT) Date Job title

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed Date Name (PRINT)

Statement of patient or person with parental responsibility for patient

I agree to the procedure described above.

Signature Date

Name (PRINT) Relationship to patient

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed: Name (PRINT) Date Job title

APPENDIX V – GP CORRESPONDENCE

Following are copies of the recruitment letter sent out to the GP practices inviting participation and the information sheet which was enclosed by the original data collectors in 2003.

10/05/2002

**West Midland Postgraduate
G P Education Unit**

21 MAY 2002

Tel:
Fax:
Email:

Dear Dr

I am writing to you to ask for your support with a new research project being undertaken by two post-graduate students supervised by John Skelton at the University of Birmingham.

This observational project provides video data for two studies that will contribute to an ongoing programme of research into effective Doctor-Patient communication to inform both education at undergraduate level and continuing professional development. This project reflects governmental and, in particular, current regional policy regarding the importance of effective communication skills for health professionals.

Overall this project will require the collection of 150 video-taped General Practice consultations, from ten practices and two to three doctors within each practice. The data collection will take place in and around the Birmingham area. The research proposal has full ethical approval granted by West Midlands MREC Ref. No. MT/AB/MREC/01/7/89.

Part of this study will ask selected GPs to recreate consultations taken from the original data set with professional role-players from the Interactive Skills Unit 3-6 months following their initial consultation. This aims to investigate the differences between "real" and "standardised" patient consultations, analysing specifically the role-players' contribution as a learning tool, an area in which very little work has been completed.

You will be receiving a call from one of the two principal researchers Andrew Shanks and/or Phil Croft during the course of the next few weeks to discuss your potential involvement in this research project.

If you are interested in taking part in this project please complete the slip below and return to Andrew Shanks at the Interactive Skills Unit (address below).

Yours sincerely

Steve Field

Dr S Field
Regional Postgraduate Dean

We are interested in supporting the Video Observational Project described above and would be happy to discuss the potential involvement. We will expect to hear from Phil Croft and/or Andrew Shanks in the next few weeks.

Signed by Dr Divall

INFORMATION FOR PRACTICES

Using Video Consultations to Inform Medical Training Development

Proposed start date:	October 2001
Duration:	First Round 1 month, (approximately three months later) Second Round 1 month, (approximately three months later) Third Round 1 month.
Commitment:	Anticipated at three days per Practice during Round 1, and 1 day per Practice during Rounds 2 & 3.

What is the study about?

The principle research question we are seeking to answer is this:

What evidence can be derived from video taped consultations to enable training improvements in communication skills for medicine?

Study 1: Patient Participation Strategies in GP Consultations will be analysing linguistically the nature of 'patient initiations' during the typical GP consultation. Study 2: Role-player Effectiveness in Medical Education [REMEd] will be comparing the performance of role-players (often referred to as Standardised Patients) with their real life counterparts.

Study management

The patients will be recruited as they attend the Practice on the days when filming is due to take place. We will be asking Practice staff to make an initial approach to the patient. The researchers will be on hand to answer any questions that the patients may have and ensure that appropriate consent is sought.

Patient consent

In order to ensure that the patient fully and freely consents to being videotaped we ask that the GP concerned checks that the patient has initialed a consent form agreeing to be recorded before the consultation. Following the consultation we ask that the GP makes sure that the patient signs the consent form and retains a copy of this and the Patient Information Sheet provided when they were recruited.

Equipment

By arrangement with each individual practice and GP within that practice it is anticipated that the only necessary equipment will be a standard VHS video camera positioned (wherever possible) to ensure a profile view of GP and patient. Blank videocassettes will be supplied by the researchers on filming days. The researchers will supply any other necessary equipment (including video cameras where Practices do not have their own).

What happens next

The data collected will form the basis of the two studies named above, and it is anticipated that the data will be retained for a period of no longer than 20 years to enable ongoing study at the University of Birmingham Medical School on how consultation styles change over a period of time.

INFORMATION FOR PRACTICES

Using Video Consultations to Inform Medical Training Development

What will the practice input be?

It is expected that the Practice will supply (wherever possible and subject to negotiation) the video equipment used in the data collection. It is also anticipated that the Reception staff will make the initial recruitment overture to the patient, and direct them to the researchers who will ensure that any questions the patients may have are fully answered. It is anticipated that the GP will subsequently manage the consent process when the patient enters their consulting room.

Each GP involved will be asked to record consultations during two morning or afternoon surgeries and one evening surgery.

For those GPs agreeing to take part in the ongoing data collection required by Study 2 it is anticipated that this will involve two single sessions (morning, afternoon or evening by arrangement) with a professional role-player from the University of Birmingham Medical School. The first of these sessions will be arranged approximately three months on from the original data collection, and the second of those sessions (subject to funding) a further three months on from then.

The process itself will look like this:

1. Display a poster announcing that filming will be taking place three weeks before the first arranged date;
2. GPs to warn frequent attenders for up to three weeks before filming that filming may be taking place on the patient's subsequent attendance;
3. Researchers arrive on the filming day and take their place in a private room;
4. Reception staff will greet the patients and offer them a Patient Information Sheet;
5. Patients requiring further information will be directed to the researchers before going in to see the GP;
6. The GP will ensure that the patient has consented to be filmed and will then ensure that the camera is turned on and recording;
7. Following the consultation, the GP will ask for signed consent to ensure that the patient is still happy to be a part of the studies;
8. A copy of the consent form will be given to the patient, one will accompany the finished videotape and another will be retained in the patient's file.

Practice payments

Payment will be made to all staff involved on the following scales:

£37.00 per hour for GPs;

£12.00 per hour for Practice Managers;

£7.00 per hour for Reception staff.

Other payments for equipment usage as negotiated.

Thank you for your involvement in these studies.

APPENDIX VI - PATIENT CORRESPONDENCE

Following are copies of the recruitment letters given to patients inviting participation and the information sheet which was enclosed by the original data collectors in 2003.

Patient Information Sheet

Study 1 ~ Patient Participation Strategies in GP Consultations

Study 2 ~ Role-player Effectiveness in Medical Education

You are being invited to take part in two research studies. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The purpose of the studies?

Study 1 ~ In order to help doctors consult more effectively, this study aims to develop a consistent method of analysing how doctors and patients communicate. In particular, to study how and why patients introduce new information and questions into a consultation, and what doctors do when this happens. **Study 2** ~Trained Role-players (sometimes called Standardised Patients) are frequently used in medical education to enable both medical students and qualified doctors to practice and develop their consulting skills. This study aims to determine, with your help, whether role-players represent people such as yourself accurately.

Why have I been chosen?

You have been invited to take part in this study because you have come to see your doctor today. **Study 1** will be looking at 150 patients in total at 10 different Practices in the West Midlands area. To minimise the inconvenience to yourself and to your doctor (by conducting separate studies) **Study 2** will be looking in detail at approximately 30 of those 150 patients.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

Your involvement in this study will only be for the period of your visit to the doctor today. You will not need to make any future visits. The following list will explain exactly what will happen to you today:

1. If you agree to take part in this study you will be asked to sign a consent form. This form will be your agreement to take part in the study.
2. You should then hand your consent form to your doctor.
3. Your doctor will then videotape your consultation. If your consultation includes a physical examination you will be offered a position out of view of the camera whilst the examination is taking place. The doctor will also give you the option of having the recording paused until the physical examination is completed. You can ask your doctor to stop taping completely at this, or at any other stage in your consultation and have the tape erased. This will cause no problems whatsoever and will not affect the care you receive.
4. At the end of your visit your doctor will ask you whether you are still happy to be included in this study. If you are happy then your doctor will ask you to sign the consent form. You will be given a copy of your consent form and you should take this information sheet away with you. (If you change your mind after the

consultation your doctor will erase the videotape before you leave and your participation in the study will be at an end).

5. Following your consultation we will ask you to answer a few brief questions about how the consultation went. These answers will **not** be passed on to your doctor in any way that will directly identify them as yours.
6. We will then record your responses in a secure computer database at the University of Birmingham. The videotape will be handed to the research team for secure storage at the University of Birmingham. We will be using your ID number at this practice and will not be recording your name and address or any other contact details.

What do I have to do?

We ask you to simply visit your doctor as you normally do. Always remember that you have the right to withdraw from the study at any time if you are at all uncomfortable.

What is being tested?

Study 1 is looking particularly closely at how doctors and patients work together to agree on an appropriate course of treatment. From the videotape the researchers will be looking at how both you and the doctor sit, talk and finally arrive at a joint decision on what to do next. Study 2 will attempt to recreate some of these consultations with role-players in an attempt to analyse the differences between 'real' patients such as yourself and 'professional' patients used in training and education. In this instance it will be the role-players who are being tested so that we can determine how 'real' they are.

What are the possible disadvantages and risks of taking part?

We believe that there are no disadvantages or risks to your health in taking part in either of these related studies.

The only potential disadvantages relate to the confidentiality of your visit today. If you agree to take part your visit will be recorded on videotape and a written record of that videotape will be produced for the purposes of analysis. Please feel free to ask the researchers about this. They will be very happy to explain to you in detail the measures that have been put in place to ensure that your confidentiality is fully respected.

What are the possible benefits of taking part?

There is no immediate benefit to you from taking part in this study. The information that we will get from this study may help us to find ways of improving the skills of present and future doctors.

Study 1 is looking at the ways in which people such as you talk to doctors. This is so that we can look at ways in which doctors can be trained to treat you more effectively in the future.

Study 2 is also looking at how people such as you talk to doctors. This is so that we can more effectively train role-players in the future. The more effective a role-player is, the better the training they are able to offer to medical students and doctors.

What happens when the research study stops?

As explained above, all data will be stored with maximum regard for confidentiality and will not be passed on to any parties outside of the University of Birmingham without your specific and written consent. All videotapes will be erased by 1st October 2004. Anonymised transcripts of your interview (from which your name and any other information from which you may be personally identified) will be retained and used for research purposes only.

What if something goes wrong?

In the first instance you may wish to talk to your doctor if you have any complaint with the way that you have been treated by the research team or their representative.

In the unlikely event that you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the surgery will have your name and address removed so that you cannot be recognised from it.

In all cases where results are made public your identity will not be described in any way that may lead to you being personally identified.

Who is organising and funding the research?

Funding for this study has been supplied by the University of Birmingham Medical School.

Your doctor will not be paid for including you in this study.

Contact for Further Information



Thank you very much for taking the time to read through this information and for agreeing to take part in these studies.

APPENDIX VII - PATIENT QUESTIONNAIRE

Following is a copy of the “Patient Questionnaire” used by the original data collectors in 2003. Part one was for completion by the doctor, the second and third parts were completed by the patient after the consultation. The second part invites patients to evaluate the consultation by completing the Patient Enablement Instrument (Howie et al 1999) and part 3 records “ethnicity.”

Patient Questionnaire ~
Using Video Consultations to Inform Medical Training Development

To be completed by the Doctor

Consultation Date

Please circle one
am pm

Practice Pt. ID

Patient Age

Patient Gender M F

Patient's Body Mass Index =

Does the patient speak English as their 1st language?

Please circle one
Yes No

To be completed by the Patient

The Patient Enablement Instrument

As a result of your visit to the doctor today do you feel you are

	Much better	Better	Same or less	Not applicable
able to cope with life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to understand your illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to cope with your illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to keep yourself healthy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Much more	More	Same or less	Not applicable
confident about your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to help yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please turn over

Ethnicity Questionnaire

How would you describe your ethnic origin (please tick one box)

A White

British

Irish

Any other white background

(Please write in) _____

B Mixed

White and Black Caribbean

White and Black African

White and Asian

Any other mixed background

(Please write in) _____

C Black or Black British

Caribbean

African

Any other mixed background

(Please write in) _____

D Asian or Asian-British

Indian

Pakistani

Bangladeshi

Any other Asian background

(Please write in) _____

E Chinese or other ethnic group

Chinese

Any other

(Please write in) _____

APPENDIX VIII - GP QUESTIONNAIRE

The demographic information collected from the GPs by the original data collectors in 2003 was done so informally. Information collected:

- Gender
- Whether full-time (F/T) or part-time (P/T)
- Year admitted to GMC register
- Number of partners in the practice
- Country of training
- Whether or not they were a GP trainer

“Year admitted to GMC register” was recorded instead of age as number of years practising medicine was considered to be a more useful measure.

APPENDIX IX - CLINICAL ISSUES

Table 6 – Clinical issues

ID	GP	Problems presented by patient	GP queries	Co-morbidity	Existing investigations & specialist input	Diagnosis	Interventions/treatment
P1	D1	Back pain Repeat prescription – acne cream				Strained muscle	Normal activities Paracetamol
P2	D1	Thyroxine dose Repeat prescription thyroxine Blood test – RA	RA	Rheumatoid arthritis (RA) Smoking cessation	Special diet Physiotherapy		Thyroxine review, self management plan Analgesic review Bloods
P3	D1	Alcoholic liver disease		Masseter muscle spasm (jaw)	U/S Maxillary-facial specialist		Hepatology referral, Review
P4	D1	Shoulder and arm pain ?exacerbated by medication Repeat prescription - prostate problems Rash on back		Prostate	Physiotherapy	Worn, torn shoulder ligaments & neck problems	Reassurance Advice re: analgesia Steroid cream
P6	D1	Sick note for stress related skin condition – hand Decline routine cervical smear					Sick note Letter from P6 re: smear
P7	D1	Productive cough now resolved. Advice re: new inhaler					Assessment & inhaler advice
P8	D1	Blepharitis (inflamed eyelid)	MS	Multiple sclerosis decreased muscle tone	Specialist Physiotherapy Orthotic referral		Advice sheets Antibiotic cream
P9	D1	Menorrhagia, erratic menstrual cycle				?Endometriosis	Gynaecology referral Analgesic review
P10	D2	Cough Acne Repeat prescription - diabetes	Smoking cessation	Diabetes	Diabetologist		Antibiotics for chest & spots Practice diabetic clinic
P11	D2	Painful foot				?Bony spur	Analgesic review X-ray Chiropody
P12	D2	Productive cough, nausea, insomnia	BMI review Result 24 blood	Diabetes ?Hypertension	Cardiologist Ophthalmologist	24hr tape NAD	Letter to cardiac specialist Antibiotics

ID	GP	Problems presented by patient	GP queries	Co-morbidity	Existing investigations & specialist input	Diagnosis	Interventions/treatment
P12	D2	Productive cough, nausea, insomnia	BMI review Result 24 blood pressure cardiac monitor Anxiety	Diabetes ?Hypertension	Cardiologist Ophthalmologist	24hr tape NAD	Letter to cardiac specialist Antibiotics
P19	D4	Unresolved tonsillitis ?ecoli				?Ecoli	Extended antibiotics Throat swab
P20	D5	Left ear pain	Eyelid inflammation Alcohol intake		Ophthalmologist	Ear infection	Antibiotics
P21	D5	Cold & fever	FBC results	?Haemophilia	ENT specialist	Tonsillitis	Extended antibiotics
P23	D5	Upset stomach, cold, fluey symptoms, fever, feeling faint, nausea, sweating, shortness of breath, stress, palpitations		Knee injury		Viral illness	Advice to rest for 1wk Sick note Review if palpitations continue
P24	D5	Repeat prescription – anxiety & insomnia, indigestion	Medication review			?Helicobacter pylori	Appt for bloods
P25	D6	Right ear pain		20wks pregnant		Otitis externa	Antibiotics & ear drops
P27	D6	Anxiety, dizziness, background headache, neck twitch, emotional lethargy, migraines, partial memory loss ?due to head injury 34yrs ago			Practice counsellor	Stress	Community psychiatric nurse Sick note Review
P28	D6	Knee pain Wife's repeat prescription	Repeat prescriptions	Diabetes Hypertension	Practice diabetic clinic	Irritation of the articular properties of the knee cap & ?arthritis	Anti-inflammatory Review if needed
P29	D6	Burning pain in lungs & breathlessness		Pancreatic & oesophageal pain Osteoarthritis Asbestosis ?Hypertension		ECG NAD ? Lung inflammation	Peak flow Temperature ECG B/P Steroids B/P review appt
P30	D1	Follow up – blood results for 'depression.'				Depression	P30 to choose prozac v counselling

ID	GP	Problems presented by patient	GP queries	Co-morbidity	Existing investigations & specialist input	Diagnosis	Interventions/treatment
P30	D1	Follow up – blood results for ‘depression.’				Depression	P30 to choose prozac v counselling v watchful waiting with wife
P31	D1	Back & neck pain with altered leg sensation, stiff shoulders, dizziness & palpitations Right finger				Bruising to the coccyx Osteophyte on finger due to osteoarthritis	Reassurance
P32	D1	Cholesterol results ?Cystitis Repeat prescription for husband		Hypertension			Urinalysis Dietary advice Cystitis medication
P37	D7	Sore throat				URTI	Advice re: fluids and Calpol Antibiotics
P38	D7	Repeat prescription – anti-depressants Nipple discharge				Drug side effect	BNF & reassurance
P39	D7	Repeat prescription – anti-hypertensives	Review of back pain	Hypertension			B/P Dose increase for back pain
P44	D7	Diabetic review Neck twitch, shoulder pain		Methaemoglobinemia			No revisions needed 6 month review
P45	D4	Cold		Asthma			Peak flow Reviews inhaler doses 2wk review
P46	D5	X-ray results Ankle & associated limb pain Sick note				NAD	Rheumatology referral Reviews analgesia Sick note
P47	D5	Diabetic review Suicidal depression			Diabetologist	Hyperglycaemia	Emergency admission
P48	D5	Infected injection site Groin rash				Infected injection site Fungal groin infection	Antibiotics Cream Showering advice
P50	D7	Repeat prescriptions weight loss Right leg pain	Barium meal appt	Heart problems	Recent admission for dental surgery		Weight Revises prescription
P51	D4	Hypertension preventing dental extraction Stress Smoking cessation			Dental problems	Hypertension	B/P Manual pulse Advised to take prescribed anti-hypertensives

ID	GP	Problems presented by patient	GP queries	Co-morbidity	Existing investigations & specialist input	Diagnosis	Interventions/treatment
P51	D4	Hypertension preventing dental extraction Stress Smoking cessation			Dental problems	Hypertension	B/P Manual pulse Advised to take prescribed anti-hypertensives Recommences anti-hypertensives 2wk review
P52	D7	Repeat prescription	Reviews RA bloods & pain control	Rheumatoid arthritis Thyroxine	Rheumatologist		Updates practice records from hospital records
P55	D7	Sticky eyes ?uveitis affecting the iris Repeat prescription – thyroid, gabapentin, pain killers, anti-depressants		Thyroxine ?Epilepsy or neuropathic pain		Conjunctivitis	Eye drops Repeat bloods –results to be phoned & thyroxine dose advised.
P58	D2	Asthma control		Work & general well-being		Improving	Peak flow Reassurance Inhaler doses adjusted
P62	D2	Chest pain		Brother's suicide		Muscle pain	GP corrects misunderstanding about antacids Advised to discuss feelings with family 2wk review
P63	D4	Cough, vomiting		Asthma Whooping cough		No lower lobe chest infection Asthma exacerbation	Peak flow Antibiotics Recommences inhaler
P64	D4	Cold, fever, anorexia,					Temperature Keep cool, drink plenty, anti-pyretics
P65	D4	Repeat prescription & bloods Prostate Mole Smoking cessation		Hypertension Hypercholesterolemia			B/P Bloods Antibiotics 3-4wk review
P66	D5	MRSA anxiety – spots, sore throat, dry nose Aspirin therapy Repeat prescription – analgesia & antacids Cholesterol levels		Varicose veins Psoriasis Arthritis		No MRSA Cholesterol NAD	Reassurance & explanations for MRSA & cholesterol Nasal swab
P68	D6	Failure of life insurance application		?Cellulitis			Agrees to ring insurance company

ID	GP	Problems presented by patient	GP queries	Co-morbidity	Existing investigations & specialist input	Diagnosis	Interventions/treatment
P68	D6	Failure of life insurance application		?Cellulitis Chest infection			Agrees to ring insurance company D6 to call p68
P69	D6	Repeat prescription – inhalers		Respiratory Back pain	Respiratory specialist Physio		Puts medications on repeat Review every 3 rd repeat
P70	D6	Vomiting, constipation, poor urine output, drowsy				Tummy bug	Temperature Plenty fluids, no food, review morning if no better

REFERENCES

- Adams A, CD Buckingham, A Lindenmeyer, JB McKinlay, C Link, L Marceau & S Arber (2008) "The influence of patient and doctor gender on diagnosing coronary heart disease." *Sociology of Health & Illness*. 30 (1): 1-18.
- Anderson L & P Sharpe (1991) "Improving patient and provider communication: a synthesis and review of communication interventions." *Patient Education and Counseling*. 17 (2): 99-134.
- Arborelius E, T Timpka & JM Nyce (1992) "Patients comment on video-recorded consultations - the "good" GP and the "bad"." *Scandinavian Journal of Social Medicine*. 20 (4): 213-6.
- Arndt H & R Janney (1979) "Interactional and linguistic models for the analysis of speech data: An integrative approach." *Sociologia Internationalis*. 17 (1-2): 3-45.
- Arndt H & R Janney (1985) "Politeness revisited: Cross-model supportive strategies." *International review of applied linguistics in language teaching*. 23 (4): 281-300.
- Aronsson K & U Sätterlund-Larsson (1987) "Politeness Strategies and Doctor-Patient Communication. On the Social Choreography of Collaborative Thinking." *Journal of Language and Social Psychology*. 6 (1): 1-27.
- Atkinson J & P Drew (1979) *Order in court*. London: Macmillan.
- Austin JL (1962) *How to do things with words: The William James Lectures delivered at Harvard University in 1955*. Oxford: Clarendon Press.
- Back MF & CY Huak (2005) "Family centred decision making and non-disclosure of diagnosis in a South East Asian oncology practice." *Psycho-Oncology*. 14 (12): 1052-1059.
- Balint E (1969) "The possibilities of patient-centered medicine." *Journal of the Royal College of General Practitioners*. 17 (82): 269-76.
- Balint M (1955) "The doctor, his patient and the illness." *The Lancet*. 265 (6866): 683-688.
- Balint M (1956) *The doctor, his patient and the illness*. London: Pitman.
- Barratt A (2008) "Evidence Based Medicine and Shared Decision Making: the challenge of getting both evidence and preferences into health care." *Patient Education & Counseling*. 73 (3): 407-12.
- Barry C, F Stevenson, N Britten, N Barber & C Bradley (2001) "Giving voice to the lifeworld. More effective, more humane care? A qualitative study of doctor-patient communication in general practice." *Social science & medicine*. 53 (4): 487-505.

- Beach M (2006) "Appendix A - What is Patient-Centered Communication?" *In An Ethical Force Program™ Consensus Report. Improving Communication - Improving Care.* American Medical Association (ed.): American Medical Association: 99-102.
- Becker MH & LA Maiman (1975) "Sociobehavioral Determinants of Compliance with Health and Medical Care Recommendations." *Medical Care.* 13 (1): 10-24.
- Beisecker AE & TD Beisecker (1990) "Patient Information-Seeking Behaviors When Communicating with Doctors." *Medical Care.* 28 (1): 19-28.
- Berger PL & T Luckmann (1967) *The social construction of reality: A treatise in the sociology of knowledge.* Harmondsworth: Penguin.
- Biber D, G Leech & S Conrad (2002) *Longman Student Grammar of Spoken and Written English.* Harlow, Essex: Longman.
- Blanchard CG, MS Labrecque, JC Ruckdeschel & EB Blanchard (1988) "Information and decision-making preferences of hospitalized adult cancer patients." *Social Science & Medicine.* 27 (11): 1139–1145.
- Bliesener T & J Siegrist (1981) "Greasing the wheels: Conflicts on the round and how they are managed." *Journal of Pragmatics.* 5 (2-3): 181-204.
- Blum-Kulka S (1982) "Learning how to say what you mean in a second language: A study of the speech act performance of learners of Hebrew as a second language." *Applied Linguistics.* 3 (1): 29-59.
- Blum ML (1968) *Industrial psychology : its theoretical and social foundations* New York: Harper & Row.
- Bousfield D & MA Locher (2008) "Introduction: Impoliteness in language." *In Impoliteness in language: Studies on its interplay with power in theory and practice* Bousfield, D & MA Locher (eds.) New York: De Gruyter Mouton.
- Braddock C, Fihn SD, Levinson W, Jonsen AR & Pearlman RA (1997) "How doctors and patients discuss routine clinical decisions. Informed decision making in the outpatient setting." *Journal of General Internal Medicine.* 12 (6): 339-45.
- Britten N, FA Stevenson, CA Barry, N Barber & CP Bradley (2000) "Misunderstandings in prescribing decisions in general practice: qualitative study." *BMJ.* 320 (7233): 484-488.
- Brody H (1993) *The healer's power.* London: Yale University Press.
- Brown G & G Yule (1983) *Discourse analysis.* Cambridge: Cambridge University Press.
- Brown J (2008) "How clinical communication has become a core part of medical education in the UK." *Medical Education.* 42 (3): 271-278.

- Brown P & SC Levinson (1987) *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press.
- Bryman A (2001) *Social research methods*. Oxford: Oxford University Press.
- Buckingham CD & A Adams (2006) "Employing XML-based technologies to elicit mental-health risk knowledge." *In Current perspectives in healthcare computing 2006*. Bryant, J (ed.) Swindon: BCS HIF: 284- 291.
- Bugge C & A Jones (2007) "Methods for studying patient participation." *In Patient Participation in Health Care Consultations: Qualitative Perspectives*. Collins, S, N Britten, J Ruusuvaori & A Thompson (eds.) Maidenhead: Open University Press: 22-40.
- Bullon S (ed.) (1990) "Collins COBUILD English grammar." London: Collins.
- Byrne PS & BEL Long (1973) *Learning to care : person to person*. Edinburgh: Churchill Livingstone.
- Byrne PS & BEL Long (1976) *Doctors Talking to Patients*. London: Royal College of General Practitioners.
- Campbell IK (1982) "Audio-visual recording in the surgery: do patients mind?" *Journal of the Royal College of General Practitioners*. 32 (242): 548-9.
- Campion P (1987) "Communication: learning from our patients." *The Practitioner*. 231 (1433): 1056.
- Campion P, J Foulkes, R Neighbour & P Tate (2002) "Patient centredness in the MRCGP video examination: analysis of large cohort." *BMJ*. 325 (7366): 691-692.
- Campion PD, NM Butler & AD Cox (1992) "Principle Agendas of Doctors and Patients in General Practice Consultations." *Family Practice*. 9 (2): 181-190.
- Carabine J (2001) "Unmarried motherhood 1830–1990. A genealogical analysis." *In Discourse as data. A guide for analysis*. Wetherell, M, Taylor, S. & Yeats, SJ (ed.) London: Sage: 267-310.
- Carter R & M McCarthy (2006) *Cambridge Grammar of English: A Comprehensive Guide*. Cambridge: Cambridge University Press.
- Cassell EJ (1991) *The nature of suffering and the goals of medicine*. New York: Oxford University Press.
- Chamberlain-Webber J (2004) "What does the GMS contract mean?" *Professional Nurse*. 19 (10): 14-7.
- Charles C, A Gafni & T Whelan (1997) "Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)." *Social Science & Medicine*. 44 (5): 681-692.

Chatwin J, S Collins, I Watt & R Field (2007) "A feeling of equality: Some interactional features that build rapport and mutuality in a therapeutic encounter." *In Patient Participation in Health Care Consultations: Qualitative Perspectives*. Collins, S, N Britten, J Ruusuvuori & A Thompson (eds.) Maidenhead: Open University Press: 83-103.

Cheek J (2004) "At the Margins? Discourse Analysis and Qualitative Research." *Qualitative health research*. 14 (8): 1140-50.

Chew-Graham CA, G Cahill, C Dowrick, A Wearden & S Peters (2008) "Using Multiple Sources of Knowledge to Reach Clinical Understanding of Chronic Fatigue Syndrome." *The Annals of Family Medicine*. 6 (4): 340-348.

Chisholm A & LCJ Askham (2006) *Setting standards: The views of members of the public and doctors on the standards of care and practice they expect of doctors*. Oxford: Picker Institute.

Coleman T (2000) "Using video-recorded consultations for research in primary care: advantages and limitations." *Family Practice*. 17 (5): 422-427.

Collins S (2005) "Explanations in consultations: the combined effectiveness of doctors' and nurses' communication with patients." *Medical Education*. 39 (8): 785-796.

Collins S, N Britten, J Ruusuvuori & A Thompson (2007) *Patient Participation in Health Care Consultations: Qualitative Perspectives*. Maidenhead: Open University Press.

Collins S, N Britten, J Ruusuvuori & A Thompson (2007) "Understanding the process of patient participation." *In Patient Participation in Health Care Consultations: Qualitative Perspectives*. Collins, S, N Britten, J Ruusuvuori & A Thompson (eds.) Maidenhead: Open University Press: 3-40.

Collins S, P Drew, I Watt & V Entwistle (2005) "'Unilateral' and 'bilateral' practitioner approaches in decision-making about treatment." *Social Science & Medicine*. 61 (12): 2611-2627.

Collins S, S Peters & I Watt (2011) "Medical communication." *In The Routledge Handbook of Applied Linguistics*. Simpson, J (ed.): Taylor & Francis Group: 96-110.

Coulthard M (1985) *An introduction to discourse analysis*. London: Longman.

Coupland J, N Coupland & JD Robinson (1992) "'How are you?': Negotiating phatic communion." *Language in Society*. 21 (02): 207-230.

Coupland J, JD Robinson & N Coupland (1994) "Frame Negotiation in Doctor Elderly Patient Consultations." *Discourse & Society*. 5 (1): 89-124.

Cox A (1989) "Eliciting patients' feelings." *In Communicating with medical patients*. Stewart, M & D Roter (eds.) London: Sage Publications.

Cox J & H Mulholland (1993) "An instrument for assessment of videotapes of general practitioners' performance." *British Medical Journal*. 306 (6884): 1043-1046.

Crabtree BF & WL Miller (1999) *Doing qualitative research*. London: Sage Publications.

Crisp N (2005) *Chief Executive's Report to the NHS*. London: Department of Health.

Culpeper J (2009) *Impoliteness: Using and Understanding the Language of Offence*. ESRC project website. [online]. Accessed 20/07/2012. Available from: <http://www.lancs.ac.uk/fass/projects/impoliteness/>.

Dale J, H Sandhu, R Lall & E Glucksman (2008) "The patient, the doctor and the emergency department: A cross-sectional study of patient-centredness in 1990 and 2005." *Patient Education and Counseling*. 72 (2): 320-329.

Davey HM, J Lim, PN Butow, AL Barratt & S Redman (2004) "Women's preferences for and views on decision-making for diagnostic tests." *Social Science & Medicine*. 58 (9): 1699-1707.

de Haes H (2006) "Dilemmas in patient centeredness and shared decision making: A case for vulnerability." *Patient Education and Counseling*. 62 (3): 291-298.

de la Croix A & J Skelton (2009) "The reality of role-play: interruptions and amount of talk in simulated consultations." *Medical Education*. 43 (7): 695-703.

Degner L & J Sloan (1992) "Decision making during serious illness: What role do patients really want to play?" *Journal of Clinical Epidemiology*. 45 (9): 941-50.

Degner LF, LJ Kristjanson, D Bowman, JA Sloan, KC Carriere, J O'Neil, B Bilodeau, P Watson & B Mueller (1997) "Information needs and decisional preferences in women with breast cancer." *JAMA*. 277 (18): 1485-1492.

DoH (1995) *Target payments, cervical cytology* [online]. SFA Scotland. Accessed 06/01/11. Available from: <http://www.sfa.scot.nhs.uk/>.

DoH (1999) *Protecting and using patient information: A manual for Caldicott Guardians*. London: Department of Health.

DoH (2000) *Department of Health, NHS Plan. A plan for investment. A plan for reform*. London: Department of Health.

DoH (2001) *The expert patient: A new approach to chronic disease management for the 21st century*. London: Department of Health.

DoH (2003a) *Building on the best: choice, responsiveness and equity in the NHS*. London: Department of Health.

DoH (2003b) *Investing in General Practice: The New General Medical Services Contract*. London: Department of Health.

DoH (2003c) *Investing in general practice: the new general medical services contract. Annex A: Quality indicators - Summary of points*. London: Department of Health.

- DoH (2004) *Choosing Health white paper* London: Department of Health.
- DoH (2004) *Quality and Outcomes Framework* [online]. London Department of Health, UK. Accessed 13/12/10. Available from: <http://www.dh.gov.uk/en/Healthcare/Primarycare/PMC/Quality/OutcomesFramework/index.htm>.
- DoH (2006) *Choice Agenda* [online]. Department of Health, UK. Accessed 15/5/06. Available from: http://www.dh.gov.uk/SiteMap/AZSiteIndex/fs/en?CONTENT_ID=4067705&chk=T2hswg.
- DoH (2009a) *Implementation of the right to choice and information set out in the NHS Constitution*. London: Department of Health.
- DoH (2009b) *Enabling choice* [online]. Department of Health, UK. Accessed 8/6/09. Available from: <http://www.dh.gov.uk/en/Healthcare/PatientChoice/Enablingchoice/index.htm>.
- DoH (2010) *Equity and excellence: Liberating the NHS* [online]. Department of Health, UK. Accessed 19/07/2010. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf.
- DoH (2011a) *How DH works* [online]. Department of Health, UK. Accessed 03/02/2011. Available from: <http://www.dh.gov.uk/en/Aboutus/HowDHworks/index.htm>.
- DoH (2011b) *Health and Social Care Bill* [online]. Department of Health, UK. Accessed 20/0/2011. Available from: <http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.i-v.html>.
- DoH (2012) *The month: for the NHS leadership community*. Department of Health, UK.
- Doran T, C Fullwood, H Gravelle, D Reeves, E Kontopantelis, U Hiroeh & M Roland (2006) "Pay-for-performance programs in family practices in the United Kingdom." *New England Journal of Medicine*. 355 (4): 375.
- Dowell J, A Jones & D Snadden (2002) "Exploring medication use to seek concordance with 'non-adherent' patients: a qualitative study." *British Journal of General Practice*. 52 (474): 24-32.
- Drew P (2005) "Conversation analysis." *In Handbook of language and social interaction*. Fitch, KL & RE Sanders (eds.) London: Lawrence Erlbaum Associates: 71-102.
- Drummond K & R Hopper (1993) "Back channels revisited: acknowledgment tokens and speakership incipency." *Research on Language and Social Interaction*. 26 (2): 157-177.
- Edgar I (1996) *Health & society part 1 bachelors' module*. Durham University.

Edwards A & G Elwyn (2006) "Inside the black box of shared decision making: distinguishing between the process of involvement and who makes the decision." *Health Expectations*. 9: 307–320.

Edwards A, G Elwyn, K Hood, M Robling, C Atwell, M Holmes-Rovner, P Kinnersley, H Houston & I Russell (2003) "The development of COMRADE - a patient-based outcome measure to evaluate the effectiveness of risk communication and treatment decision making in consultations." *Patient Education and Counseling*. 50 (3): 311-322.

Edwards D & J Potter (1992) *Discursive psychology*. London: Sage.

Edwards M, M Davies & A Edwards (2009) "What are the external influences on information exchange and shared decision-making in healthcare consultations: a meta-synthesis of the literature." *Patient Education & Counseling*. 75 (1): 37-52.

Eelen G (2001) *A critique of politeness theories*. Manchester: St. Jerome's Press.

Elwyn G (2006) "Idealistic, impractical, impossible? Shared decision making in the real world." *British Journal of General Practice*. 56: 403-404.

Elwyn G, A Edwards & P Kinnersley (1999) "Shared decision-making in primary care: the neglected second half of the consultation." *British Journal of General Practice*. 49: 477-482.

Elwyn G, A Edwards, S Mowle, M Wensing, C Wilkinson, P Kinnersley & R Grol (2001a) "Measuring the involvement of patients in shared decision-making: a systematic review of instruments." *Patient Education and Counseling*. 43 (1): 5-22.

Elwyn G, A Edwards, M Wensing, R Hibbs, C Wilkinson & R Grol (2001b) "Shared decision making observed in clinical practice: visual displays of communication sequence and patterns." *Journal of Evaluation in Clinical Practice*. 7 (2): 211-221.

Engel GL (1977) "The Need for a New Medical Model: A Challenge for Biomedicine." *Science*. 196 (4286): 129-136.

Entwistle VA, T Sheldon, A Sowden & I Watt (1998) "Evidence-informed patient choice. Practical issues of involving patients in decisions about health care technologies." *International Journal of Technology Assessment in Health Care* 14 (2): 212-225.

Epstein RM, P Franks, K Fiscella, CG Shields, SC Meldrum, RL Kravitz & PR Duberstein (2005) "Measuring patient-centered communication in Patient-Physician consultations: Theoretical and practical issues." *Social Science & Medicine*. 61 (7): 1516-1528.

Ervin-Tripp S (1976) "Is Sybil there? The structure of some American English directives." *Language in Society*. 5 (1): 25-66.

Eva KW & GR Norman (2005) "Heuristics and biases a biased perspective on clinical reasoning." *Medical Education*. 39 (9): 870-872.

- Eyssen IC, MP Steultjens, J Dekker & CB Terwee (2011) "A Systematic Review of Instruments Assessing Participation: Challenges in Defining Participation." *Archives of Physical Medicine and Rehabilitation*. 92 (6): 983-997.
- Fairclough N (2001) "The Discourse of New Labour: Critical Discourse Analysis." *In Discourse as data. A guide for analysis*. Wetherell, M, Taylor, S. & Yeats, SJ (ed.) London: Sage: 229-266.
- Fairclough NL (1989) *Language and power*. Harlow: Longman.
- Fairclough NL (1992) *Critical Language Awareness*. London: Longman.
- Fairclough NL (1995) *Critical Discourse Analysis: Papers in the Critical Study of Language*. London: Longman.
- Feinmann J (2011) "Shared decision making is not always a priority for patients, website finds." *BMJ*. 342: :d1881.
- Field S (1995) "The use of video recording in general practice education: a survey of trainers in the West Midlands region." *Education for General Practice*. 6: 49-58.
- Fletcher C (1980) "Listening and talking to patients. I: The problem." *BMJ*. 281 (6244): 845-847.
- Foucault M (1963) *Naissance de la clinique - une archéologie du regard médical*. Paris: PUF (*The Birth of the Clinic: An Archaeology of Medical Perception*).
- Francis R (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry*. Norwich, The Stationery Office.
- Fraser B (1990) "Perspectives on politeness." *Journal of Pragmatics*. 14 (2): 219-236.
- Fraser B & W Nolen (1981) "The association of deference with linguistic form." *International Journal of the Sociology of Language*. 27: 93-109.
- Freedman B (1993) "Offering truth. One ethical approach to the uninformed cancer patient." *Archives of Internal Medicine*. 153 (5): 572-6.
- Gafaranga J & N Britten (2007) "Patient participation in formulating and opening sequences." *In Patient Participation in Health Care Consultations: Qualitative Perspectives*. Collins, S, N Britten, J Ruusuvaori & A Thompson (eds.) Maidenhead: Open University Press: 104-120.
- Gask L, D Goldberg, AL Lesser & T Millar (1988) "Improving the psychiatric skills of the general practice trainee: an evaluation of a group training course." *Medical Education*. 22 (2): 132-138.
- Gaston CM & G Mitchell (2005) "Information giving and decision-making in patients with advanced cancer: A systematic review." *Social Science & Medicine*. 61 (10): 2252-2264.

- Giles H, N Coupland & J Coupland (1991) *Contexts of accommodation*. Cambridge: Cambridge University Press.
- Gillespie R, D Florin & S Gillam (2002) *Changing Relationships : Findings from the Patient Involvement Project*. London: King's Fund.
- Glaser B & A Strauss (1967) *Grounded Theory: The Discovery of Grounded Theory*. New York: de Gruyter.
- GMC (2001) *Good Medical Practice*. London: General Medical Council.
- GMC (2002) *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*. London: General Medical Council.
- GMC (2006) *Good Medical Practice*. London: General Medical Council.
- GMC (2009) *Tomorrow's Doctors*. London: General Medical Council.
- GMC (2012) *Good Medical Practice 2012: Draft for consultation* [online]. Available from: http://www.gmc-uk.org/Good_Medical_Practice_2012___Draft_for_consultation.pdf_45081179.pdf.
- GMC (2012) *Your feedback: What makes a good doctor?* [online]. Accessed 11/02/2013. Available from: <http://www.gmc-uk.org/guidance/10059.asp>.
- Goffman E (1967) *Interaction ritual: Essays in face to face behavior*. New York: Garden City.
- Goodyear-Smith F & S Buetow (2001) "Power issues in the doctor-patient relationship." *Health Care Analysis*. 9 (4): 449-62.
- Gore J & J Ogden (1998) "Developing, validating and consolidating the doctor-patient relationship: the patients' views of a dynamic process." *British Journal of General Practice*. 48 (432): 1391-1394.
- Grainger K (c2002) *Working Papers on the Web: Politeness or Impoliteness?: Verbal Play on the Hospital Ward* [online]. (taken from her PhD thesis at Sheffield Hallam University) Linguistic Politeness Research Group. 2006. Available from: <http://extra.shu.ac.uk/wpw/politeness/grainger.htm>.
- Grice HP (1975) "Logic and Conversation." *In Syntax and Semantics 3: Speech Acts*. Cole P & M J (eds.) New York: Academic Press: pp41-58.
- Grice P (1989) *Studies in the way of words* Cambridge MA: Harvard University Press.
- Gu Y (1990) "Politeness phenomena in modern Chinese." *Journal of pragmatics*. 14 (2): 237-257.
- Guadagnoli E & P Ward (1998) "Patient participation in decision-making." *Social Science & Medicine*. 47 (3): 329-339.

- Gulland A (2011) "Welcome to the century of the patient." *BMJ*. 342: d2057.
- Gwyn R & G Elwyn (1999) "When is a shared decision not (quite) a shared decision? Negotiating preferences in a general practice encounter." *Social Science & Medicine*. 49 (4): 437-447.
- Hack T, LF Degner & DG Dyck (1994) "Relationship between preferences for decisional control and illness information among women with breast cancer: a quantitative and qualitative analysis." *Social Science & Medicine*. 39 (2): 279-89.
- Hack TF, LF Degner, P Watson & L Sinha (2006) "Do patients benefit from participating in medical decision making? Longitudinal follow-up of women with breast cancer." *Psycho-Oncology*. 15 (1): 9-19.
- Hak T (1999) ""Text" and" con-text": Talk bias in studies of health care work." *In Talk, Work and Institutional Order. Discourse in Medical, Mediation and Management Settings*. Sarangi, S & C Roberts (eds.) Berlin: Mouton de Gruyter: 427-452.
- Halliday MAK (2004) *An introduction to functional grammar*. London: Hodder Arnold.
- Hamann J, R Cohen, S Leucht, R Busch & W Kissling (2005) "Do patients with schizophrenia wish to be involved in decisions about their medical treatment?" *American Journal of Psychiatry*. 162 (12): 2382-2384.
- Harris S (2001) "Being Politically Impolite: Extending Politeness Theory to Adversarial Political Discourse." *Discourse & Society*. 12 (4): 451-472.
- Harris S (2003) "Politeness and power: Making and responding to 'requests' in institutional settings." *Text*. 23 (1): 27-52.
- Harris S (2003) "Politeness and power: Making and responding to requests in institutional settings." *Text-Interdisciplinary Journal for the Study of Discourse*. 23 (1): 27-52.
- Haynes BR, AK McKibbin & R Kanani (1996) "Systematic review of randomised trials of interventions to assist patients to follow prescriptions for medications." *The Lancet*. 348 (9024): 383-386.
- Hays RB (1990) "Assessment of general practice consultations: content validity of a rating scale." *Medical Education*. 24 (2): 110-116.
- Haywood K, S Marshall & R Fitzpatrick (2006) "Patient participation in the consultation process: A structured review of intervention strategies." *Patient Education and Counseling*. 63 (1-2): 12-23.
- Heath C (1992) "The delivery and reception of diagnosis in the general-practice consultation." *In Talk at work: Interaction in institutional settings*. Drew, P & J Heritage (eds.) Cambridge: Cambridge University Press: 235-267.

- Heinz B (2003) "Backchannel responses as strategic responses in bilingual speakers' conversations." *Journal of Pragmatics*. 35 (7): 1113-1142.
- Hellenthal N & L Ellison (2008) "How patients make treatment choices." *Nature Clinical Practice Urology*. 5 (8): 426-33.
- Helman C (2001) *Culture, Health and Illness*. London: Hodder Arnold.
- Henbest RJ & MA Stewart (1989) "Patient-centeredness in the consultation. 1: a method for measurement." *Family Practice*. 6 (4): 249.
- Henderson A, D Shum & W-T Chien (2006) "The development of picture cards and their use in ascertaining characteristics of Chinese surgical patients' decision-making preferences." *Health Expectations*. 9 (1): 13-24.
- Heritage J (2009) "Negotiating the Legitimacy of Medical Problems: A Multi-phase Concern for Patients and Physicians." *In Communicating to Manage Health and Illness*. Brashers, D & D Goldsmith (eds.) New York: Routledge: 161-178.
- Heritage J & DW Maynard (2006) "Problems and Prospects in the Study of Physician-Patient Interaction: 30 Years of Research." *Annual Review of Sociology*. 32 (1): 351-374.
- Heritage J & S Sefi (1992) "Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first time mothers." *In Talk at Work: Interaction in Institutional Settings*. Drew P & H J (eds.) Cambridge, UK: Cambridge University Press: 359-417.
- Herzmark G (1985) "Reactions of patients to video recording of consultations in general practice." *British Medical Journal Clinical Research Ed*. 291 (6491): 315-7.
- Holmes J (1984) "Modifying illocutionary force." *Journal of Pragmatics*. 8 (3): 345-365.
- Holmes J (1995) *Women, men and politeness*. London: Longman.
- Holmes J (2000) "Politeness, Power and Provocation: How Humour Functions in the Workplace." *Discourse Studies*. 2 (2): 159-185.
- Holmes J, M Marra & B Vine (2012) "Politeness and impoliteness in ethnic varieties of New Zealand English." *Journal of Pragmatics*. 44 (9): 1063-1076.
- Holmes J & M Stubbe (2003) *Power and politeness in the workplace : A sociolinguistic analysis of talk at work*. London: Longman.
- Holtgraves T (1992) "The linguistic realization of face management: Implications for language production and comprehension, person perception, and cross-cultural communication." *Social Psychology Quarterly*. 55 (2): 141-159.
- Houtkoop (1986) "Summarizing in doctor-patient interaction." *In Discourse analysis and public life: Papers of the Groningen Conference on Medical and Political Discourse*. Ensink, T, A van Essen & T van der Geest (eds.) Dordrecht: Foris: 201-224.

Hoving C, A Visser, PD Mullen & B van den Borne (2010) "A history of patient education by health professionals in Europe and North America: from authority to shared decision making education." *Patient Education & Counseling*. 78 (3): 275-81.

Howe A (1996) "Detecting psychological distress: can general practitioners improve their own performance?" *British Journal of General Practice*. 46 (408): 407-410.

Howie JGR, DJ Heaney, M Maxwell, JJ Walker, GK Freeman & H Rai (1999) "Quality at general practice consultations: cross sectional survey." *BMJ*. 319 (7212): 738-743.

Huisman M (2001) *Ethno/CA News: Recent PhD's - Marjan Huisman* [online]. Summary of thesis entitled "Besluitvorming in vergaderingen: organisaties, interactie en taalgebruik" [Decision making in meetings: Organisations, interaction and language use] The Free University of Amsterdam. Accessed 11/03/2010. Available from: <http://www2.fmg.uva.nl/emca/phds.htm#Marjan>.

Humphris GM & S Kaney (2000) "The Objective Structured Video Exam for assessment of communication skills." *Medical Education*. 34 (11): 939-945.

Hurwitz B, T Greenhalgh & V Skultans (2008) *Narrative Research in Health and Illness*. John Wiley & Sons.

Huygen FJ, HG Mokkink, A J Smits, J A van Son, W A Meyboom & JTv Eyk (1992) "Relationship between the working styles of general practitioners and the health status of their patients." *British Journal of General Practice*. 42 (357): 141-44.

Hyland K (1996) "Writing Without Conviction? Hedging in Science Research Articles." *Applied Linguistics*. 17 (4): 433-454.

Ide S (1982) "Japanese sociolinguistics: Politeness and women's language." *Lingua*. 57 (2-4): 357-385.

Ide S (1989) "Formal forms and discernment: two neglected aspects of linguistic politeness." *Multilingua*. 12 (1).

Jarosch J & F Allhoff (2001) "Appendix B - Ethics and Patient-Centered Communication." In *An Ethical Force Program™ Consensus Report. Improving Communication - Improving Care*. Association, AM (ed.): American Medical Association: 103-8.

Jefferson G (1984a) "On the organisation of laughter in talk troubles." In *Structures of Social Action: Studies in Conversation Analysis*. Atkinson, M & J Heritage (eds.) Cambridge: Cambridge University Press: 346-369.

Jefferson G (1984b) "Transcript Notation." In *Structures of Social Action: Studies in Conversation Analysis*. Atkinson, M & J Heritage (eds.) Cambridge: Cambridge University Press: ix-xvi.

Jones A & S Collins (2007) "Nursing assessments and other tasks: Influences on participation in interactions between patients and nurses." In *Patient Participation in Health Care*

Consultations: Qualitative Perspectives. Collins, S, N Britten, J Ruusuvaori & A Thompson (eds.) Maidenhead: Open University Press: 143-163.

Jones R (1995) "Why do qualitative research?" *BMJ*. 311 (6996): 2.

Joosten EAG, L DeFuentes-Merillas, GH de Weert, T Sensky, CPF van der Staak & CAJ de Jong (2008) "Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status." *Psychotherapy & Psychosomatics*. 77 (4): 219-26.

Jowett SM, J Macleod, S Wilson & FD Hobbs (2000) "Research in primary care: extent of involvement and perceived determinants among practitioners from one English region." *The British Journal of General Practice*. 50 (454): 387.

Kahn G, B Cohen & H Jason (1979) "Teaching interpersonal skills in family practice: results of a national survey." *Journal of Family Practice*. 8 (2): 309-16.

Kahneman D & A Tversky (2000) *Choices, values, and frames*. Cambridge: Cambridge University Press.

Kaner E, B Heaven, T Rapley, M Murtagh, R Graham, R Thomson & C May (2007) "Medical communication and technology: a video-based process study of the use of decision aids in primary care consultations." *BMC Medical Informatics and Decision Making*. 7 (1): 2.

Kaplan M (1996) *Decision theory as philosophy*. Cambridge: Cambridge University Press.

Kaplan RM (2004) "Shared medical decision making: A new tool for preventive medicine." *American Journal of Preventive Medicine*. 26 (1): 81-83.

Kaplan S, S Greenfield & J Ware (1989) "Assessing the effects of physician-patient interactions on the outcomes of chronic disease." *Medical Care* 27(suppl): S110-S127.

Kasper G (1990) "Linguistic politeness: Current research issues." *Journal of Pragmatics*. 14 (2): 193-218.

Keirns CC & SD Goold (2009) "Patient-Centered Care and Preference-Sensitive Decision Making." *JAMA*. 302 (16): 1805-1806.

Kenny P, S Quine, A Shiell & S Cameron (1999) "Participation in treatment decision-making by women with early stage breast cancer." *Health Expectations*. 2: 159-68.

King M, I Nazareth, F Lampe, P Bower, M Chandler, M Morou, B Sibbald & R Lai (2005) "Conceptual framework and systematic review of the effects of participants' and professionals' preferences in randomised controlled trials." *Health Technology Assessment*. 9 (35): 1-191.

Kinmonth AL, A Woodcock, S Griffin, N Spiegel & MJ Campbell (1998) "Randomised controlled trial of patient centred care of diabetes in general practice: impact on current wellbeing and future disease risk." *BMJ*. 317 (7167): 1202-1208.

Kleinman A (1975) "Explanatory models in health care relationships. Health of the family." *In National Council for International Health (now Global Health Council)*. Washington, DC.

Koester A (2006) *Investigating Workplace Discourse*. London: Routledge.

Kuch C, MP Stoffel, F Scheibler, C Barth & H Pfaff (2005) "Shared-decision making in ESRD: Data from QiN on control preference of patients." *Nephrology Dialysis Transplantation*. 20 (Suppl 5): V326-V326.

Kurtz SM, J Silverman & J Draper (2005) *Teaching And Learning Communication Skills In Medicine*. Oxford: Radcliffe Publishing.

Lakoff (1973) "The logic of politeness."

Lakoff R (1972) "Language in context." *Language*. 48 (4): 907-927.

Lakoff R (1979) "Stylistic strategies within a grammar of style." *In Language sex and gender*. Orasanu, Jea (ed.) The annals of the New York academy of sciences: 53-80.

Lakoff RT (1989) "The limits of politeness: Therapeutic and courtroom discourse." *Multilingua*. 8 (2-3): 101-129.

Lam W, R Fielding, M Chan, L Chow & E Ho (2003) "Participation and Satisfaction with Surgical Treatment Decision-Making in Breast Cancer Among Chinese Women." *Breast Cancer Research & Treatment*. 80 (2): 171-80.

Lambert BL (1995) "Directness and deference in pharmacy students' messages to physicians." *Social Science & Medicine*. 40 (4): 545-555.

Langewitz W, M Denz, A Keller, A Kiss, S Ruttimann & B Wossmer (2002) "Spontaneous talking time at start of consultation in outpatient clinic: cohort study." *BMJ*. 325: 682-3.

Larsen JH & O Risor (1997) "Telephone consultations at the emergency service, Copenhagen County: analysis of doctor-patient communication patterns." *Family Practice*. 14 (5): 387-393.

Laver J (1975) "Communicative functions of phatic communion." *In The organization of behaviour in face-to-face interaction*. Kendon, A, R Harris & M Key (eds.) The Hague: Mouton: 215-38.

Laver J (1981) "Linguistic routines and politeness in greeting and parting." *In Conversational routine*. Coulmas, F (ed.) The Hague: Mouton: 289-304.

Layton R (1997) *An introduction to theory in anthropology*. Cambridge: Cambridge University Press.

Lee A & H Wu (2002) "Diagnosis disclosure in cancer patients - when the family says "no!"" *Singapore Medical Journal*. 43 (10): 533-8.

Leech G & J Svartvik (1975) *A communicative grammar of English*. London: Longman.

Leech GN (1980) *Explorations in semantics and pragmatics*. Amsterdam: John Benjamins Publishing Company.

Leech GN (1983) *Principles of pragmatics*. London: Longman Publishing Group.

Lester H, L Tait, E England & J Tritter (2006) "Patient involvement in primary care mental health: a focus group study." *British Journal of General Practice*. 56: 415-422.

Levenstein J, JB Belle, W Weston, M Stewart, E McCracken & I McWhinney (1989) "Patient-centred clinical interviewing." *In Communicating with medical patients*. Stewart, M & D Roter (eds.) London: Sage Publications: 107-120.

Levinson S (1983) *Pragmatics*. Cambridge: Cambridge University Press.

Levinson W, R Gorawara-Bhat & J Lamb (2000) "A study of patient clues and physician responses in primary care and surgical settings." *JAMA*. 284: 1021-7.

Levinson W & D Roter (1993) "The effects of two continuing medical education programs on communication skills of practicing primary care physicians." *Journal of General Internal Medicine*. 8 (6): 318-324.

Lewin S, Z Skea, V Entwistle, M Zwarenstein & J Dick (2001) "Interventions for providers to promote a patient-centred approach in clinical consultations (Review)." *Cochrane Database of Systematic Reviews* (4): Art. No.: CD003267. DOI: 10.1002/14651858.CD003267.

Lindesmith ARAaOC, IL: Aldine- (1968) *Addiction and Opiates*. Chicago, IL: Aldine-Atherton.

Lipkin MJ, T Quill & R Napodano (1984) "The medical interview: a core curriculum for residencies in internal medicine." *Annals Internal Medicine*. 100 (2): 277-84.

Locher MA & RJ Watts (2005) "Politeness theory and relational work." *Journal of Politeness Research. Language, Behaviour, Culture*. 1 (1): 9-33.

Lohrova H (2011) *Internal meetings: The process of decision-making in workplace discourse*. PhD thesis: University of Birmingham.

LPRG (2008) "Fourth International Symposium on Politeness: 'East meet West'." *In Linguistic Politeness Research Group*. Budapest, Hungary, 2nd-4th July.

LPRG (c2002) *Working Papers on the Web: Vol 3* [online]. Linguistic Politeness Research Group. 2006. Available from: <http://extra.shu.ac.uk/wpw/politeness/>.

Maguire P, S Fairbairn & C Fletcher (1986) "Consultation skills of young doctors: I--Benefits of feedback training in interviewing as students persist." *Br Med J (Clin Res Ed)*. 292 (6535): 1573-1576.

Makoul G (2001) "Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement." *Academic Medicine*. 76 (4): 390-393.

- Makoul G & ML Clayman (2006) "An integrative model of shared decision making in medical encounters." *Patient Education and Counseling*. 60 (3): 301-312.
- Malmkjær K (1991) *The linguistics encyclopedia*. London: Routledge.
- Marinker M (1997) *From compliance to concordance: achieving shared goals in medicine taking*. London: Royal Pharmaceutical Society of Great Britain.
- Marinker M & J Shaw (2003) "Not to be taken as directed." *BMJ*. 326 (7385): 348-349.
- Marra M (2003) *Decisions in New Zealand business meetings: A sociolinguistic analysis of power at work*. PhD thesis: Victoria University of Wellington.
- Marshall T, S Bryan, P Gill, S Greenfield & K Guttridge (2006) "Predictors of patients' preferences for treatments to prevent heart disease." *Heart*. 92 (11): 1651-1655.
- Martin E & PM Martin (1984) "The reactions of patients to a video camera in the consulting room." *Journal of the Royal College of General Practitioners*. 34 (268): 607-10.
- Maxwell G (1976) *An evaluation of social skills training*. University of Otago.
- Maynard DW & J Heritage (2005) "Conversation analysis, doctor-patient interaction and medical communication." *Medical Education*. 39 (4): 428-435.
- McGivern G & R Adams (2006) "Clinically owned reflective practice and tick box exercises: comparative analysis of GP and consultant appraisal in practice." *Clinician in Management*. 14 (3): 129-141.
- McGregor S (2006) "Roles, power and subjective choice." *Patient education and counseling*. 60 (1): 5-9.
- McKenna C (2002) "GPs vote "yes" for new contract framework." *BMJ*. 325 (7356): 119.
- McKinlay J, C Link, S Arber, L Marceau, A O'Donnell & A Adams (2006) "How Do Doctors in Different Countries Manage the Same Patient? Results of a Factorial Experiment." *Health Services Research*. 41 (6): 2182-2200.
- McWhinney I (1989) "The need for a transformed clinical method." *In Communicating with medical patients*. Stewart, M & D Roter (eds.) London: Sage Publications: 25-40.
- McWhinney R (1981) *An introduction to family medicine*. New York: Open University Press.
- McWilliam CL, JB Brown & M Stewart (2000) "Breast cancer patients' experiences of patient-doctor communication: a working relationship." *Patient Education and Counseling*. 39 (2-3): 191-204.
- Mead N & P Bower (2000) "Patient-centredness: a conceptual framework and review of the empirical literature." *Social Science & Medicine*. 51 (7): 1087-1110.

- Mertens D (2004) *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods*. Thousand Oaks CA: SAGE Publications.
- Merz JF & B Fischhoff (1990) "Informed consent does not mean rational consent: Cognitive limitations on decision making." *Journal of Legal Medicine*. 11: 321-50.
- Meyer TM & MM Mark (1995) "Effects of psychosocial interventions with adult cancer patients: A meta-analysis of randomized experiments." *Health Psychology*. 14 (2): 101-8.
- Middleton JF, RK McKinley & CL Gillies (2006) "Effect of patient completed agenda forms and doctors' education about the agenda on the outcome of consultations: randomised controlled trial." *British Medical Journal*. 332 (7552): 1238-41.
- Miles MB & AM Huberman (1984) *Qualitative data analysis : a sourcebook of new methods*. Beverly Hills: Sage Publications.
- Milne R & S Oliver (1996) "Evidence-based Consumer Health Information: Developing Teaching in Critical Appraisal Skills." *International Journal for Quality in Health Care*. 8 (5): 439-445.
- Mishler EG (1984) *The Discourse of Medicine: Dialectics of Medical Interviews*. Greenwood Publishing Group.
- Moumjid N, A Gafni, A Bremond & M-O Carrere (2007) "Shared decision making in the medical encounter: are we all talking about the same thing?" *Medical Decision Making*. 27 (5): 539-46.
- Neighbour R (1987) *The inner consultation : how to develop an effective and intuitive consultation*. Lancaster: MTP Press Limited.
- NHS (2007) *The Expert Patients Programme* [online]. National Health Service. Accessed Sept 2011. 2011. Available from: <http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/expert-patients-programme.aspx>.
- NHS (2010) *National service frameworks and strategies* [online]. National Health Service. Last updated 01/02/2010. Accessed 06/01/11. Available from: <http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx>.
- North M (2002) *Greek Medicine* [online]. Bethesda National Library of Medicine. Accessed 01/11/10. Available from: http://www.nlm.nih.gov/hmd/greek/greek_oath.html.
- O'Driscoll J (2007) "Brown & Levinson's face: How it can-and can't-help us to understand interaction across cultures." *Intercultural Pragmatics*. 4 (4): 463-492.
- OED Online (1989a) "*decision, n*" [online]. The Oxford English Dictionary. 2nd ed Oxford University Press. Accessed March 2008. Available from: <http://www.oed.com/services/citing.html>.

OED Online (1989b) "*polite, n*" [online]. The Oxford English Dictionary. 2nd ed Oxford University Press. Accessed June 2008. Available from: <http://dictionary.oed.com/cgi/entry/50182865>.

OED Online (1989c) "*politeness, adj*" [online]. The Oxford English Dictionary. 2nd ed. Oxford University Press. Accessed 16/12/08. Available from: <http://dictionary.oed.com/cgi/entry/50182861>.

Ong LML, JCJM de Haes, AM Hoos & FB Lammes (1995) "Doctor-patient communication: A review of the literature." *Social Science & Medicine*. 40 (7): 903-918.

Pan A, Q Sun, A Bernstein, M Schulze, J Manson, M Stampfer, W Willett & F Hu (2012) "Red meat consumption and mortality: Results from 2 prospective cohort studies." *Archives of Internal Medicine*. 172 (7): 555-563.

Parsons T (1951) *The social system*. New York: Free Press.

Patton MQ (2001) *Qualitative Research & Evaluation Methods*. SAGE Publications.

Pendleton D & J Hasler (1983) *Doctor-patient communication*. London: Academic Press.

Pendleton D, T Schofield, P Tate & P Havelock (1984) *The consultation. An approach to learning and teaching*. Oxford: Oxford University Press.

Peräkylä A & J Ruusuvuori (2007) "Components of participation in health care consultations: A conceptual model for research." *In Patient Participation in Health Care Consultations: Qualitative Perspectives*. Collins, S, N Britten, J Ruusuvuori & A Thompson (eds.) Maidenhead: Open University Press: 167-175.

Pilnick A (1998) "‘Why Didn’t You Say Just That?’ Dealing with Issues of Asymmetry, Knowledge and Competence in the Pharmacist/client Encounter." *Sociology of Health & Illness*. 20 (1): 29-51.

Pilnick A & R Dingwall (2011) "On the remarkable persistence of asymmetry in doctor/patient interaction: A critical review." *Social Science & Medicine*. 72 (8): 1374-1382.

Pinker S (2007) "The evolutionary social psychology of off-record indirect speech acts." *Intercultural Pragmatics*. 14 (4): 437-462.

Platt FW, DL Gaspar, JL Coulehan, L Fox, AJ Adler, WW Weston, RC Smith & M Stewart (2001) "Tell Me about Yourself": The Patient-Centered Interview." *Annals of Internal Medicine*. 134 (11): 1079-1085.

Pomerantz A (1978) "Compliment responses: notes on the cooperation of multiple constraints." *In Studies in the organization of conversational interaction*. Schenkein, J (ed.) New York: Academic Press: 79-112.

Pomerantz A (1984) "Agreeing and disagreeing with assessments: some features of preferred/dispreferred turn shapes." *In Structures of social action*. Atkinson, J & J Heritage (eds.) Cambridge: Cambridge University Press: 57-101.

Premi J (1991) "An assessment of 15 years' experience in using videotape review in a family practice residency." *Academic Medicine*. 66 (1): 56-7.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982) *Making Health Care Decisions. The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*. Washington.

Pringle M, S Robins & G Brown (1984) "Assessing the consultation: methods of observing trainees in general practice." *British Medical Journal (Clinical research ed.)*. 288 (6431): 1659-1660.

Pringle M & C Stewart-Evans (1990) "Does awareness of being recording affect doctors' consultation behaviour?" *British Journal of General Practice*. 40 (340): 455-8.

QSR (2006, 2008) *NVivo qualitative data analysis software*. Melbourne: QSR International Pty Ltd.

Quirk R, S Greenbaum, G Leech & J Svartvik (1972) *A grammar of contemporary English*. Harlow, Essex: Longman.

RCGP (1972) *The Future GP: Learning and Teaching*. London: Royal College of General Practitioners/BMJ Publications.

RCGP (2005) *General Practice in the UK: A Basic Overview*. *RCGP Information Sheet No4* [online]. Royal College of General Practitioners. Accessed 13/07/09. Available from: http://www.rcgp.org.uk/pdf/ISS_INFO_04_MAY05.pdf.

RCGP (2008) *Good Medical Practice for General Practitioners*. London: Royal College of General Practitioners.

RCGP (2009) *Examination for membership (MRCGP): Detailed guide to the performance criteria* [online]. Royal College of General Practitioners. Accessed 4/6/09. Available from: http://www.rcgp.org.uk/gp_training/mrcgp/video_workbook/guidance/performance_criteria.aspx.

RCGP (2010a) *CSA Information for Candidates* [online]. Royal College of General Practitioners. Accessed 4/10/10. 2010. Available from: <http://www.rcgp-curriculum.org.uk/nmrcgp/csa.aspx>.

RCGP (2010b) *Video recording* [online]. Royal College of General Practitioners. Accessed 7/1/11. MRCGP update: September 2010. Available from: <http://www.rcgp-curriculum.org.uk/nmrcgp/csa.aspx>.

RCGP (2011) *The Work of the College* [online]. Royal College of General Practitioners. Accessed 3/2/11. Available from: http://www.rcgp.org.uk/about_us/the_work_of_the_college.aspx.

Reckless WC, D Simon & E Murray (1957) "The 'Good' Boy in a High Delinquency Area." *The Journal of Criminal Law, Criminology, and Police Science*. 48 (1): 18-25.

- Richards L (1999) *Using NVivo in Qualitative Research*. London: Sage Publications.
- Richards T (1998) "Partnership with patients." *BMJ*. 316 (7125): 85-86.
- Richards T (2001) "Empowering consumers." *BMJ*. 322 (7285): 562.
- Richards T (2005) "Introduction " *In Applying conversation analysis*. Richards, K & P Seedhouse (eds.) New York: Palgrave Macmillan.
- Roberts C, V Wass, R Jones, S Sarangi & A Gillett (2003) "A discourse analysis study of 'good' and 'poor' communication in an OSCE: a proposed new framework for teaching students." *Medical Education*. 37 (3): 192-201.
- Robertson M, J Moir, J Skelton, J Dowell & S Cowan (2011) "When the business of sharing treatment decisions is not the same as shared decision making: A discourse analysis of decision sharing in general practice." *Health: An interdisciplinary journal for the social study of health, illness and medicine*. 15 (1): 78-95.
- Robertson ME (2004) *A discourse analysis of the nature of shared decision-making in general practice consultations*. PhD thesis: University of Dundee.
- Robins LS & FM Wolf (1988) "Confrontation and politeness strategies in physician-patient interactions." *Social Science & Medicine*. 27 (3): 217-221.
- Robinson JH, LC Callister, JA Berry & KA Dearing (2008) "Patient-centered care and adherence: definitions and applications to improve outcomes." *Journal of the American Academy of Nurse Practitioners*. 20 (12): 600-7.
- Roethlisberger F & W Dickson (1939) *Management and the Worker*. Cambridge, Mass.: Harvard University Press.
- Rosenstock I (1966) "Why people use health sources." *Milbank Memorial Fund Quarterly*. 44 (3): 94-124.
- Roter D & J Hall (1992) *Doctors talking with patients, patients talking with doctors*. Dover MA: Auburn House.
- Roter D & S Larson (2002) "The Roter interaction analysis system (RIAS): utility and flexibility for analysis of medical interactions." *Patient Education and Counseling*. 46 (4): 243-251.
- Rothenbacher D, MP Lutz & F Porzsolt (1997) "Treatment decisions in palliative cancer care: Patients' preferences for involvement and doctors' knowledge about it." *European Journal of Cancer*. 33 (8): 1184-1189.
- Rutter DR & GP Maguire (1976) "History-taking for medical students : II--evaluation of a training programme." *The Lancet*. 308 (7985): 558-560.

Saba GW, ST Wong, D Schillinger, A Fernandez, CP Somkin, CC Wilson & K Grumbach (2006) "Shared Decision Making and the Experience of Partnership in Primary Care." *Annals of Family Medicine*. 4 (1): 54-62.

Sackett DL, WMC Rosenberg, JAM Gray, RB Haynes & WS Richardson (1996) "Evidence based medicine: what it is and what it isn't." *BMJ*. 312 (7023): 71-72.

Sacks H (1974) "An analysis of the course of a joke's telling in conversation." *In Explorations in the ethnography of speaking*. Bauman, R & J Sherzer (eds.) Cambridge: Cambridge University Press: 337-353.

Sacks H (n.d.) *Aspects of the sequential organisation of conversation*. unpublished lecture series.

Salzburg (2011) "Salzburg statement on shared decision making." *BMJ*. 342 (d1745).

Sandvik M, H Eide, M Lind, PK Graugaard, J Torper & A Finset (2002) "Analyzing medical dialogues: strength and weakness of Roter's interaction analysis system (RIAS)." *Patient Education and Counseling*. 46 (4): 235-241.

Sarangi S & C Roberts (eds.) (1999) "Talk, Work and Institutional Order. Discourse in Medical, Mediation and Management Settings." Berlin: Mouton de Gruyter.

Schwartz A, M Hasnain, AR Eiser, E Lincoln & AS Elstein (2006) "Patient-Physician Fit: An Exploratory Study of a Multidimensional Instrument." *Medical Decision Making*. 26 (2): 122-133.

Searle JR (1969) *Speech acts: An essay in the philosophy of language*. Cambridge: Cambridge University Press.

Shatzman L & A Strauss (1973) *Field research*. Englewood Cliffs, NJ: Prentice Hall.

Sheehan B, Ann Adams & Frances Griffiths (2005) *Improving the detection and management of depression amongst older primary care patients: a feasibility study using video recording* [online]. Accessed 21/10/08. Available from: <http://www2.warwick.ac.uk/fac/med/staff/projects/?ssn=B/gHVJouE1I=&inst=WARWICK>.

Sifianou M (1992) *Politeness phenomena in England and Greece*. Oxford: Clarendon.

SIL (2004b) *What is an elliptical construction?* [online]. Dallas Summer Institute of Linguistics. Accessed 30/01/11. Available from: <http://www.sil.org/linguistics/GlossaryOfLinguisticTerms/WhatIsAnEllipticalConstruction.htm>.

Silverman J, SM Kurtz & J Draper (1998) *Skills for Communicating with Patients*. Oxford: Radcliffe Medical Press.

Siminoff LA (1989) "Cancer patient and physician communication: Progress and continuing problems." *Annals of Behavioral Medicine*. 11: 108-12.

- Simpson M, R Buckman, M Stewart, P Maguire, M Lipkin, D Novack & J Till (1991) "Doctor-patient communication: the Toronto consensus statement." *BMJ*. 303 (6814): 1385-1387.
- Skelton J (2008) *Language and Clinical Communication: This Bright Babylon*. Oxford: Radcliffe Publishing.
- Skelton JR (2005) "Everything you were afraid to ask about communication skills." *British Journal of General Practice*. 55 (510): 40-46.
- Skelton JR & FDR Hobbs (1999) "Concordancing: use of language-based research in medical communication." *The Lancet*. 353 (9147): 108-111.
- Skelton JR, AM Wearn & FDR Hobbs (2002) "'I' and 'we': a concordancing analysis of how doctors and patients use first person pronouns in primary care consultations." *Family Practice*. 19 (5): 484-488.
- Skelton JR & J Whetstone (2012) "English for Medical Purposes and Academic Medicine: looking for common ground." *In Ibérica 24*.
- Slowther A, G Lewando Hundt, R Taylor & J Purkis (2009) *Non UK qualified doctors and Good Medical Practice: The experience of working within a different professional framework. Report for the General Medical Council*. London: General Medical Council.
- Spencer-Oatey H (1992) *Cross-cultural Politeness: British & Chinese Conceptions of the Tutor-student Relationship*. PhD thesis: Lancaster University.
- Spencer-Oatey H (2000a) "Introduction: Language, culture and rapport." *In Culturally speaking: managing rapport through talk across cultures*. Spencer-Oatey, H (ed.) London: Continuum International Publishing Group: 1-8.
- Spencer-Oatey H (2000b) *Culturally speaking: managing rapport through talk across cultures*. London: Continuum International Publishing Group.
- Spencer J (2003) "Learning and teaching in the clinical environment." *BMJ*. 326 (7389): 591-594.
- Spiers J (1998) "The use of facework and politeness theory." *Qualitative Health Research*. 8 (1): 25-47.
- Spiers J (2000) *Saving face: Expressing and negotiating vulnerability in culturally mismatched home care nurse-patient dyads*. PhD thesis: University of California San Francisco.
- Steginga S, S Occhipinti, RA Gardiner, J Yaxley & P Heathcote (2002) "Making decisions about treatment for localized prostate cancer." *BJU International*. 89 (3): 255-260.
- Stevens J (1974) "Brief Encounter." *Journal of the Royal College of General Practitioners*. 24 (5): 5-22.

Stevenson FA, CA Barry, N Britten, N Barber & CP Bradley (2000) "Doctor-patient communication about drugs: the evidence for shared decision making." *Social Science & Medicine*. 50 (6): 829-840.

Stewart M (1995) "Effective physician-patient communication and health outcomes: a review." *Canadian Medical Association Journal*. 152 (9): 1423–1433.

Stewart M, J Belle Brown, WW Weston, IR McWhinney, CL McWilliam & TR Freeman (eds.) (2003) "Patient-centered Medicine: Transforming the Clinical Method." Oxford: Radcliffe Publishing.

Stewart M, J Brown, WW Weston, IR McWhinney, CL McWilliam & TR Freeman (1995) "Studies of health outcomes and patient-centred communication." *In Patient-centered Medicine*. Stewart, M, J Brown, WW Weston, IR McWhinney, CL McWilliam & TR Freeman (eds.) Thousand Oaks, CA: Sage Publications: 185–190.

Stewart M & D Roter (1989) "Introduction." *In Communicating with medical patients*. Stewart, M & D Roter (eds.) London: Sage Publications: 17-23.

Stivers T (2005) "Parent resistance to physicians' treatment recommendations: one resource for initiating a negotiation of the treatment decision." *Health Communication*. 18 (1): 41–74.

Stott N & R Davis (1979) "The exceptional potential in each primary care consultation." *Journal of the Royal College of General Practitioners*. 29 (201): 201-5.

Strauss A & J Corbin (1998) *Basics of Qualitative Research*. Thousand Oaks, California: SAGE Publications.

Street RL (1991) "Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics." *Social Science & Medicine*. 32 (5): 541.

Sullivan CJ (2011) "The utility of the deviant case in the development of criminological theory." *Criminology*. 49 (3): 905-920.

Sullivan F & CW Jeremy (2005) "Why is this patient here today?" *BMJ*. 331 (7518): 678-680.

Sutherland H, H Llewellyn-Thomas, G Lockwood, D Trichler & J Till (1989) "Cancer patients: Their desire for information and participation in treatment decisions." *Journal of the Royal Society of Medicine*. 82 (5): 260-3.

Swan M (1995) *Practical English Usage*. Oxford: Oxford University Press.

Tamblyn RM, DJ Klass, GK Schnabl & ML Kopelow (1991) "The accuracy of standardized patient presentation." *Medical Education*. 25 (2): 100-9.

Tannen D (1992) *Talking Voices: Repetition, Dialogue, and Imagery in Conversational Discourse*. Cambridge: Cambridge University Press.

Taylor J (1989) *Linguistic categorization : prototypes in linguistic theory*. Oxford: Clarendon.

- Taylor K (2009) "Paternalism, participation and partnership - The evolution of patient centeredness in the consultation." *Patient Education and Counseling*. 74 (2): 150-155.
- The Lancet (2011) "Taking shared decision making more seriously." *The Lancet*. 377 (9768): 784-784.
- Thomas J (1995) *Meaning in interaction : an introduction to pragmatics*. London: Longman.
- Thompson A (2007) "The meaning of patient involvement and participation in health care consultations: A taxonomy." *In Patient Participation in Health Care Consultations: Qualitative Perspectives*. Collins, S, N Britten, J Ruusuvuori & A Thompson (eds.) Maidenhead: Open University Press: 43-64.
- Thompson A, J Ruusuvuori, N Britten & S Collins (2007) "An integrative approach to patient participation in consultations." *In Patient Participation in Health Care Consultations: Qualitative Perspectives*. Collins, S, N Britten, J Ruusuvuori & A Thompson (eds.) Maidenhead: Open University Press: 176-193.
- Thompson SC, JS Pitts & L Schwankovsky (1993) "Preference for involvement in medical decision-making situational and demographic influences." *Patient Education and Counseling*. 22: 133-140.
- Towle A & W Godolphin (1999) "Framework for teaching and learning informed shared decision making." *British Medical Journal*. 319 (7212): 766-769.
- Trevena L & A Barratt (2003) "Integrated decision making: definitions for a new discipline." *Patient Education and Counseling*. 50 (3): 265-268.
- Tsui ABM (1994) *English conversation*. Oxford University Press.
- Tylee A, P Freeling & S Kerry (1993) "Why do general practitioners recognize major depression in one woman patient yet miss it in another?" *British Journal of General Practice*. 43 (373): 327-330.
- Tylee A, P Freeling, S Kerry & T Burns (1995) "How does the content of consultations affect the recognition by general practitioners of major depression in women?" *British Journal of General Practice*. 45 (400): 575-8.
- Vainio H, M Hakama, F Bianchini & J Cheney (2005) *Cervix Cancer Screening - IARC Handbooks of Cancer Prevention v. 10*. Oxford: Oxford University Press.
- Van Den Haak MJ, MDT De Jong & PJ Schellens (2003) "Retrospective vs. concurrent think-aloud protocols: testing the usability of an online library catalogue." *Behaviour & Information Technology*. 22 (5): 339.
- Verhaak PFM (1988) "Detection of Psychologic Complaints by General Practitioners." *Medical Care*. 26 (10): 1009-1020.

- Vu NV, MM Marcy, JA Colliver, SJ Verhulst, TA Travis & HS Barrows (1992) "Standardized (simulated) patients' accuracy in recording clinical performance check-list items." *Medical Education*. 26 (2): 99-104.
- Wang J (2006) "Questions and the exercise of power." *Discourse & Society*. 17 (4): 529-48.
- Ward J & R Sanson-Fisher (1996) "Accuracy of Patient Recall of Opportunistic Smoking Cessation Advice in General Practice." *Tobacco Control*. 5 (2): 110-113.
- Wardhaugh R (2006) *An introduction to sociolinguistics*. Oxford: Blackwell Publishing Professional.
- Waterworth S & K Luker (1990) "Reluctant collaborators: do patients want to be involved in decisions concerning care?" *Journal of Advanced Nursing*. 15 (8): 971-6.
- Watts R (2003) *Politeness*. Cambridge: Cambridge University Press.
- Watts RJ (1992) "Linguistic politeness and politic verbal behaviour: Reconsidering claims for universality." *In Politeness in language: Studies in its history, theory, and practice*. Watts, R, S Ide & K Ehlich (eds.) Berlin/New York: Mouton de Gruyter: 43-69.
- Wawer MJ, AAR Tobian, G Kigozi, X Kong, PE Gravitt, D Serwadda, F Nalugoda, F Makumbi, V Ssempiija, N Sewankambo, S Watya, KP Eaton, AE Oliver, MZ Chen, SJ Reynolds, TC Quinn & RH Gray (2011) "Effect of circumcision of HIV-negative men on transmission of human papillomavirus to HIV-negative women: a randomised trial in Rakai, Uganda." *The Lancet*. 377 (9761): 209-218.
- Williams B (1994) "Patient satisfaction: a valid concept?" *Social Science & Medicine*. 38 (4): 509-16.
- Wissow L, D Roter & M Wilson (1994) "Pediatrician interview style and mothers' disclosure of psychosocial issues." *Pediatrics*. 93: 289-95.
- Wolf A, Nasser JF, Wolf AM & S JB. (1996) "The impact of informed consent on patient interest in prostate-specific antigen screening." *Archives of Internal Medicine*. 156 (12): 1333-6.
- Woods D & C Fassnacht (2006, 2008) *Transana v2.3 & v2.12*. <http://www.transana.org>. Madison, WI: The Board of Regents of the University of Wisconsin System.
- Wooffitt R (2010) *Conversation analysis and discourse analysis: A comparative and critical introduction*. London: Sage Publications.